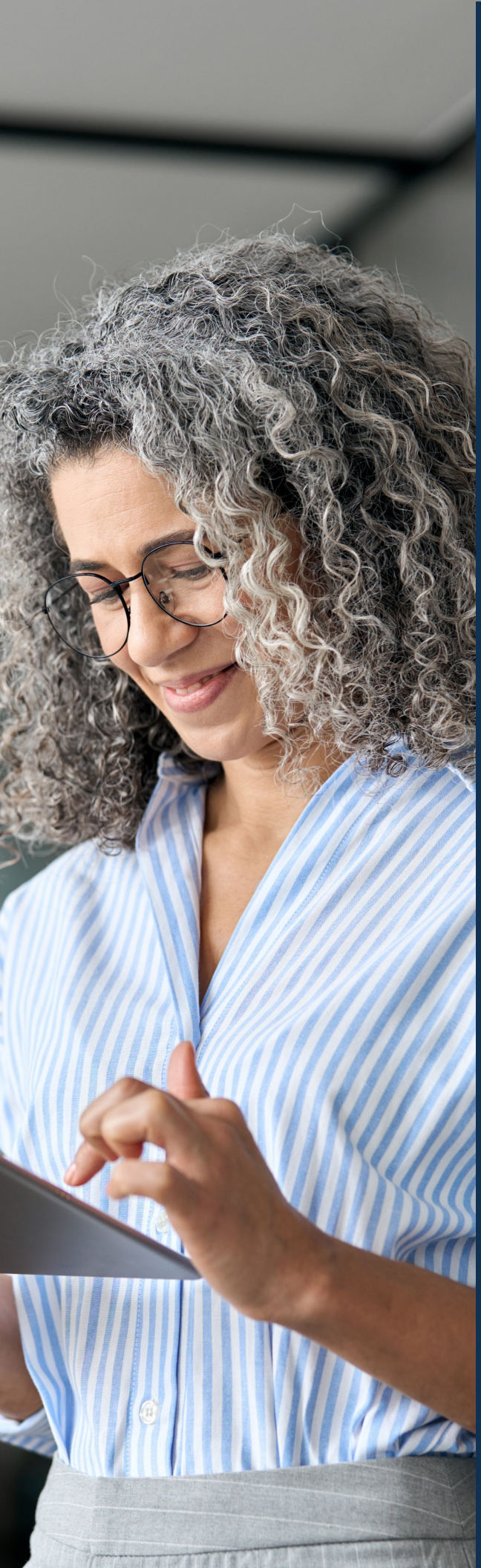


CBP
Creative Benefit Plans
INSURANCE MADE EASY

2024: Third Quarter

Compliance Digest

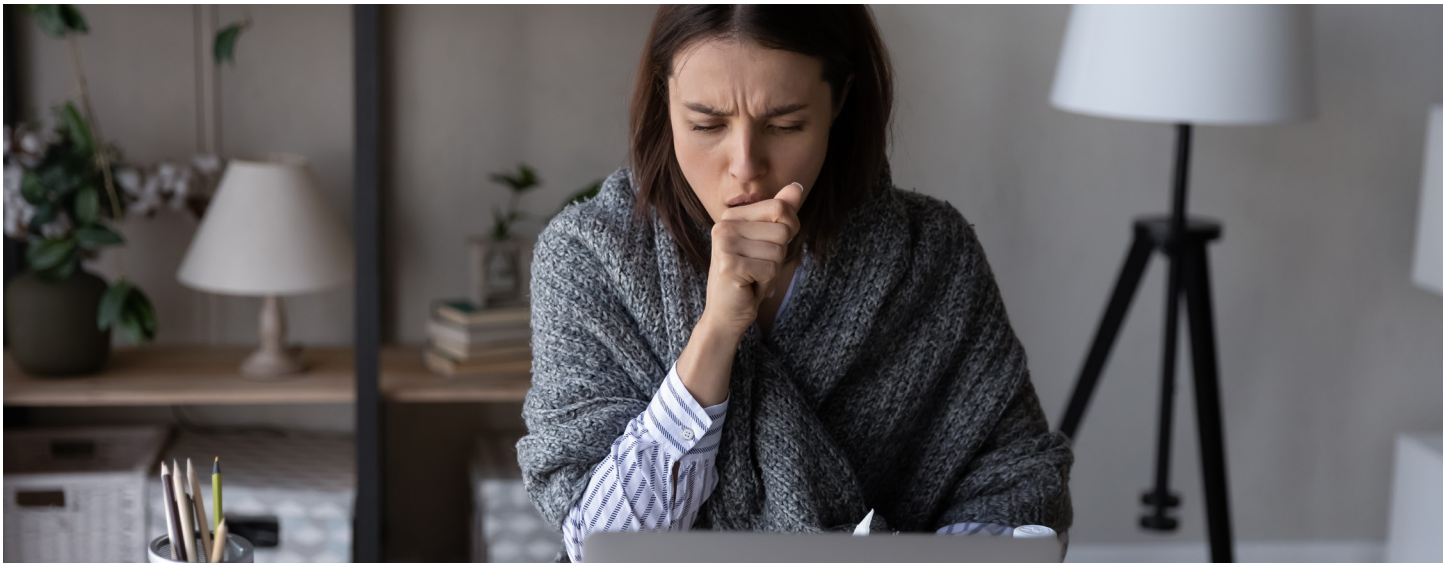
Compliance Bulletins Released July to September

2024 Compliance Bulletins: Third Quarter

July

August

September



Connecticut Significantly Expands Paid Sick Leave Law

Issued date: 07/09/24

Connecticut Governor Ned Lamont signed a bill that will greatly expand paid sick leave benefits to nearly all Connecticut employees by 2027. This update highlights the changes from the current law to the new law. The new provisions become effective January 1, 2025 (except where noted).

Employer Coverage

The current law applies to employers who employ 50 or more “service workers” in the state of Connecticut based on the number of Connecticut employees on its payroll for the week containing October 1.

The new law will apply to all employees working in Connecticut based on the number of Connecticut employees on the employer’s payroll as of January 1 as follows:

- Effective January 1, 2025: employers with 25 or more employees
- Effective January 1, 2026: employers with 11 or more employees
- Effective January 1, 2027: employers with 1 or more employees.

The following employers are excluded under both the current and new law:

- Any business establishment classified in sector 31, 32 or 33 in the North American Industrial Classification System (Manufacturing), or
- Any nationally chartered nonprofit that provides all the following services: recreation, childcare and education.

Employee Coverage

Paid sick leave is currently available to service workers. The new law will cover all employees except:

- Seasonal employees who work 120 days or less,
- An employee who is a member of multi-employer health plan that is maintained pursuant to a collective bargaining agreement between a construction-related union and employer, and
- Self-employed individuals.

Accrual of Leave

Under the current law, employees accrue 1 hour of paid sick leave for every 40 hours of service performed. Employees may earn up to 40 hours of paid sick leave per year.

