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LEGISLATIVE UPDATE OUTLINE

Bostock SCOTUS Decision

On June 15, 2020, the U.S. Supreme Court issued a landmark opinion in *Bostock v. Clayton County Georgia.* Among other things, this decision incorporated an individual's sexual orientation or gender identity status into the definition of sex under Title VII of the Civil Rights Act of 1964, which makes it unlawful for "an employer to fail or refuse to hire or discharge an individual, or otherwise discriminate against any individual with respect to his [or her] compensation, terms, conditions, or privileges of employment, because of the individual's race, color, religion, sex, or national origin." The Bostock ruling took effect immediately upon its holding on June 15, 2020.

While this decision largely revolved around employment (hiring and firing) and treatment of your employees, it does have implications on employee benefit plans. In dicta, the SCOTUS holding discussed other areas of discrimination including "fringe benefits." Applicable regulations define "fringe benefits" as medical, hospital, accident, life insurance and retirement plans, profit sharing, bonus plans, leave, and other terms, conditions, and privileges of employment.

Now that the term "sex" includes sexual orientation and gender identity, health plans must ensure that their plan provisions do not discriminate against individuals on the basis of sex. Areas where a plan could see challenges include exclusions for gender dysphoria, sex reassignment surgery, hormone therapy treatment related to gender identity, or family planning benefits for LGBTQ employees.

Little Sisters of the Poor SCOTUS Decision

On July 8, 2020, the U.S. Supreme Court upheld two Trump-era rules expanding religious and moral exemptions to the ACA's contraceptive mandate. This issue started in 2014 with the Hobby Lobby Case – where Hobby Lobby challenged the ACA contraceptive mandate claiming they were a religious organization and it violated their religious and moral beliefs to force them to pay for contraception.

This recent case, *Little Sisters of the Poor v. Pennsylvania,* held that the government had the authority under the ACA to adopt broad religious and moral exemptions to the contraceptive mandate and the rules did not violate the Administrative Procedure Act. This ruling confirms two things:

- Employer that object to the coverage of contraceptives for religious or moral reasons can decline contraceptives for employees or students.
- The accommodation process, which enabled employees and students of objecting employers to access contraceptives without cost sharing, is optional.

Health Care and the Election

Access to affordable health care remains a high priority for voters in this election. Both candidates have made managing health care coverage (not necessarily costs) among their top domestic priorities. However, their approaches differ.

Biden favors maintaining and expanding coverage under the ACA and would keep the employer mandate in place. He also supports a "public option" similar to Medicare. He also supports lowering the Medicare-eligible age to 60. Trump opposes the ACA, and is supporting a SCOTUS challenge to the ACA as unconstitutional.

Trump's plan (to date) focused on allowing employers to use various health reimbursement arrangements to reimburse employees who want to buy coverage on the exchange. He has promoted regulatory efforts to require hospitals and health care providers to be transparent about their pricing. Both candidates support ending "surprise billing" by out of network providers. Currently there is only state legislation addressing this issue but nothing on the federal level.

Challenges to the ACA

On November 10, 2020, the SCOTUS will hear oral arguments on whether the ACA is constitutional. The Court is expected to rule on the matter before its term ends in June 2021. A vacancy on the nine-justice supreme court was created by the death of Ruth Bader Ginsburg on September 18, 2020. Amy Coney Barret was confirmed this week. In the meantime, the health care law remains in full effect during litigation, including all employer coverage obligations and reporting requirements.

The case that made its way to the SCOTUS has a complex and complicated procedural history. I won't bore you with the details. Suffice it to say there are a number of possible outcomes including:

- To dismiss the case on technical grounds, leaving the statute in place. The court could decide, for instance, that Texas and the individual plaintiffs lacked standing to bring the lawsuit.
- To affirmatively uphold the ACA.
- To uphold the statute while finding the individual mandate to be void without its penalty, essentially maintaining the status quo.
- To uphold the statute but void both the individual mandate and other provisions closely linked to the mandate.
- To strike down the law in full, although that option has been viewed as unlikely by legal analysts. Should it happen, however, the effect of the ruling would likely be delayed, giving Congress the opportunity to correct the statute's constitutional defects or to pass a replacement health care law.

We are carefully watching the case and analyzing the response to all potential outcomes.

CARES Act

The CARES Act created/modified, among other things, the Paycheck Protection Program, student loans, unemployment insurance, deferred social security tax payments, employee retention tax credits, etc. However, specific to group health plans, the CARES Act:

Expanded use of HSAs

The CARES Act allows high-deductible health plans (HDHPs) paired with health savings accounts (HSAs) to cover telemedicine free of cost sharing for plan years beginning on or before Dec. 31, 2021. A new safe

harbor permits HDHPs to cover telehealth and other remote care services before participants have met their deductible without affecting their eligibility to make HSA contributions.

