ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES: PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, Ken Johnson, Amy Heppner, and Laurie Kirkwood provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley, Carolyn, Ken, Amy, and Laurie are senior members in the Health Benefits Practice. Answers are provided as *general guidance* on the subjects covered in the question and are *not provided as legal advice* to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

YEAR-END HEALTH BENEFITS ROUND UP—2022

The beginning of 2022 was already shaping up to be a busy year for health plans, with several provisions from the Consolidated Appropriations Act, 2021 ("CAA") going into effect, the expected release of the biennial Report to Congress for compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA"), and COVID-19 still at the top of the news cycle. And then came the opinion in *Dobbs v. Jackson Women's Health Organization (Dobbs*). What a year it has been!

In this article we revisit some of the most pressing issues for employers, plan sponsors, plan administrators and service providers, and health insurers and provide some practice pointers heading into 2023.

CONSOLIDATED APPROPRIATIONS ACT OF 2021 ("CAA")

The CAA established protections for consumers related to transparency in health care, comparative analyses requirements under MHPAEA, compensation disclosure requirements for indirect compensation received by brokers and consultants, prescription drug reporting, and no "gag clauses" in service agreements.

The CAA also added the No Surprises Act ("NSA"), which addresses several patient protections such as surprise billing, ID cards, provider directory requirements, maintenance of a price comparison tool, and continuity of care requirements.

Generally, except as otherwise noted, the CAA requirements are applicable to most group health plans, including grandfathered plans, but are not applicable to excepted benefits, account-based plans (e.g., HRAs, FSAs) or stand-alone retiree health plans.

CAA/TRANSPARENCY--PRESCRIPTION DRUG REPORTING

The CAA requires group health plans and health insurers to report to CMS certain information related to medical and prescription drug spending. The initial report is due December 27, 2022, with annual reporting required every June 1 thereafter (for the prior calendar year).

Fully-insured plans are able to shift the reporting burden to the insurance carrier entirely by written agreement, and the liability for failure to report shifts to the carrier.

Self-insured plans are also able to relieve themselves of the reporting obligation by entering into a written agreement with TPA or pharmacy benefit manager ("PBM") to take on some or all of the reporting responsibility, but liability for any reporting failures of the TPA or PBM remain with the plan itself.

For many plans, coordination will be required among the plan sponsor, TPA, and PBM to ensure that all the required information is submitted on time, which will be challenging for plans with multiple vendors and/or benefit package options.

Initially, the Centers for Medicare & Medicaid Services ("CMS") was allowing just one data file per plan, but this restriction has proven to be too limiting.

CMS issued new guidance in time for the upcoming initial filing deadline on December 27, 2022, confirming that it will accept multiple data files of the same type from the same group health plan if "extenuating circumstances" prevent vendors from working with each other. CMS will use the plan-level data files (i.e., the "P2 files") to link a particular group health plan with the data files submitted by its various vendors.

Practice Pointers:

- Work with plan vendors to ensure that all vendors have all the required information for the P2 file, including providing each vendor's name and EIN to the other vendors
- Confirm that each of the plan's vendors will submit a P2 file that uses a unique plan name and number for each separate benefit package option offered by a plan.
- If the plan cannot confirm that vendors use unique plan names and numbers for each benefit package option, the plan can either:
    - confirm that at least one reporting entity's P2 file identifies all of the plan's other vendors (by name and EIN), or
    - submit its own P2 file identifying all of the plan's vendors (by name and EIN), which would require an account to access CMS's Health Insurance Oversight System ("HIOS").

- If applicable, document the "extenuating circumstances" preventing vendors from working together.

CAA—NO SURPRISES ACT

The NSA addresses several patient protections effective for plan years beginning on or after January 1, 2022. These protections include a prohibition against "surprise billing" from out-of-network service providers and facilities for emergency services, certain non-emergency ancillary services, and air ambulance services.

Plans and insurers are limited to applying in-network reimbursement levels for cost-sharing, and any cost-sharing payments from the participant related to the services must apply the in-network deductible and out-of-pocket maximums in the same manner as if the services had been provided by a participating provider.