The new law will allow employees to accrue 1 hour of paid sick leave for every 30 hours worked. Employees may earn up to 40 hours of paid sick leave per year. In addition, the new law presumes that exempt employees work 40 hours each week, except each exempt employee whose normal work week is less than 40 hours will accrue paid sick leave based on the hours worked in their normal week. Employers must allow employees to retain their accrued sick leave if transferred to another part of the company, or if employees are acquired by a successor employer.

Employee Eligibility

Under the current law, there is a 680 hour (about 85 days) waiting period before benefits may be payable. Under the new law, benefits will be available on or after 120 calendar days of employment. Under both laws, the maximum benefit cannot exceed the maximum number of accrued hours.

Carryover of Leave

Currently, up to 40 hours of unused sick leave may be carried over into the following calendar year.

Carryover will be the same under the new law; however, in lieu of any carryover from the current year to the following year, an employer may frontload an employee's paid sick leave that meets or exceeds the benefits under the law.

Permitted Uses of Leave

Paid sick leave may be used for:

- An employee's or family member's illness, injury, or health condition;
- The medical diagnosis, care or treatment of an employee's or family member's mental or physical illness, injury or health condition;
- Preventative medical care for an employee or family member;
- A mental health wellness day; or

- Medical care or counseling for an employee who is a victim of family violence or sexual assault; obtaining services from a victim services organization; relocating; or participating in civil or criminal proceedings related to the family violence or sexual assault. Parents or guardians of victims may take leave for these purposes as well.

In addition, the new law expands permissible uses of paid sick leave to include the following:

- A determination by a health authority having jurisdiction, an employer of the employee, an employer of a family member or a health care provider, that such employee or family member poses a risk to the health of others due to such employee's or family member's exposure to a communicable illness, whether or not the employee or family member contracted the communicable illness; and

- Closure by order of a public official, due to a public health emergency of either an employer's business or a family member's school or place of care.

The new law expands the definition of "family member" that currently only recognizes a spouse and child. Beginning January 1, 2025, a family member means a spouse, sibling, child, grandparent, grandchild, or parent of an employee or an individual related to the employee by blood or affinity whose close association the employee shows to be equivalent to those family relationships.

Employee Notice to Employer

Currently, if an employee's need to use paid sick leave is foreseeable, an employer may require up to 7 days advance notice. If the leave is unforeseeable, an employer may require notice be given as soon as practicable. For sick leave of 3 or more consecutive days, an employer may require reasonable documentation that the leave is being taken for one of the reasons permitted under the law.

The new law removes the foreseeable notice and documentation requirements. In addition, an employer may not require an employee to provide any documentation that a leave is for one of the reasons permitted under the law.

Employer Notice to Employees

Under the current law, employers must provide notice to each employee of their rights under the law upon hire. To comply with the notice requirement, employers may display a poster in a conspicuous place, accessible to employees, at the employer's place of business that contains the information required by the law, in both English and Spanish.

The new law requires employers to post a notice to employees as described above and provide written notice to employees by January 1, 2025. The Connecticut Department of Labor ("CTDOL") will create a model poster and written notice for employers. These materials will be available on the CTDOL's website.

Record Retention

Beginning January 1, 2025, employers will need to retain records, for a period of 3 years, that includes the number of hours of paid sick leave accrued by or provided to an employee and the number of hours used by the employee in the current year.

Anti-Retaliation

Under both laws, an employer may not take retaliatory personnel action or discriminate against an employee because the employee requests or uses earned sick leave either in accordance with this act or the employer's own earned sick leave policy. An employee has a right to file a complaint with the CTDOL for any violation under either law.

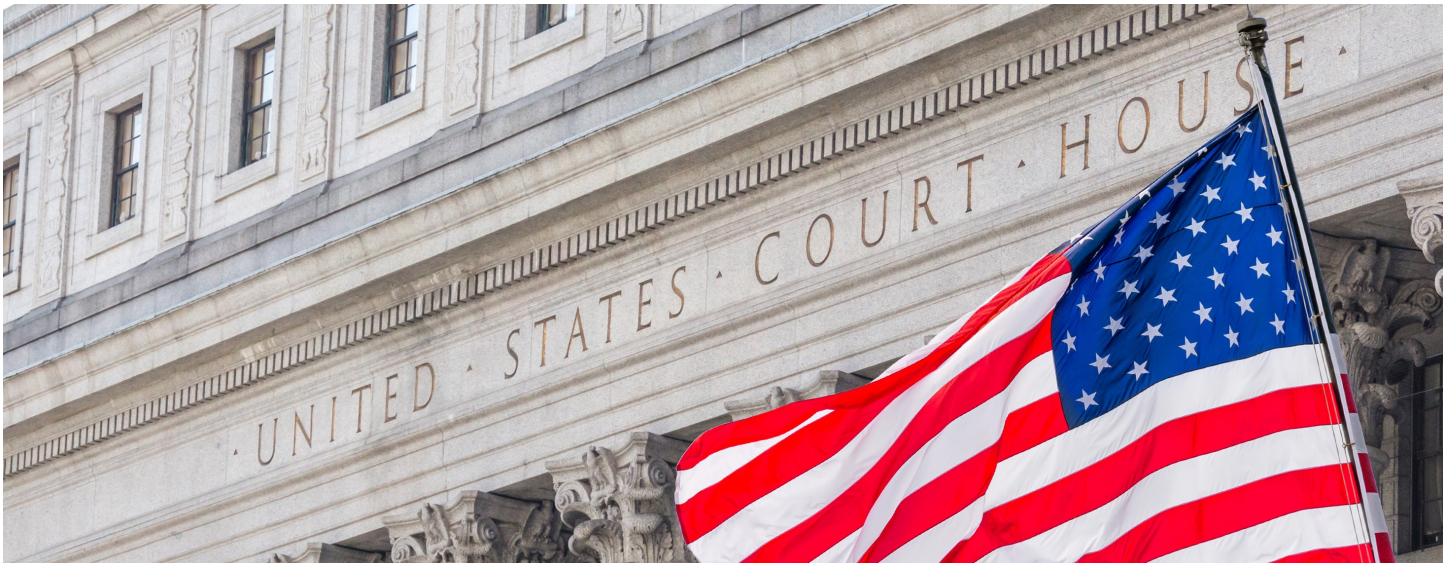
Penalties

Under both laws, the CTDOL may assess a civil penalty of not more than $500 dollars per violation of the law for each employer's retaliatory actions against an employee.

Under both laws, the CTDOL may assess a civil penalty of not more than $100 dollars for each employer's violation of the laws' provisions.

Employer Action

Employers with 25 or more employees have a relatively short time (until January 1, 2025) to make appropriate changes to their paid sick leave or Paid Time Off policy for Connecticut employees to comply with the requirements of the new law. Employers should work with their employment-law attorney or resource to understand and implement the details of these new rules. Employers will need to update their payroll systems to correctly track and report employees' paid sick leave accruals. In addition, employers should consider how to educate and communicate their paid sick leave policy to human resources personnel, managers, and employees. For example, employers may need to update their employee handbook for this purpose.



