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THE RISK REPORT

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Proposed Regulations

New Mental Health Parity Rules Would Expand Care

THE BIDEN administration in July 2023 proposed new regulations aimed at requiring health insurers to expand their mental health coverage.

The proposal aims to bring insurers into compliance with existing law requiring that they cover mental health benefits in parity with physical health services.

Despite that law, many insured Americans struggle to access mental health care, often because its difficult to geta referral or their health plan does not have enough providers in its network, forcing them to go to providers outside of the network and paying significantly more.

It's hoped that by adding new provisions that would require insurers to regularly assess how well they are complying with the law, it will be easier to receive in-network mental health care. Additionally, the rules aim to eliminate barriers that keep people from accessing care when they need it.

The Mental Health Parity and Equity Act has been on the books since 2007, but the sudden demand for counseling services caught insurers off guard with too few providers in their networks to meet the demand. The regulations — proposed by the Departments of Health and Human Services, Labor and Treasury — would:

Require health plans to measure outcomes to make improvements. The rules require insurers to regularly analyze:

- How much it pays out-of-network providers,
- How often prior authorization is required, and
- The rate of denials for prior authorization requests.

The goal of the analysis is to help insurers identify areas where they are failing to meet the law's requirements.

The proposed regulation then require that they take steps to remedy those shortfalls, such as adding more mental health professionals to their networks or reducing red tape to get access to them.

Stipulate what plans can and cannot do. The proposed rules would also emphasize that health plans may not circumvent the spirty of the law and take other steps to restrict access to mental health and substance use disorder care, such as:

- Instituting more restrictive prior authorization rules,
- Applying other medical management techniques, or
- Using narrower networks

The proposal would require health plans to use similar factors in setting out-of-network payment rates for mental health and substance use disorder providers as they do for medical providers.

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Religious Accommodation

SCOTUS Sets New Bar for Declining Requests

A RECENT DECISION by the U.S. Supreme Court will make it more difficult for employers to deny employees' requests for religious accommodations in the workplace.

The unanimous decision by the court in the case of *Groff vs. DeJoy* basically upends a standard for accommodating religious beliefs that has been in place since 1977.

The case concerns a mail carrier who asked not to work on Sundays due to his religious beliefs, after his employer, the U.S. Postal Service, contracted with Amazon to deliver its packages on Sundays.

The ruling will require that employers take a new approach to handling their employees' requests for religious accommodations in the workplace. Legal experts say the decision could spur a slew of new requests as well as renewed ones from employees whose requests had been declined.

The case

When mail carrier Gerald E. Groff's USPS location started requiring its staff to work on Sundays to fulfill the Amazon contract, he was able to swap shifts with co-workers. But they grew resentful and stopped swapping shifts with him. After a number of shifts went unfilled, the USPS informed him that it could not reasonably accommodate his request not to work on Sundays.

Groff quit and sued U.S. Postmaster General Louis DeJoy alleging Title VII religious discrimination and the case made its way to the Supreme Court, which sided with him in his appeal.

In its decision, the court wrote that an employer must accommodate an employee's religious practice as long as the proposed accommodation does not create "substantial increased costs in relation to the conduct of [the company's] particular business."

The decision jettisons a standard that has been in place since SCOTUS's 1977 decision in *Trans World Airlines, Inc. vs. Hardison*: That if making accommodation constitutes more than a *de minimis* cost to the employer, then the request was considered an "undue hardship" and the employer could deny the request. Even the Equal Employment Opportunity Commission deferred to this standard.

How it changes the equation

"Substantially" increasing costs in relation to the company's operations is a significantly higher bar and burden of proof for employers that reject religious accommodation requests.

One of the key takeaways from the decision is that employers must explore all of their options, like voluntary shift-swapping.

It also warned that "a hardship that is attributable to employee animosity to a particular religion, to religion in general, or to the very notion of accommodating religious practice cannot be considered 'undue.'" In other words: If other employees don't like the fact that their colleague is getting a certain day off, that is no excuse for denying the request.

In light of this ruling, you should revisit your workplace policies for dealing with religious accommodations. If you receive a request and are unsure how to proceed, consider consulting with counsel. ❖

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Rules Aim to Make Mental Health Care More Accessible

The takeaway

The proposed rule is good news for any of your staff that have been having a hard time accessing mental health or substance abuse services.

The regulators are hoping that the legislation achieves their goals of:

- Making mental health care accessible to more people,
- Ensuring that mental health professionals' pay is comparable to that of physical medicine practitioners, and
- By ensuring comparable pay and boosting demand, attracting more individuals to pursue careers in mental health professions to increase the number of mental health providers.

The proposed regulations still need to be put out for public comment and will likely be changed as the agencies get to work writing the final version. ❖

Changes May be Coming to PBMs Affecting Plan Costs

AS LAWMAKERS and regulators increasingly scrutinize the nation's largest pharmacy benefit managers, you and your employees may stand to benefit.

PBMs play a significant role in the health insurance ecosystem by contracting with insurers and self-insured employers to control their drug costs. But reports over the past few years have questioned just how well these influential players help employers, health plans and enrollees actually save payers money. They've also been accused of keeping most of the savings they generate instead of passing them on to their clients and health plan enrollees.