Out-of-network providers and facilities are prohibited from billing patients for more than the applicable cost-sharing amount. To the extent that the out-of-network provider and plan cannot agree on the initial payment amount, the parties can enter into open negotiations, which can escalate to an independent dispute resolution ("IDR") process.

As for high-deductible health plans ("HDHPs") and health savings accounts ("HSAs"), the CAA clarifies that surprise billing protections should not interfere with HSA eligibility or the status of a plan as an HDHP.

Eligibility to contribute to an HSA will not be affected for any period merely because the person received benefits for medical care subject to and in accordance with the surprise billing protections. Nor will a plan fail to be treated as an HDHP for providing additional payments to the provider in accordance with these protections.

The NSA also establishes new rules for plan ID cards and provider directories. Effective for plan years beginning on or after January 1, 2022, plan ID cards must include information about plan deductibles, out-of-pocket maximums, telephone number, and website address.

A group health plan must maintain a regularly updated database of providers and facilities on public website, and a prompt response protocol for inquiries about provider/facility network status. Plans that fail to provide accurate information regarding network status cannot impose cost-sharing levels higher than in-network cost-sharing levels if a participant relies on the misinformation obtained from the database, provider directory, or response protocol about in-network status.

The provider directory requirement is currently implemented using a good faith interpretation, with more detailed rules pending.

The NSA protects some patients from having to immediately switch providers in the middle of an ongoing course of treatment in the event that their in-network provider (or facility) ceases to be part of the provider network.

For patients that are considered continuing care patients (generally individuals undergoing a course of treatment for a serious and complex condition; scheduled for non-elective surgery; pregnant; or terminally ill), the plan must notify the patient if contractual issues result in the provider/facility no longer being in the plan's network or no longer being able to provide the services.

Continuing care patients may be eligible for up to a maximum of 90 days of transitional care, during which time the patient can continue the treatment under the same terms and conditions as would have applied had the termination not occurred (that is, in-network rates and coverage for the same items and services).

CAA—MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT ("MHPAEA") NQTL ANALYSES

The CAA amended MHPAEA, requiring plans to perform and document "comparative analyses of the design and application" of any nonquantitative treatment limitations ("NQTLs") that are imposed on mental health/substance use disorder ("MH/SUD") benefits.

In a nutshell, NQTLs are non-numerical limits on the scope or duration of the benefits, such as prior authorization requirements, step therapy/fail-first policies, and limits on access to out-of-network providers. As of early 2021, plans were required to make the NQTL comparative analysis and other specific information available upon request by a state or federal agency.

The Department of Labor ("DOL"), Department of Health and Human Services ("HHS"), and the Internal Revenue Service ("IRS") have each been tasked with requesting and collecting a minimum of twenty (20) analyses per year.

On January 25, 2022, the tri-agencies released their biennial MHPAEA report to Congress, and the findings indicate that plans are falling far short of MHPAEA's requirements. The MHPAEA report included a laundry list of failures:

- Failure to document comparative analysis before designing and applying the NQTL;
- Conclusory assertions lacking specific supporting evidence or detailed explanation;
- Lack of meaningful comparison or meaningful analysis;
- Non-responsive comparative analysis;
- Failure to identify the specific MH/SUD and medical/surgical benefits or MHPAEA benefit classification/s affected by an NQTL;
- Limiting scope of analysis to only a portion of the NQTL at issue;
- Failure to identify all factors;
- Lack of sufficient detail about identified factors;
- Failure to demonstrate the application of identified factors in the design of an NQTL; and
- Failure to ***demonstrate*** compliance of an NQTL as ***applied*** (DOL emphasis).

In addition to listing common failures, DOL referenced several useful tools available on the DOL website, including self-compliance tools, "warning signs", an "under the hood" look at a MHPAEA audit, and an enforcement fact sheet. Focusing on mental health issues and funding MHPAEA compliance has bipartisan support in congress, and plan sponsors would be wise to review their plan's testing and compliance.