Supreme Court Overturns a Landmark Decision: Chevron

Issued date: 07/16/24

On June 28, 2024, in a pair of cases, *Loper Bright Enterprises v. Raimondo and Relentless Inc. v. Department of Commerce* (collectively, *Loper Bright*), the U.S. Supreme Court held that the Administrative Procedure Act ("APA"), which governs the process by which federal agencies develop and issue regulations, requires federal courts to exercise their independent judgement on whether an agency has acted within its statutory authority and not defer to agency interpretation of the law when a statute is ambiguous.

This decision overturns long-standing precedent established in *Chevron U.S.A. Inc., v. Natural Resources Defense Council, Inc.* ("Chevron") that required federal courts to defer to an executive agency's reasonable interpretation of ambiguous statutory provisions the agency administers (often referred to as *Chevron* deference).

In *Loper Bright*, the Court held the APA requires federal courts to "decide all relevant questions of law and interpret statutory provisions" and "must exercise their independent judgment in deciding whether an agency has acted within its statutory authority." Agency interpretation of an ambiguous (or silent) statute will no longer have preferential deference in a court action, as it did under *Chevron*.

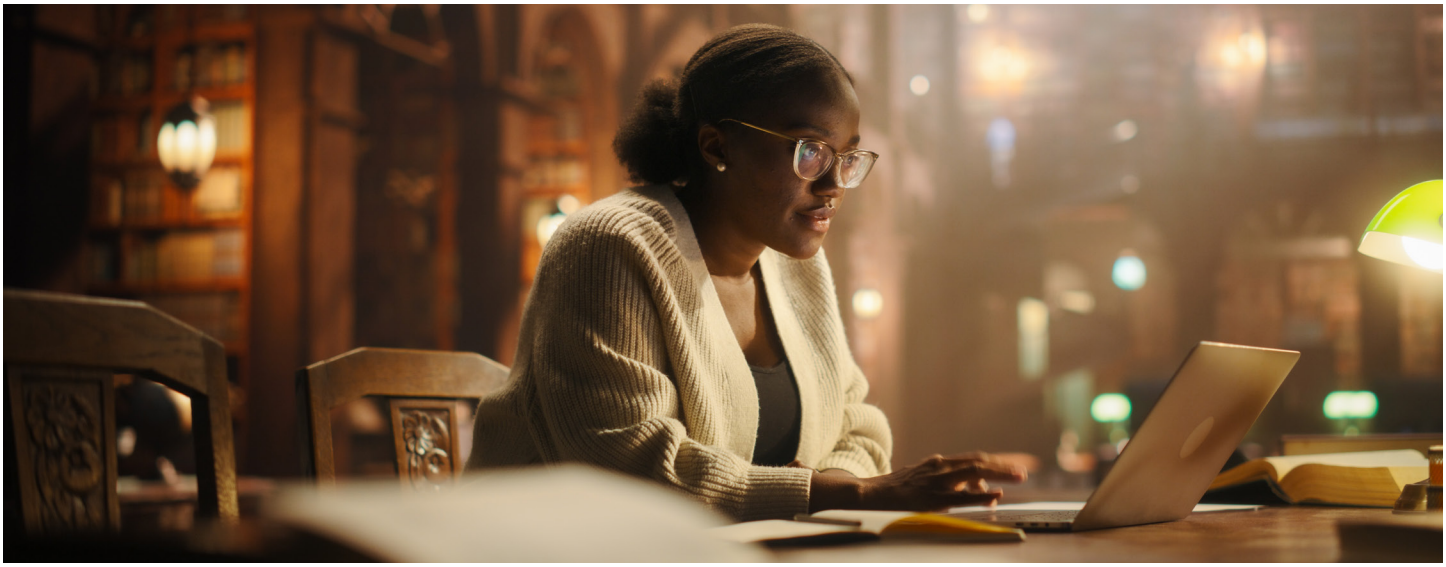
While there is no deference, courts may consider (among other information at its disposal) an agency's "body of experience and informed judgement" especially on factual determinations within the agency's expertise. Further, the decision noted that if Congress gives the agency the authority in the statute to interpret terms, then that can be considered in court review and is given more weight than when the statute is silent.

Finally, the Court's opinion confirms that overruling *Chevron* does not call into question prior cases that relied on the *Chevron* framework. The Court specifically notes that the past decisions remain law and the reliance on *Chevron* alone is not sufficient to overturn them.

Employer Action

There are a lot of questions about what comes next. This decision may have far-reaching implications over the regulated community, including employers that sponsor health and welfare programs subject to agency interpretation from the Departments of Labor, the Treasury and Health and Human Services (collectively, “the Departments”), among others. As a result of this decision, there may be an increase in litigation challenging regulations or other agency rules.

For now, employers should continue to follow guidance from the Departments and monitor case developments.



Frequently Asked Questions About Educational Assistance Programs

Issued date: 07/19/24

The Internal Revenue Service (“IRS”) released a fact sheet which provides answers to frequently asked questions (“FAQs”) related to employer educational assistance programs created under Section 127 (“§ 127”) of the Internal Revenue Code (“the Code”). In addition, the IRS provided a sample plan document for an educational assistance benefit plan that employers can utilize when designing a program.

Background

Employees may exclude certain educational assistance benefits from gross income if they are provided under an employer sponsored § 127 educational assistance program. This means an employee will not have to pay income tax on the amount of benefits up to $5,250 per calendar year and the employer should not include the benefits in the calculation of wages, tips and other compensation shown in box 1 of the employee’s W-2 form.

Amounts paid under a § 127 educational assistance program are generally deductible by the employer as a business expense under § 162.

As part of the Coronavirus Aid, Relief and Economic Security Act of 2020 (“CARES Act”), § 127 was expanded to include student loan payments through 2025.

Q&A on Educational Assistance Programs

What is an educational assistance program?

§ 127 educational assistance program is a separate written plan of an employer for the exclusive benefit of its employees to provide employees with educational assistance. To qualify, the program must be **written**, may not discriminate in favor of officers, shareholders, self-employed or highly compensated employees, and satisfy other requirements.

The IRS provides a sample plan document to assist employers in establishing a qualified educational assistance program under § 127. An employer may tailor its plan to include, for example, conditions for eligibility, when an employee's participation in the plan begins, and prorated benefits for part-time employees. The sample plan document can be found at https://www.irs.gov/pub/irs-pdf/p5993.pdf

What are educational assistance benefits?

§ 127 benefits include payments for tuition, fees and similar expenses, books, supplies and equipment, and the payments may be for either undergraduate or graduate-level courses. The payments do not have to be for work-related courses.

§ 127 benefits also include principal or interest payments on qualified education loans incurred by the employee. These payments must be made by the employer after March 27, 2020, and before January 1, 2026, to qualify (unless extended by future legislation).

