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Planning for 2024: Compliance for health and welfare benefit plans (updated)

This article has been updated to include 2024 benefit limits and the compliance calendar was adjusted to reflect the leap year.

With 2024 on the horizon, plan sponsors should be aware of health and welfare compliance topics they may need to act on in the coming year. This planner provides a discussion of key issues for consideration and a calendar outlining important deadlines.

Mental Health Parity and Addiction Equity Act (MHPAEA) non-quantitative treatment limit (NQTL) comparative analysis

The Consolidated Appropriations Act, 2021 (CAA 2021) requires that plan sponsors of group health plans that provide mental health and substance use disorder benefits and medical/surgical benefits must be able to produce a comparative analysis to the Department of Labor (DOL) and Health and Human Services (HHS) upon request which demonstrates their compliance with the non-quantitative treatment limitations (NQTL) requirement of the Mental Health Parity and Addiction Equity Act (MHPAEA).

In August, the DOL, Treasury, and HHS published proposed amendments to the regulations implementing MHPAEA and new regulations regarding the implementation of the NQTL comparative analysis requirements. While the proposed rules are not yet finalized, employers should be aware of these developments and how they may impact the administration of their plans.

For now, sponsors of self-insured group health plans should have a comparative analysis detailing the design and application of NQTLs for the mental health benefits covered by the plan, if requested by the agencies. Plan sponsors should work with their TPAs and mental and behavioral health providers to assess their plans and complete the analysis. To assist in this effort, a MHPAEA self-

compliance tool is available on the DOL's website — section F of the tool addresses the NQTL requirements.

Dobbs' decision impacts to monitor

On June 24, 2022, the Supreme Court in *Dobbs v. Jackson Women's Health Organization* overturned its previous decision in *Roe v. Wade,* holding that the constitution does not prohibit the citizens of each state from regulating or prohibiting abortion. As a result, states now have the power to pass laws banning or restricting reproductive health care services. As state action has impacted access to abortion in many parts of the country, this has created new challenges and decision points for some multistate employer plan sponsors.

One such issue involves the regulation of medication abortion. Since the *Dobbs* decision, there have been numerous legal challenges regarding the regulation of abortion via prescription drugs. Recently, the U.S. Food and Drug Administration (FDA) announced changes to the protocol for mifepristone, which is a two-drug regimen used to end a pregnancy. The updated protocol states that mifepristone no longer needs to be dispensed in person by a health care provider, pharmacies can become certified to dispense mifepristone, and the prescription can be sent by mail. In April, it is legal until a final decision is reached on the merits of the case.

In light of the numerous legal challenges surrounding the *Dobbs* ruling, employers should continue to monitor state action to determine whether their employees may be impacted. Employers should also continue to monitor the status of medication abortion and how this could affect coverage requirements.

Prescription drug data collection

A new transparency provision in the CAA 2021 required employer-sponsored health plans and health insurance issuers to report information about prescription drugs and health care spending to the federal government annually. This reporting process is referred to as the prescription drug collection report ("RxDC Report"). Insurers and plans must submit information on spending, drugs that are prescribed most frequently, prescription drug rebates from manufacturers, premiums, and patient cost-sharing. Employers may rely on third parties, such as issuers, third-party administrators (TPAs), or pharmacy benefit managers (PBMs) to prepare and submit the RxDC report for their health plans. The annual deadline for the RxDC report is June 1, covering data collected in the preceding calendar year. The next RxDC report is due June 3, 2024 and will cover data for 2023.

Gag clause attestation

The No Surprises Act (NSA) was enacted in December 2020 under the CAA 2021 and provided new protections against unanticipated out-of-network medical bills. In addition to the provisions regarding surprise medical billing, the NSA also included a new prohibition on "gag clauses," contract terms that restrict plans from providing cost or quality-of-care information to plan

participants, accessing de-identified claims data, and sharing the information, per privacy regulations, with a business associate.

The NSA requires that all group health plans (including fully insured, level-funded, self-insured, and grandfathered plans) attest annually on a website provided by the Centers for Medicare and Medicaid Services (CMS) that they do not have any agreements that include these types of provisions. The first of these attestations was due on December 31, 2023 and will cover the period from December 27, 2020 (or, if later, the effective date of the plan or insurance coverage) through the date of attestation. The attestation requirement does not apply to excepted benefits (such as standalone dental or vision plans), health reimbursement arrangements (HRAs), or other account-based plans (such as FSAs). See our October 5, 2023 *FYI* for additional details on the gag clause attestation requirement.