Practice pointers:

- Carefully review the Report to Congress and the DOL's recommended compliance tools.
- Develop a practice of regularly checking for what is (and is not) a compliant NQTL, as this is a constantly developing area of MHPAEA compliance
- Carefully review your plan's NQTL analysis to ensure it includes statutorily required elements.
- For self-insured plans, consult legal counsel to amend your agreement with your TPA to ensure that that a proper and comprehensive NQTL analysis is included.

THE TRANSPARENCY IN COVERAGE ("TIC") RULES

The DOL, HHS, and IRS issued regulations in 2020 to implement the ACA's Transparency in Coverage rules ("TiC"). TiC requires most group health plans and insurers to post machine-readable files ("MRFs") that disclose in-network negotiated rates, allowed amounts paid to out-of-network providers, and fee-for-service prescription drug costs at the pharmacy-location level on a public website.

The MRFs must be based on a rolling 90-day period, updated monthly. Self-insured plans without public websites for posting a link to the MRFs will be in compliance if the plan's TPA (or some other third party) posts a link to the files on a public website.

The January 1, 2022, deadline was extended to July 1, 2022 (although the deadline for posting prescription drug information has been delayed pending further guidance).

TiC also requires plans and insurers to make individual disclosures of cost-sharing information to a participant/beneficiary (or their authorized representative) through an internet self-service tool and/or on paper.

Among other things, these individual disclosures must provide an estimate of the covered person's liability. For paper copy requests, disclosures must be provided within 2 business days of receiving the request, and plans may impose a limit of 20 providers per request.

For plan years beginning on or after January 1, 2023, disclosures can be limited to the 500 listed in the regulations, with all other services being made available for plan years beginning on or after January 1, 2024.

In a similar mandate, the CAA also requires plans to offer price comparison information both by telephone and online to allow participants/beneficiaries to compare cost-sharing for specific items or services from in-network providers.

The tri-agencies have aligned the deadlines under the ACA and CAA for these online price comparison tools to January 1, 2023. Although similar, there are some substantive differences between the TiC and CAA requirements.

For example, the CAA requirement does not have a telephonic connection requirement. Also, while the TiC requirement for a self-service tool does not apply to grandfathered plans, the nearly identical requirement in the CAA will.

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These TiC requirements do not apply to grandfathered health plans, excepted benefits, HRAs, or stand-alone retiree plans. Plan sponsors can place the TiC disclosure responsibilities on the insurer or TPA by written agreement, but the liability for any failures remains with the plan sponsors of self-insured plans. Fully-insured plans can shift liability for failures to the insurer through a written agreement between the plan and the insurer.

The TiC regulations provide for good faith compliance relief. Plans/isnsurers acting in good faith and with reasonable diligence will not fail to be in compliance solely because of an error or omission in a disclosure required, so long as the plan or issuer corrects the information as soon as practicable. Nor will the plan/issuer be out of compliance if its internet website is temporarily inaccessible, provided that it makes the information available as soon as practicable.

To the extent compliance with TiC requires a plan/issuer to obtain information from any other entity, a good faith reliance on such information will not be a compliance failure, unless the plan/issuer knows, or reasonably should have known, that the information is incomplete or inaccurate.

TiC Practice Pointers:

- Agreements with insurers and TPAs should specifically address who is obligated to post and maintain information required by TiC.
- Self-insured plans that have contracted with a TPA or third party to post MRFs must monitor the TPA(s) to ensure compliance.
- Plans without public websites should confirm that the TPA has posted a link to the required information on a public website.
- Review (and revise, if necessary) plan procedures for authorized representatives, and ensure that disclosure to the authorized representative complies with applicable security and privacy requirements.
- Stay updated for guidance regarding deadlines for prescription drug costs.

ADDITIONAL CAA 2021 REMINDERS

CAA 2021 also enabled plan sponsors to modify their FSA carryover, grace period, and election change provisions as a result of COVID. While the window for these provisions has closed, plan amendments reflecting such changes are required by December 31, 2022.

Under the CAA "gag-rule" prohibition, plans and insurers cannot enter into agreements with providers, provider networks, TPAs, or any entity that offers access to a network of providers if it would prevent the plan or insurer from disclosing or gathering information necessary to comply with CAA.