§ 127 benefits do not include payments for the following items:

- Meals, lodging or transportation.
- Tools or supplies (other than textbooks) that the employee can keep after completing the course of instruction (for example, educational assistance does not include payments for a computer or laptop that the employee keeps).
- Courses involving sports, games, or hobbies unless they:
    - Have a reasonable relationship to the business of the employer, or
    - Are required as part of a degree program.

An employer may choose to provide some or all of the educational assistance described above. The terms of the plan may limit the types of assistance provided to employees.

What is the total amount that an employee can exclude from gross income under § 127?

Under § 127, the total amount that an employee can exclude from gross income for payments of principal or interest on qualified education loans and other educational assistance combined is $5,250 per calendar year on a "use it or lose it" basis.

What is a qualified education loan?

A qualified education loan is a loan for education at an eligible educational institution. Eligible educational institutions include any college, university, vocational school, or other postsecondary educational institution. The Department of Education determines whether an organization is an eligible education institution. A loan does not have to be issued or guaranteed under a federal postsecondary education loan program to be a qualified education loan.

How can payments of qualified education loans be made?

An employer may provide § 127 payments of principal or interest on an employee's qualified education loans for the employee's own education directly to a third party, such as an educational provider or loan servicer, or make payments directly to the employee.

Are employer payments of qualified education loans for an employee's spouse and/or dependents excluded from gross income under § 127?

No. Under § 127, an educational assistance program must be provided for the exclusive benefit of the employee and not for the education of a family member such as a spouse or dependent. If a spouse or dependent is also an employee of the employer, they may be able to receive benefits under the program as an employee.

Can student debt be reimbursed under a § 127 educational assistance program?

It can be reimbursed if the debt was incurred as a result of expenses that are permissible benefits under § 127 of the Code (such as tuition, books, equipment, qualified education loans). The employer may reimburse the employee for these expenses as educational assistance benefits, and the employee could then use those funds to help satisfy his or her debt. To be excluded from the employee's gross income, the employee must be prepared to substantiate the expenses to the employer.

Can self-employed individuals, shareholders and owners received educational assistance under a § 127 educational assistance program?

While there are no specific income limits for receiving educational assistance benefits, an educational assistance program must satisfy certain nondiscrimination requirements, including not being discriminatory in favor of employees who are highly compensated employees.

An individual who is self-employed within the meaning of § 401(c)(1) may receive educational assistance. Shareholders and owners (or their spouses or dependents) may receive educational assistance as long as total contributions to the shareholder/owner class does not exceed 5 percent of the amounts paid or incurred by the employer for educational assistance during
the year.

As a practical matter, if the owners are the only employees, they cannot receive educational assistance under § 127 because of the 5 percent benefit limitation described above.

Are there other exclusions from gross income for educational assistance?

There may be other exclusions under the tax code that can apply for educational assistance, including an exclusion for working condition fringe benefits and an educator expense deduction. Discussion of these exclusions is beyond the scope of this article.

Employer Action

Employers that have (or are considering) an education assistance program should review these IRS FAQs and should note the following:

- Any education assistance program should be a separate written plan to take advantage of the tax benefits.
- The combined total amount of the exclusion is $5,250 per calendar year.

- Only eligible expenses can be provided on a tax favored basis. For a limited time, this includes assistance for principal and interest payments on qualified education loans when the payments are made after March 27, 2020, and before January 1, 2026.

- The program is provided for the exclusive benefit of the employee and does not include the employee's spouse or family members.

Change Healthcare Data Breach HIPAA Considerations

Issued date: 07/24/24

Earlier this year, Change Healthcare, a large health payment processing company, announced a massive data breach which compromised personal information, including health information. Many large health insurance carriers and third-party administrators ("TPAs") utilize Change Healthcare for claims processing and payment. Recently, Change Healthcare announced it is in the late stages of its data review and has identified certain customers whose members' or patients' data was impacted. This includes protected health information ("PHI") of millions of health plan beneficiaries, possibly in the range of one-third of all Americans. The Department of Health and Human Services ("HHS") has initiated an investigation. In addition, dozens of lawsuits have been filed.

Multiple insurance carriers and TPAs of employer-sponsored group health plans, including UnitedHealthcare, some Blues plans, Cigna, and Aetna, have now begun informing plan sponsors that their data may have been disclosed as a result of the data breach. It is expected that more service providers will be notifying impacted plans in the future. The mailing process to affected individuals is expected to begin in late July. Change Healthcare has published a Payer list that reflects the parties that utilize Change Healthcare's services and could be impacted by the breach.

This data breach has far-ranging implications, from concerns around benefit plan claims payments to the unauthorized release of PHI. It is important that plan sponsors of impacted health plans understand the requirements and obligations that the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") places on "covered entities" in the event of a PHI breach. Covered entities are health plans, health care clearinghouses, and health care providers.

Background

HIPAA's privacy, security, and breach rules apply directly to "covered entities" and have strict requirements around the safeguarding of PHI. PHI is any personally identifiable health information that is created, received, maintained, or transmitted by a covered entity or its business associates. A "business associate" is a person or entity that performs certain functions or activities that involve the use or disclosure of PHI on behalf of, or provides services to, a covered entity.

Among the many requirements imposed by HIPAA, and of particular relevance here, are the obligations for a covered entity to:

- Maintain breach notification procedures;
- Obtain a signed business associate agreement with any business associate who may create, transmit, retain, or use the covered entity's PHI; and
- In the event of a PHI breach, provide certain notifications to impacted individuals, HHS, and in certain cases, the media.

In the event of a breach of PHI, covered entities must notify impacted individuals of the breach "without unreasonable delay" and, in any case, no later than 60 days after the breach is discovered. Where the breach occurred at a business associate, the business associate must also notify the covered entity without unreasonable delay and no later than 60 days after the breach is discovered.

In addition, the Office of Civil Rights ("OCR") must be notified by the covered entity of any PHI breach. If less than 500 individuals are impacted by the breach, OCR must be notified within 60 days following the end of the calendar year in which the breach occurred. If more than 500 individuals are affected, the covered entity must notify OCR at the same time that they notify impacted individuals. In addition, "prominent media outlets" in the state or region must be notified if more than 500 individuals are impacted in a single state.

HHS Guidance

HHS published guidance specifically addressing the Change Healthcare breach and the requirements under HIPAA applicable to covered entities.

The guidance confirmed that covered entities are permitted to delegate HIPAA's notification obligations to a third party (in this case, to Change Healthcare). Importantly, however, HHS emphasized that the responsibility to comply with these requirements ultimately remains with the covered entity. If a covered entity delegates these requirements to such a third party and the third party fails to comply with these requirements, the covered entity would ultimately be held responsible for the noncompliance.