As a result of these issues and more, PBMs have been targeted by various state attorneys general, and more recently by regulators and Congress. Bipartisan legislation has been introduced that would increase transparency of these secretive organizations and ensure that payers get a bigger cut of rebates and other savings PBMs generate.

Almost every health plan has some type of arrangement with a PBM, so any changes in how they operate may result in lower pharmaceutical outlays for patients.

How they operate

PBMs are intermediaries, acting as go-betweens for insurance companies, self-insured employers, drug manufacturers and pharmacies with the stated goal of controlling pharmaceutical costs for employers and health plan enrollees.

PBMs typically contract with insurers (or self-insured employers) and pharmacies. They charge health plans fees for administering their prescription drug claims and create formularies that spell out the prices that pharmacies receive for each drug on the list.

Commonly, the price the plan pays for a drug is more than the pharmacy receives for it. The PBM collects the difference between the two prices. One big knock on PBMs is that their contracts are opaque, keeping their costs hidden from the health plans and pharmacies.

It can do this because the health plan does not know what the PBM's arrangement is with pharmacies and the drug companies. Also, the plan doesn't know the details of the PBM's arrangements with its competitors.

PRACTICES UNDER SCRUTINY

- **Spread pricing** — A PBM charges health plans more than it pays the pharmacy for a medication and retains the difference in costs.
- **Rebates** — PBMs receive rebates from drugmakers in exchange for the PBM giving their products preferred status and greater market share on the plan formularies.
- **Clawbacks** — These are remuneration fees that pharmacies that dispense Medicare Part D (outpatient) drugs have to pay PBMs, which can charge these fees long after a pharmacy has filled a prescription.

Legislation

As of May 8, there were four new measures on PBM reforms that were passed by the Senate Health, Education, Labor and Pensions Committee. All the bills aim to make PBMs more transparent and would eliminate a number of practices observers say are causing most of the problems.

The most expansive of these bills is the Pharmacy Benefit Manager Reform Act (S. 1339), sponsored by Senators Bernie Sanders (I-VT) and Bill Cassidy (R-LA), which would:

- Ban spread pricing,
- Ban certain clawback provisions in PBM contracts, and
- Require that the rebates drug companies pay PBMs be passed through to plan sponsors.

The effect on health plans

The appetite is strong in Congress to rein in PBMs, and if any of these bills become law they would likely usher in greater regulation and transparency for the industry.

While it's unclear how PBMs will react and how they may alter their practices, the laws have the potential to reduce costs for:

- Employers in the form of reduced premiums, and
- Employees in the form of lower out of pocket costs.

We'll keep you informed of any developments on these measures if they move forward. ❖

Changing Needs

Handling Health Insurance for Remote Workers

SINCE THE COVID-19 pandemic, more employers are allowing their staff to work remotely on a permanent basis, often allowing them to never have to set foot in the office again.

This newfound freedom for American workers has allowed many of them to leave the cities they were living in for small towns or even more remote areas around the country. But for employers who have instituted work-from-home policies, they are faced with navigating a more confusing employee benefits landscape.

Employers will typically purchase group health insurance with networks that are mainly local or regional. This makes sense for a company with one location or multiple locations in a city or region, since all the employees will be living near work.

But when an employee moves, they can't take the network with them, and the employer will need to make new coverage arrangements.

If you allow your employees to work remotely, you have a few options for those who plan to move out of state.

The PPO option

If they are currently enrolled in a health maintenance organization, they would have to give up their plan, since HMO plans contract just with medical providers in a specific area. Preferred provider organizations also have networks with which they contract, but some of the nation's largest PPOs offer more flexibility.

The main thing is having a way out of the HMO contract, as that usually requires a "qualifying event." If an employee moves out of state or out of an HMO's service area, that would likely be considered a qualifying event to allow them to choose a new health plan.

The answer for most employers is to place the worker in a nationwide PPO. One of the most common choices is Blue Cross/Blue Shield because of the breadth of its coverage. But some other large players may also offer a good PPO plan that can be used anywhere in the country.

We can help you with this process and ensure that your employee is set up with coverage, wherever they are moving.

Another option

Some employers are taking another approach to out-of-state remote workers. They are setting up individual coverage health reimbursement arrangements (ICHRA), which they fund with pre-tax money that the employees can use to purchase a health plan on an Affordable Care Act exchange.

ICHRAs were made legal during the Trump administration to give employers another option for helping their workers secure health coverage. Some ICHRA administrators are also available to help ensure that the contributions comply with the ACA affordability test and to help plan enrollees choose coverage that is best for them.

Employees Moving Out of State?

During your next open enrollment, if you have workers who live out of state, you'll want to ensure they have a plan that they can use in their area. If they are already enrolled in a PPO, that's a good start, as they are more likely to have dispersed networks.

We can help you review your current plan offerings, and in particular your PPOs. We'll look for PPOs that have networks that allow enrollees to use in-network benefits in any state.

It's important that you have a policy requiring your remote staff to notify you if they plan to move out of state, so you can start the process of changing health plans.

Both you and the employee (and their family) will want to ensure that they have continuity of coverage if they move. ❖