Finally, CAA 2021 requires that entities receiving $1,000 or more in total annual direct and indirect consulting and brokerage commission and fees for ERISA covered health plans (including excepted benefit health plans) disclose such fees upon contract or renewal of the services agreement on or after December 27, 2021.

Direct compensation is compensation from the plan itself—i.e., plan assets. Amounts paid directly by the employer/plan sponsor would not be considered plan assets, generally, but participant contributions are always plan assets. Indirect compensation generally means amounts paid to brokers/consultants by any entity other than the plan or employer/plan sponsor (e.g., from a TPA or insurer).

Although this requirement is very similar to a disclosure requirement for retirement plans that has been in place since 2012, determinations of direct compensation may be more difficult for health plans due to the careful analysis that may be needed to determine which amounts are plan assets.

Unlike some of the other CAA requirements, this disclosure requirement applies to all group health plans, including excepted benefits like stand-alone dental and vision, Health FSAs, certain EAPs providing medical care, wellness programs providing medical care, and HRAs.

Disclosure Practice Pointers:

- Identify all consultants and brokers with respect to any group health plan.
- Determine whether any service provider receives any direct compensation and the amount of that compensation.
- If known, determine whether the service provider receives any indirect compensation and the amount of that compensation.

- Make a demand to any covered service provider who has not provided adequate disclosure.
- Establish and document that a responsible fiduciary actually reviews the disclosures and determines that the compensation is reasonable.

DOBBS AND THE EMERGENCE OF MEDICAL TRAVEL BENEFITS

After a draft opinion in *Dobbs* was leaked in May 2022, many plan sponsors began exploring options for providing abortion benefits to participants who lived in states that were likely to ban or restrict the procedure.

By the time the final Dobbs opinion was posted in late June, confirming that restrictions on abortion services would be left up to each state, employer sponsored medical travel emerged as a possible way to facilitate travel to less restrictive states.

For tax purposes, amounts paid for transportation primarily for and essential to legally provided medical care can be received tax free (subject to IRS dollar limits for lodging and mileage).

There are a number of different ways employers may be able to structure medical travel benefits—health reimbursement arrangements ("HRAs"), excepted benefit health reimbursement arrangements ("EBHRAs")—but each of these come with compliance complications.

Providing legally permitted coverage through the employer's traditional medical plan is likely the least complicated option, with the fewest compliance risks under laws like the Affordable Care Act ("ACA"), the Health Insurance Portability and Accountability Act ("HIPAA"), and the Consolidated Omnibus Budget Reconciliation Act ("COBRA").

All of the options for medical travel benefits may also be subject to scrutiny by states, depending on civil and criminal liability under state law. ERISA preemption may apply in some cases, but the likelihood of prevailing on a preemption argument would have to be analyzed on a state-by-state basis, and ERISA preemption does not typically operate against generally applicable criminal statutes.

Adding to the legal challenges is the basic practicality of administering a benefit that has to take into account the state where the patient is domiciled, the situs of the plan, and the state where services are available, as several third-party administrators ("TPA") have reported that this data is not tracked in a manner that lends itself easily to their current claim substantiation protocols.

These are untested issues and the outcome for employers and plans providing these benefits remains to be seen. Any employer (or administrator) considering providing or administering such benefits should consult with legal counsel to address these compliance (and potential criminal law) concerns.

Practice Pointers:

- Structuring a benefit to provide medical travel benefit through the group health plan, available only to enrollees and their enrolled dependents, and that can be used for obtaining any legally permissible covered services that are locally unavailable could help reduce some compliance risks under the IRC, ACA, HIPAA, COBRA, and MHPAEA.
- Consider plan design issues, such as: a limit to the number of times the benefit can be used per year or an annual dollar cap; taxability for lodging and mileage that exceed IRS reimbursement limits; the substantiation requirements for reimbursement (and related HIPAA issues).
- Implement fraud and abuse protocols to ensure that travel is "primarily" for covered medical services that are legally procured.
- Consult counsel familiar with applicable state laws, as civil and criminal liability may vary and could attach based on where the employee/participant resides, where the service is rendered, or even where the reimbursement is administered.