The guidance also contained relief for covered entities related to the timing of notifications. HHS noted that as of the time of their most recent update (May 31, 2024), neither Change Healthcare nor UnitedHealth Group ("UHG") (who owns Change Healthcare) had filed a breach report with HHS or notified impacted individuals. HHS stated that the 60-day notification deadline does not begin to toll until affected entities are provided with necessary information by either Change Healthcare
or UHG.

Employer Action

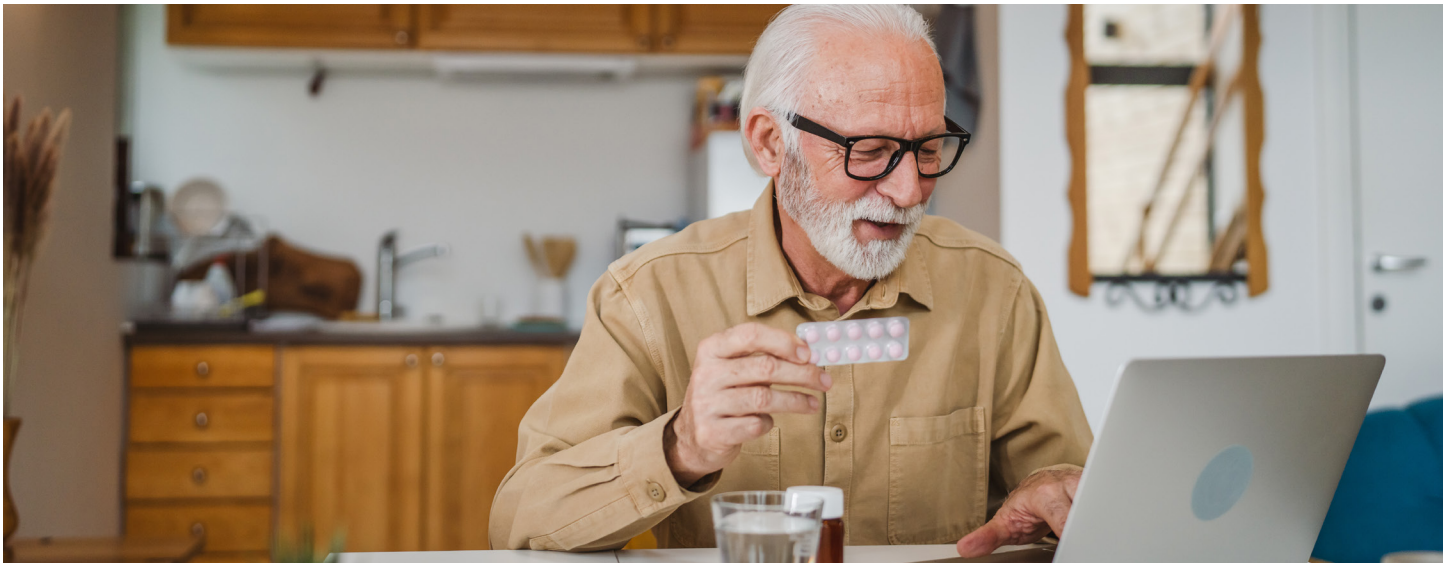
PHI breaches should always be taken seriously, especially where a breach has received as much attention and scrutiny as the Change Healthcare breach.

Fully insured plans: the covered entity with the reporting obligation is the carrier and should therefore be responsible for handling all notifications. Likewise, a provider is the covered entity with the reporting obligation. Employers may want to consider communicating to plan participants that they should expect a notice from the carrier.

Self-funded plans: the TPA is the business associate and the covered entity with the reporting obligation is the plan. Self-funded plans should consider the following:

- Await notification. TPAs are required to notify the covered entity if it was impacted by the Change Healthcare data breach. Many affected TPAs have begun the notification process (or will do so in the near future).

- Coordinate with Change Healthcare or their TPA as to which party will provide notice to impacted individuals, OCR, and media (where necessary).
  - While Change Healthcare has indicated it is willing to provide the necessary notifications, covered entities will need to determine whether they are comfortable relying on another entity since ultimate responsibility to comply rests with the covered entity.
  - Change Healthcare has set up a website that provides information about its anticipated notification procedures. Impacted plans should review this information when making the determination as to whether to delegate their notification responsibilities.
  - Plans should document whether they chose to delegate their notification requirements or not and their rationale.
  - If Change Healthcare is handling the notifications, employers should consider informing their plan participants that they should expect a notification in the future.



Changes to Medicare Part D Creditable Coverage Determination

Issued date: 07/29/24

The Inflation Reduction Act of 2022 ("IRA") made several changes that will affect the structure of the Medicare Part D prescription drug benefit program beginning in 2025. The Centers for Medicare and Medicaid Services ("CMS") released final instructions around the redesign of the program and:

- acknowledge that some group health plans offering prescription drug benefits that have met Part D creditable coverage requirements in prior years may no longer meet those requirements for plan years beginning in 2025.
- permit group health plans to continue to use the simplified determination method for determining creditable (or non-creditable) status of the prescription drug program in 2025.

Background

Employers sponsoring group health plans with prescription drug benefits are required to notify their Medicare Part D-eligible participants and beneficiaries as to whether the drug coverage provided under the plan is "creditable" or "non-creditable." This notification must be provided prior to October 15th each year. Also, following the plan's annual renewal (among other times), the employer must notify CMS of the creditable status of the drug plan.

Group health plan coverage is considered "creditable" if the actuarial value of the coverage provided equals or exceeds the value of standard prescription drug coverage provided under Medicare Part D. For most employer-sponsored group health plans, there are two ways to determine creditable status: use CMS's simplified determination tool, or obtain a certification from an actuary.

The CMS tool allows a plan to determine creditable status based on plan design features such as deductible and out-of-pocket max, while the actuarial certification method requires an analysis of claims information.

What's Changed?

The IRA made changes to the structure of the standard Medicare Part D benefit by amending which categories of benefit count toward true out-of-pocket costs and lowering the out-of-pocket max to $2,000.

Because the IRA enhances the Medicare Part D benefit, it may result in some group health plans that historically met a creditable coverage standard to lose that status unless certain plan design changes are made.

In the draft instructions for creditable coverage determinations, CMS indicated that the simplified determination tool would no longer be a valid method for determining creditable status for Calendar Year 2025. CMS reversed its earlier position, however, and will permit group health plans to use the simplified tool for 2025. CMS will re-evaluate this position for 2026, including whether to continue to use the existing methodology or establish a revised version. It is possible that plans will need to engage the services of an actuary to determine creditable status after 2025.

What Does This Mean for Group Health Plans?