Normal cost-sharing can still be imposed for telehealth visits, such as through co-pays that the plan may require after the deductible is paid. These provisions are temporary and will sunset Dec. 31, 2021, unless Congress extends them or makes them permanent.

COVID-19 testing without cost-sharing

The CARES Act extends coronavirus testing (covered without cost-sharing and outside the deductible by fully insured and self-insured plans), as required by the Families First Coronavirus Response Act to any services or items provided during a medical visit that results in coronavirus testing, including an in-person or telehealth visit to a doctor's office, an urgent care center or an emergency room. This coverage requirement remains in effect only while there is a declared public health emergency as defined under federal law. FFCRA as you know created the paid sick leave and emergency FMLA that we, as employers, have been managing over the last several months.

DPC—Proposed Rule

On June 10, the IRS published a proposed rule that would let employer-funded health reimbursement arrangements (HRAs) and HSAs pay for employees' care received through direct primary care arrangements (DPCAs) and health care sharing ministries (HCSMs). Both options have attracted interest as lower-cost alternatives to traditional employer-provided group health care plans or to nongroup health coverage purchased through an Affordable Care Act (ACA) marketplace exchange.

Marijuana

Marijuana legalization is on the ballot in five (5) states this Election Day. Currently, 33 states allow marijuana for medical use, and 11 of those states, and Washington D.C. allow marijuana for recreational use. With the majority of states already having legalized cannabis, and five more states voting on its legalization this November, its increasingly important for employers and plans to consider their stance on marijuana for future discussions.

OK--Medical Marijuana is legal.
LA--Medical Marijuana is legal.
TX--Medical Marijuana is not legal.
NM--Medical Marijuana is legal.

However, federal law continues to classify marijuana as a Schedule I narcotic, according to the DEA. This means it is not FDA-approved and health plans are not required to cover it.

Telemedicine

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COVID-19 has changed many things—among them is people's willingness to try and in some instances be forced to utilize telehealth services. The IRS announced relaxed restrictions due to COVID-19 that previously hindered telemedicine services including:

- HDHP plans can offer telehealth visits without violating the first dollar coverage rules
- FFCRA requires including the cost of telemedicine visits without cost sharing, for COVID-19 related testing

As a result of the pandemic, telehealth services experienced exponential growth. However, its success depends largely on the type of workforce involved.

Due Diligence Checklist

The Due Diligence Checklist is a list of federally required action/notices/compliance/distribution matters and the party currently performing the function. It will be maintained by Kempton and is available to Participating Employers on the portal.

Restatement

The last restatement occurred in 2018 and there have been a number of amendments since then. In addition, the 2018 restatement did not include a complete compliance review. Therefore, the 2021 restatement includes a compliance review and restatement of prior plan changes.

Subscription Agreement

Prior to 2021, most of these provisions were contained in the Plan Adoption Agreement. However, we have separated them into two documents. The Subscription Agreement contains the provisions that the Participating Employer agrees to as part of the Trust. The Plan Adoption Agreement is simply a form used at Open Enrollment to determine which benefits the Participating Employer wishes to offer. These documents were separated for ease of administration.

ERISA Distribution Requirements

ERISA requires plan sponsors, and their claims administrators, to distribute certain plan materials according to DOL guidelines. These disclosure guidelines apply to the following documents:

- Summary plan descriptions, summaries of material modifications, summary annual reports;
- Required health plan and reform notices (including EOB, benefit statements)
- Medicare creditable coverage and non-creditable coverage notices
- COBRA notices
- Financial reporting (5500 and SAR)

Under ERISA, a plan sponsor or claims administrator is allowed to electronically communicate these documents to plan participants. The rules *automatically* extent to any employee, who the plan sponsor knows, can access electronic documents at any location he or she works at and whose access to the employer's electronic information is part of his or her job duties.

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For other employees who do not regularly have access to the employer's electronic information (i.e. truck drivers, field workers, etc.), the plan sponsor or claims administrator *must receive consent* from these employees in order to electronically communicate these documents under ERISA.

Unless requested, an SPD does not need to be provided separately to dependents of an employee.

Finally, there is a third set of individuals, dependents, who do not work for the employer . The plan sponsor or claims administrator *must receive consent* from these dependents in order to electronically communicate certain documents under ERISA (not SPD but other documents).

Going forward it is the intent of the Trust to distribute as much as possible electronically to plan participants which is why we are asking for email addresses of employees of the Participating Employer.

ADVANTAGE
HEALTH PLANS TRUST