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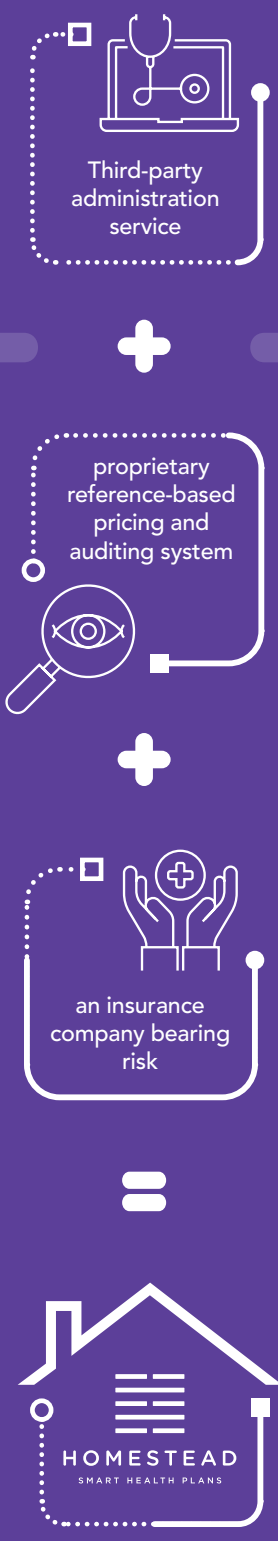

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COVID-19 AND THE PUBLIC HEALTH EMERGENCY

Although for most employers it seems as though the COVID-19 pandemic is in the rearview mirror, the National Health Emergency ("National HE") is not set to end any earlier than March 1, 2023, and the Public Health Emergency ("Public HE") was extended on October 13, 2022 for another 90 days.

Both of these deadlines could be extended again. This means a few things for health plans. Health plans are required to continue covering prescribed and over-the-counter COVID-19 tests, as well as COVID-19 vaccines and boosters until the end of the *Public* HE.

The *National* HE affects the tolling of certain deadlines during the "Outbreak Period", which continues to impact plan administration by prolonging COBRA election periods, COBRA premium payment deadlines, HIPAA Special Enrollment periods, and claims filing and appeals deadlines.

DISASTER RELIEF FILING DEADLINES

Weather-related disasters have extended several filing deadlines. Those in FEMA-designated areas with a valid extension to file their 2021 Form 5500 due to run out on October 17, 2022, will now have until February 15, 2023:

- IR-2022-173: Hurricane Ian/South and North Carolina: Sept 25/28 (respectively), 2022-Feb 15, 2023
- IR 2022-168: Hurricane Ian/Florida: Sept 23, 2022-Feb 15, 2023
- IR 2022-164: Storms and Flooding/Alaska: Sept 15, 2022-Feb 15, 2023
- IR 2022-161: Hurricane Fiona/Puerto Rico: Sept 17, 2022-Feb 15, 2023
- MS-2022-01: Mississippi Water Crisis victims: Aug 30, 2022-Feb 15, 2023

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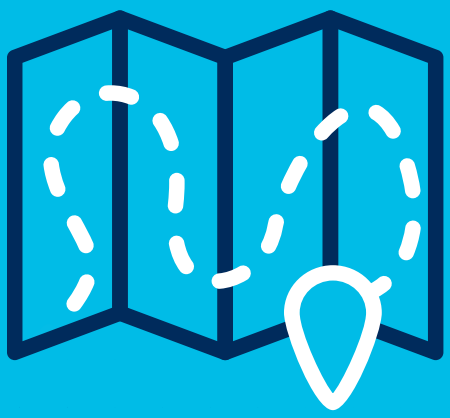

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The IRS automatically provides filing and penalty relief to any taxpayer with an IRS address of record located in the disaster area. Visit https://www.irs.gov/newsroom/tax-relief-in-disaster-situations for more information.

PROPOSED SECTION 1557 REGULATIONS

Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, or disability under any health program or activity that is receiving federal financial assistance on the grounds that such discrimination is prohibited under existing federal laws.