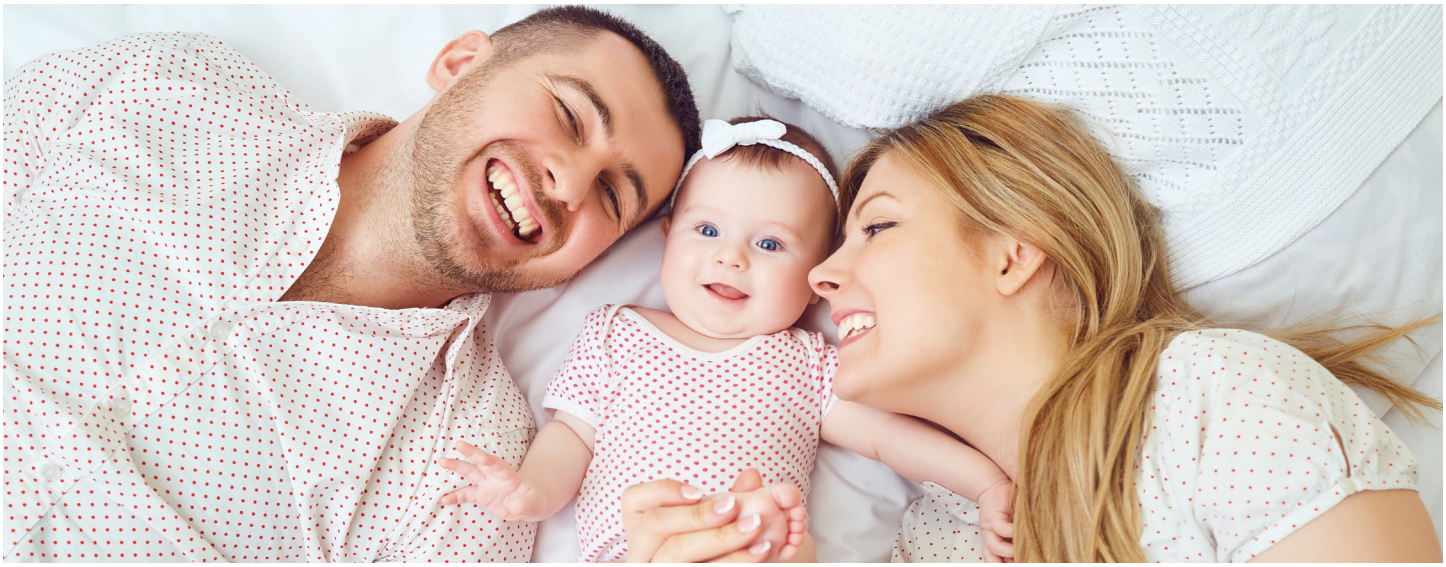
As a result of the IRA changes to the Medicare Part D benefit, some prescription drug plans that were creditable in Calendar Year 2024 will not be creditable in Calendar Year 2025.

For plan years beginning in 2025, group health plan sponsors should determine whether to:

- update prescription drug benefit coverage to maintain creditable status, or
- maintain current prescription drug benefits, even if it means becoming non-creditable.

It is important to note that a late enrollment penalty may apply to individuals who do not maintain creditable coverage for a period of 63-days or longer following their initial enrollment period for Medicare Part D.

If a prescription drug plan changes creditable status, an updated disclosure to CMS must be provided within 30 days of the change. Notice should also be provided to participants.



Rhode Island Expands Temporary Caregiver Insurance Benefits

Issued date: 07/31/24

Rhode Island Governor Daniel McKee signed a bill extending the length of Temporary Caregiver Insurance ("TCI") benefits and increasing the minimum dependent allowance beginning January 1, 2025.

Background

Currently, Rhode Island employees are eligible to receive up to six (6) weeks of wage replacement benefits to care for a seriously ill child, spouse, domestic partner, parent, parent-in-law, or grandparent, or to bond with a newborn child, adopted child or
foster child.

What is Changing?

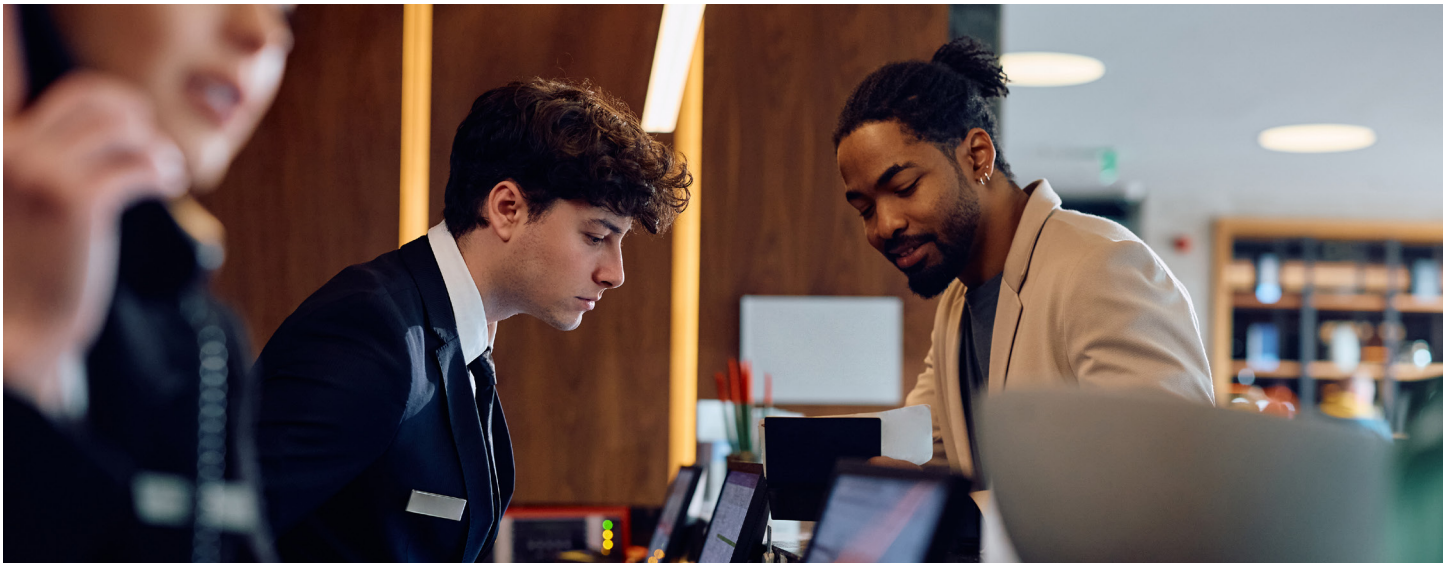
Beginning January 1, 2025, employees are eligible to receive seven (7) weeks of caregiver benefits.

Beginning January 1, 2026, employees are eligible to receive eight (8) weeks of caregiver benefits.

The bill also increased the minimum dependent allowance from $10.00 per week to $20.00 per week beginning January 1, 2025. Employees with dependents are entitled to the greater of the minimum dependent allowance or 7% of their weekly benefit amount for each dependent.

Employer Action

Employers should ensure that their leave policies, procedures and systems are updated for compliance with the TCI amendments beginning January 1, 2025.