Broker and consultant compensation disclosures

Another provision of the CAA 2021 amended Section 408(b)(2) of ERISA to require brokers and consultants who expect to receive at least $1,000 for their services from group health plans subject to ERISA (including dental and vision plans) to satisfy new compensation disclosure requirements. These rules are similar to those that have applied to pension plans. The disclosure requirements apply to contracts and arrangements for services that are entered into, extended, or renewed on or after December 27, 2021. Fiduciaries are expected to receive these statements in a reasonable amount of time prior to the commencement of a contract so that they may determine if the compensation is reasonable and appropriate for the services to be provided. The DOL issued a Field Assistance Bulletin 2021-03 setting out its temporary enforcement policy regarding the disclosure requirement. Under this policy, it will not treat a service provider as having failed to satisfy the requirement as long as it acts in good faith and reasonably interprets ERISA 408(b)(2).

ACA form distribution

Forms 1095-B or 1095-C must be provided to individuals no later than January 31 of the year following the calendar year to which the forms relate. However, the IRS issued final regulations in December 2022 that would provide a 30-day automatic extension for calendar years beginning on or after January 1, 2022. Thus, the deadline for furnishing Forms 1095-B or 1095-C to individuals for the 2023 calendar year will be March 1, 2024. The new regulations do **not** extend the ACA reporting deadlines, which remain February 28 (for paper filings) and April 1 (for electronic filings). In addition, several states have implemented separate ACA filing requirements, including California (due April 1, 2024), Washington, DC (due April 30, 2024), Massachusetts (due by January 31, 2024), New Jersey (due April 1, 2024), and Rhode Island (due April 1, 2024).

Telehealth HSA relief

On December 23, 2022, Congress passed the Consolidated Appropriations Act of 2023, which included a two-year extension of a provision allowing Health Savings Accounts (HSAs) to cover

telehealth services before participants meet their deductible. This extension will enable employers with high-deductible health plans (HDHPs) to waive participant deductibles for telehealth services without impacting participants' HSA eligibility. The provision was previously set to expire on December 21, 2022, and is now extended through December 31, 2024. Non-calendar year HDHP plans may allow predeductible telehealth through the end of any plan year that begins before January 1, 2025. Employers that extended telehealth coverage should determine if any plan document updates are needed.

Updated 2024 benefit limits

The 2024 HSA annual contribution limits and the OOP amounts for self-only and family HDHP coverage increased over the 2023 limits. (See our May 24, 2023 *FYI.*) The IRS issued the 2024 limits for qualified transportation fringe benefit, adoption assistance programs, health flexible spending accounts, and long-term care premiums. (See our November 13, 2023 *FYI Alert*.) Plan sponsors should review them and consider whether to update their plan documents to reflect these limits.

In closing

Meeting 2024 compliance goals and obligations is an important step for ensuring smooth plan operations throughout the year. In addition to the significant items noted above, plan sponsors should consider performing an annual "check-up" (i.e., a review of operational practices and fiduciary responsibilities) to address plan compliance and design considerations.

Overview of significant health and welfare benefit plan compliance tasks[1]

Updated January 4, 2024

Action item	2024 due date
January	
Report value of health coverage on Form W-2	January 31
Provide Massachusetts 1099-HC to employees and file with state	January 31
Provide ACA information reporting Forms 1095-B/C to individuals in CA	January 31
February	
File ACA information reporting returns with IRS (for paper filing)	February 28
Make any required self-insured plan payments to San Francisco for 2023	February 29
Complete CMS creditable/non-creditable coverage disclosure filing	February 29
March	
Complete DOL Form M-1 (for MEWAs)	March 1
Provide ACA information reporting forms 1095B/C to individuals	March 1
Last day for flexible spending accounts with 2½ month grace periods	March 15
April	
File ACA information reporting returns with IRS (for electronic filing)	April 1
File ACA information reporting returns with NJ, RI, and CA	April 1
File San Francisco annual reporting form for 2023	April 30
File ACA information reporting returns with D.C.	April 30
May	
File Form 990 or Form 8868 if requesting extension	May 15
June	
Prescription Drug Data Collection (RxDC) reporting	June 3
July	
Provide summary of material modifications (SMM) for prior year amendments	July 28
File Form 720 and pay PCORI fee	July 31
File Form 5500 or Form 5558 to request an extension	July 31

[1] Assumes calendar year plan and plan sponsor tax year. Other deadlines may apply such as notice deadlines based upon participant status or filing deadlines based upon plan status. Does not cover all state law reporting requirements.

Action item	2024 due date
August	
File Form 990 (if on extension) or Form 8868 if requesting additional extension	August 15
September	
Issue Summary Annual Report (if no extension)	September 30
October	
Provide notice of creditable/non-creditable prescription drug coverage to participants	October 14
File Form 5500 if on extension	October 15
November	
File Form 990 (if additional 3-month extension)	November 15
December	
Issue Summary Annual Report (if on extension)	December 15
File Massachusetts HIRD form	December 15
File gag clause prohibition compliance attestation	December 31
Deadline for any needed corrections for nondiscrimination testing	December 31

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