Final regulations have twice been issued under 1557—once in 2016, and again 2020—and a proposed rule was again published in 2022. The 2022 proposed rule would re-instate several provisions from the 2016 Final Rule that had been removed or amended by the 2020 Final Rule and made a few refinements (e.g., taglines, notices, and grievance procedures).

The 2022 proposed rules restore the 2016 application of 1557 to health insurers that receive federal funds but otherwise narrow its application to group health plans. Under the 2016 Final Rule, group health plans were included as entities that were categorically covered.

The 2022 proposed rule does not explicitly include group health plans as covered entities because many group health plans are not recipients of federal financial assistance, even if the employer, plan sponsor or TPA administering the plan are recipients. HHS proposes for complaints against group health plans to be evaluated case-by-case to determine if the plan is covered.

In a departure from its previous position, HHS is proposing to treat Medicare Part B funds as "federal financial assistance to the providers and suppliers subsidized by those funds." As we publish this article, we are awaiting the final 1557 regulations.

MISCELLANEOUS

State PBM laws and ERISA preemption: Increasingly, since *Rutledge v. Pharmaceutical Care Management Association* was decided by the U.S. Supreme Court in favor of Arkansas' regulation of PBM reimbursement levels, states are passing laws regulating PBMs that may affect group health plans. Plan sponsors—especially those with a multi-state presence—will need to stay informed of these state laws and/or address such provisions in their PBM agreements.

COBRA class actions: Employers continue to face COBRA class action lawsuits, often related to the language in the COBRA notice. One of the latest claims included an accusation that the employer discouraged employees from electing COBRA by threatening employees with fraud if any forms were filled out incorrectly.

While it may make sense to stick to the DOL model notice, even the DOL model notices are not "litigation proof." COBRA administrators and plan sponsors that self-administer COBRA should review their COBRA notices carefully in light of this recent litigation.

Telehealth and HDHPs/HSAs: Because of the COVID-19 pandemic and during 2020 and 2021, employers with HDHPs were allowed to provide coverage for telehealth services before the minimum HSA compatible deductible was met.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, allowed this pre-deductible telehealth coverage but only through 2021. The CAA extended this relief for the months of April 2022 through December 2022.

The CAA extension presents two challenges. First, beginning in 2023 and unless Congress acts to extend this relief further, participants and beneficiaries in an HDHP should be required to pay the fair market value of any telehealth services until the minimum HSA compatible deductible is met. Telehealth services that are limited to preventive services would not be disqualifying.

Also, in Notice 2020-15, the IRS provided that coverage of medical care and items purchased for testing for and treatment of COVID-19 would not be disqualifying. The coverage for COVID-19 testing and treatment is indefinite (not geared to the Public Health Emergency) but it is unclear whether the IRS will, at some point, withdraw this exception to disqualifying coverage.

Also, based on an analogy to guidance on employee assistance, disease management and wellness programs, it may be possible to provide telehealth benefits prior to meeting the minimum HSA compatible deductible if the telehealth program does not provide significant benefits in the nature of medical care or treatment.

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Unfortunately, the IRS has provided little guidance on when such benefits will be significant. The second issue is how to deal with the months of January through March of 2022. HSA eligibility is determined on a month-to-month basis so individuals enrolled in an HDHP who received pre-deductible telehealth coverage during these months may be ineligible to contribute to an HSA for those months.

Also, there is what is known as the "full contribution rule" for those who are enrolled in a HDHP with no other disqualifying coverage as of December 1 of any year.

Fixing the "Family Glitch: Under the ACA individuals are eligible for a premium tax credit for coverage obtained through the Exchange/Marketplace as long as they meet certain criteria including not being offered "affordable" employer-based coverage.

For a family member of an employee, that affordability was based on whether the employee was offered affordable employer-based self-only coverage even if the coverage was not affordable for the whole family. In fixing the family glitch the IRS now provides separate affordability determinations for employees and for family members.