2025 Seattle Hotel Employees Ordinance Expenditure Rates

Issued date: 08/01/24

The Seattle Office of Labor Standards ("OLS") announced the adjusted rates for 2025 health care expenditures required by the Improving Access to Medical Care Hotel Employees Ordinance, Seattle Municipal Code (SMC) 14.28.

Covered employers must make healthcare expenditures to or on behalf of covered employees (hourly employees who work an average of 80 hours or more per month for a covered employer) to improve their access to medical care. The amounts of the healthcare expenditure are adjusted each calendar year.

For the 2025 calendar year (January 1 to December 31, 2025), the adjusted rates are:

- $561 per month for an employee with no spouse, domestic partner, or dependents;
- $955 per month for an employee with only dependents;
- $1,124 per month for an employee with only a spouse or domestic partner;
- $1,686 per month for an employee with a spouse or domestic partner and one or more dependents.

For most covered employers, the Ordinance was effective July 1, 2020, or the next scheduled annual open enrollment period for health coverage (if offered) after July 1, 2020.

As previously reported, the requirements of the Ordinance were delayed for an ancillary hotel business with 50–250 employees worldwide that contracts, leases, or subleases with a hotel. These requirements take effect upon the later of July 1, 2025, or the earliest annual open enrollment period for health coverage (if offered) after July 1, 2025.

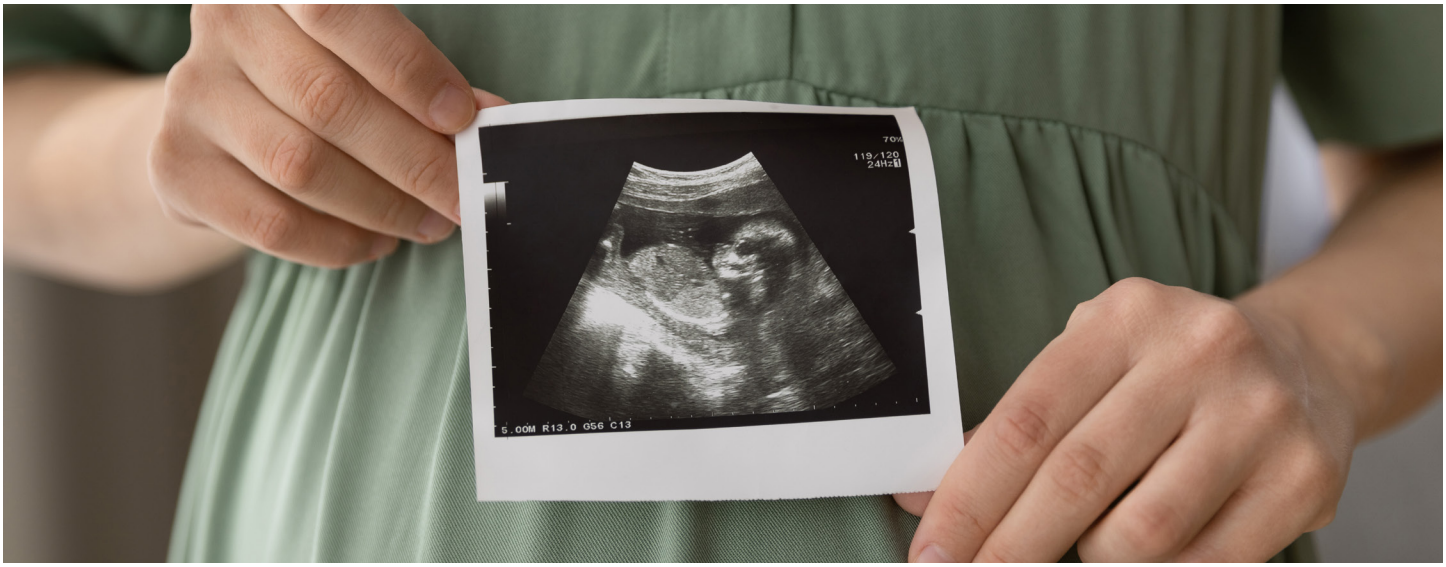
The U.S. Supreme Court declined to review the earlier decision from the 9th Circuit Court of Appeals that held the Ordinance is not preempted by ERISA. This means the Ordinance continues to stand and employers should comply with its requirements.

Employer Action

- Covered employers subject to the Ordinance should comply with the law. Ancillary businesses that had relief from this requirement should begin to prepare for the upcoming July 1, 2025 (or first plan year on or after that date) effective date. The OLS FAQs provide helpful information.

- If compliance is required for a plan year beginning in 2025, the adjusted rates should be used to determine appropriate expenditures. The adjusted rates of the expenditure should be included as part of the annual notification required to covered employees.

- Covered employers should monitor OLS FAQs and website for further information.



Model Attestation for Reproductive PHI Released

Issued date: 08/20/24

In April, the Department of Health and Human Services ("HHS") issued a final HIPAA Privacy Rule to Support Reproductive Health Care Privacy ("Privacy Rule"). Among other things, the Privacy Rule requires a regulated entity, such as a group health plan or a plan's business associate, which receives a request for protected health information ("PHI") potentially related to reproductive health care ("reproductive PHI" or "rPHI"), to obtain a signed and dated attestation from the requesting entity or individual stating that the use or disclosure is not for a prohibited purpose. The attestation requirement takes effect December 23, 2024. HHS recently released the model attestation, which includes background information and instructions.

Background

The Privacy Rule directs that a "regulated entity" cannot use or disclose PHI for:

1. conducting a criminal, civil, or administrative investigation into any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care;

2. imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating lawful reproductive health care; or

3. identifying any person for any purpose described in (1) or (2).

A "regulated entity" generally includes a group health plan (the covered entity) and a business associate of such plan.

The Privacy Rule includes specifics on what constitutes "reproductive health care," and details on when the prohibition applies.

The attestation requirement under the Privacy Rule applies when there is a request to the regulated entity for rPHI for any of the following:

- Health oversight activities;
- Judicial and administrative proceedings;
- Law enforcement; or
- Disclosures to coroners and medical examiners regarding decedents.

Attestation Information

The model attestation issued by HHS includes the above background information along with instructional information for both the person requesting the rPHI and the regulated entity. While use of the model attestation itself is not mandatory, it will likely be used in most relevant situations.

The instructional information essentially directs that a group health plan and/or the plan's business associate:

- cannot rely on the attestation to disclose the requested rPHI if:
    - the attestation is missing any required element or statement or contains other content that is not required;
    - the attestation is combined with other documents, except for documents provided to support the attestation;
    - it knows that material information in the attestation is false; or
    - a reasonable covered entity or business associate in the same position would not believe the requestor's statement that the use or disclosure is not for a prohibited purpose.
- must stop making the requested use or disclosure, if it later discovers information that reasonably shows that any representation made in the attestation is materially false, leading to a use or disclosure for a prohibited purpose as described above.
- must not make a disclosure if the reproductive health care was provided by a person other than the regulated entity and the requestor indicates that the PHI requested is for a prohibited purpose, unless the requestor supplies information that demonstrates a substantial factual basis that the reproductive health care was not lawful under the specific circumstances in which it was provided.
- must obtain a new attestation for each specific use or disclosure request.
- must maintain a written copy of the completed attestation and any relevant supporting documents.