Importantly, however, nothing has changed with regard to the ACA employer mandate (play or pay) under Section 4980H of the IRC. The play or pay penalty is only triggered if the offer of self-only coverage to the employee is not affordable. There is no penalty if coverage for family members is not affordable.

The IRS subsequently allowed an election change event for employees with family members seeking to enroll in exchange coverage.

Medicare Creditable Coverage: Medicare Part D notices (either creditable or non-creditable coverage) were due prior to October 15. Online disclosure to CMS is due no later than 60 days after the beginning date of the plan year (contract year, renewal year, etc.) and upon change of the plan's creditable coverage status.

Prescription drug cost reductions for Medicare enrollees in the Inflation Reduction Act may impact the analysis of whether employer sponsored prescription drug coverage is creditable. Plan sponsors need to be mindful of this possibility when making this calculation.

Telephone Consumer Protection Act of 1991 (TCPA): The TCPA generally restricts certain unauthorized automated calls and texts to residential and cellular phones, including some restrictions potentially applicable to health care messages.

A recent federal district court opinion, *Fiorarancio v. Wellcare Health Plans*, Inc., serves as an important reminder that even if a plan is in compliance with all other applicable laws, including HIPAA privacy requirements, the plan must still be cognizant of the TCPA when reaching out to plan participants via texts and pre-recorded messages, absent express consent.

Plan sponsors should evaluate the administrative practices of their TPAs and vendors and have clear language in service agreements with regard to which party has the responsibility to obtain proper consent (and the liability for such failures).

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Medicare Secondary Payer ("MSP"): In *Marietta Memorial Hospital Employee Health Benefit Plan v. Davita*, the U.S. Supreme Court decided the very narrow question of whether an employer-provided benefit plan violates the MSP rules when the plan treated all dialysis providers as "out-of-network," reimbursing them at the lowest rate.

In *DaVita*, the plan offered an outpatient dialysis benefit to everyone enrolled, regardless of whether the person had end stage renal disease ("ESRD").

Even though the vast majority of people who require dialysis are living with ESRD, the Court ruled that it is not a "disparate treatment" violation of MSP rules if all dialysis providers are out-of-network because all individuals enrolled in the plan had access to the same benefits, regardless of any health condition. This outcome, which some believe is not consistent with the intent of MSP rules, may be resolved by federal legislation.

Gender Identity: How gender issues can be appropriately addressed through healthcare continues to be an evolving area for health plans. Litigation against plan sponsors has centered around discrimination claims under Title VII and Section 1557.

Counsel should be consulted before limiting or excluding treatment for gender issues since this area remains a highly-debated subject among health professionals, both in the United States and worldwide.

2023 HEALTH BENEFIT ADJUSTMENTS

Included in the Table below are 2023 indexed amounts for some of the health benefit related limits and caps:

BENEFIT	2022	2023
HSA contribution max (including employee and employer contributions)	$3,650 ($7,300 family) (Rev. Proc. 2021-25)	3850/7750 in 2023.(Rev Proc 2022-24)
HSA additional catch-up contributions	$1,000 (this is not indexed)	Same
HDHP annual deductible minimum	$1,400 ($2,800 family) (Rev. Proc. 2021-25)	$1500 in 2023 (Rev Proc 2022-24)
Limit on HDHP OOP expenses	$7,050 ($14,100 family) (Rev. Proc. 2021-25)	$7500 ($15,000) in 2023
ACA limit on OOP expenses	$8,700 ($17,400 family)	$9,100 ($18,200 family)
Health FSA salary reduction max	$2,850	$3050
Health FSA carryover max	$570	$610
Limit on amounts newly available under an Excepted Benefit HRA	$1,800	$1950 in 2023
QSEHRA max reimbursement	5450 ($11,050 family)	$5850 ($11,800 family)
Transit and parking benefits	$280 (monthly)	300
401(k) employee elective deferral max	$20,500 (Catch-up contributions $6,500)	$22500 (Catch-up contributions $7,500)
Highly compensated employee	$130,000 (applies for 2022 plan year under look-back rule)	$135,000 (applies for 2023 plan year under look-back rule)
Key employee	$185,000	$200,000