The attestation itself is a single page and the requesting party must:

1. identify the party who will receive the requested rPHI.
2. identify the person from whom the use or disclosure is requested.

3. describe the specific rPHI requested, including identifying the person(s) whose protected health information is being requested.

4. check one of two boxes specifying the request is not prohibited because either:

    a. the purpose of the request is not for any investigation or imposition of liability related to reproductive healthcare; or

    b. the purpose of the request is for an investigation or imposition of liability regarding reproductive healthcare that was not lawful.

The attestation also highlights that the requesting party could be subject to criminal penalties for improperly obtaining individually identifiable health information relating to an individual or disclosing individually identifiable health information to another person.

Finally, the guidance provides that the attestation may be provided in electronic format, and electronically signed by the requesting party.

Employer Action

For employers with fully insured plans: much of the responsibility for compliance with the attestation requirement should fall on the carrier, which would be the covered entity positioned to respond to requests related to rPHI. Presumably, such employers who receive rPHI requests would refer those to the carrier.

For self-funded (including level-funded) plans: employers will need to address these issues and have an attestation notice available to respond to requests. Most likely, however, it will be the third-party administrator ("TPA"), or other vendors (such as pharmacy benefit managers ("PBMs") or behavioral health providers or provider networks), who are business associates of the self-funded plan, where such requests may typically be directed. A self-insured plan sponsor will likely need to rely on their TPA or other business associate for compliance with the attestation requirement. Thus, sponsors should work with their TPA and other business associates to ensure they will be prepared to comply with the requirement, including for requests forwarded by the sponsor, starting December 23, 2024.

Employers sponsoring both insured and self-insured plans should consider third party vendors who may be business associates of any employer health plan and may obtain rPHI and receive requests to disclose rPHI. Such vendors might include those administering:

- Health flexible spending accounts ("FSAs")
- Health reimbursement arrangements ("HRAs")
- Telehealth
- Family-forming/fertility solutions
- Specialty drug carve-outs
- Other data analytics, including brokers and consultants

Where appropriate, employers should work with such vendors to ensure they will be prepared to comply with the attestation requirement starting December 23, 2024.

Further, as previously reported, the final rule may also require self-funded plans to modify or update the following by December 23, 2024 (depending on existing language or specifics of the plan) to address rPHI:

- Policies and procedures
- Training
- Risk assessment
- Business associate agreements

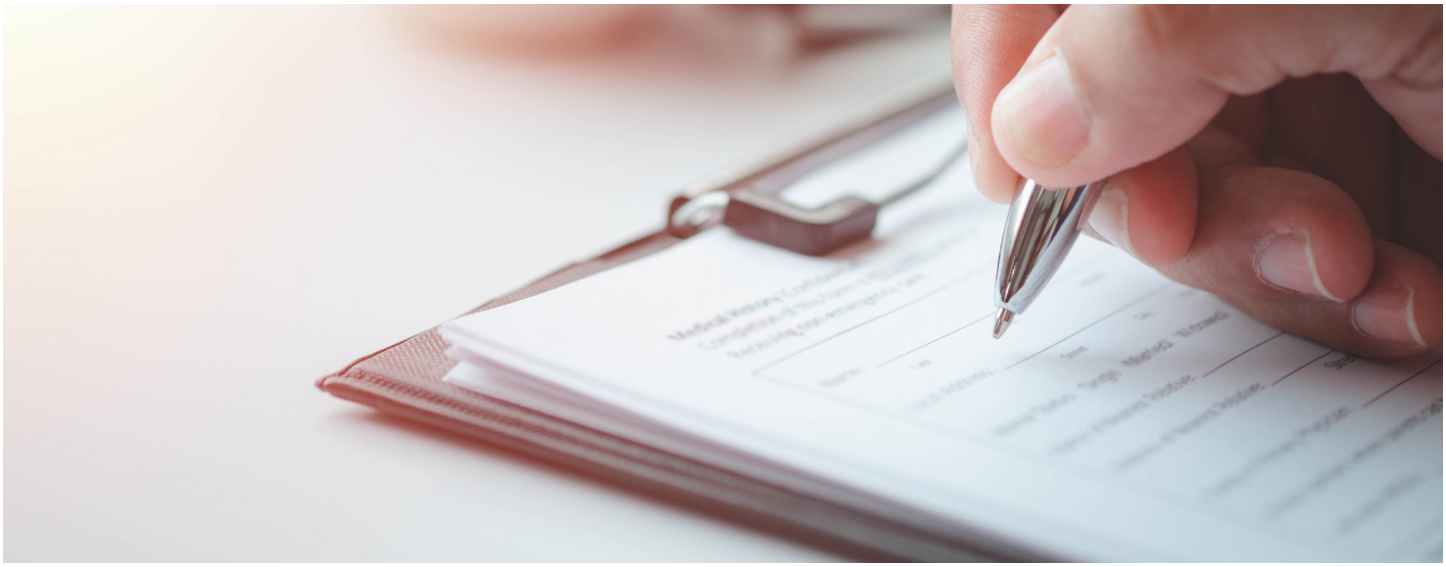
Finally, self-funded plans will need to update their notice of privacy practices to account for these changes by February 16, 2026. Carriers for fully insured plans are responsible for the notice of privacy practices and should also timely update these notices.

HHS has not yet updated their sample notice of privacy practices to reflect these changes.

We will continue to monitor and inform you of any additional important developments on the attestation requirement.

Resources

- Model Attestation for a Requested Use or Disclosure of Protected Health Information Potentially Related to Reproductive Health Care



HHS Penalties Increase for 2024

Issued date: 08/23/24

The Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (the "Inflation Adjustment Act") directs federal agencies to adjust the civil monetary penalties for inflation. On August 8, 2024, the Department of Health and Human Services ("HHS") issued final rules adjusting civil monetary penalties for inflation.

The adjusted penalties are applicable to penalties assessed on or after August 8, 2024, if the violation occurred on or after November 2, 2015.

Below are the penalties applicable to group health plans:

Description	2023 Penalty (Prior)	2024 Penalty (New)
Pre-February 18, 2009 violation of HIPAA administrative simplification provisions	$187 per violation $47,061 annual cap	$193 per violation $48,586 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision without knowledge	$137 min. $68,928 max. $2,067,813 annual cap	$141 min. $71,162 max. $2,134,831 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision with reasonable cause and not to willful neglect	$1,379 min. $68,928 max. $2,067,813 annual cap	$1,424 min. $71,162 max. $2,134,831 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND corrected during 30-day period	$13,785 min. $68,928 max. $2,067,813 annual cap	$14,232 min. $71,162 max. $2,134,831 annual cap

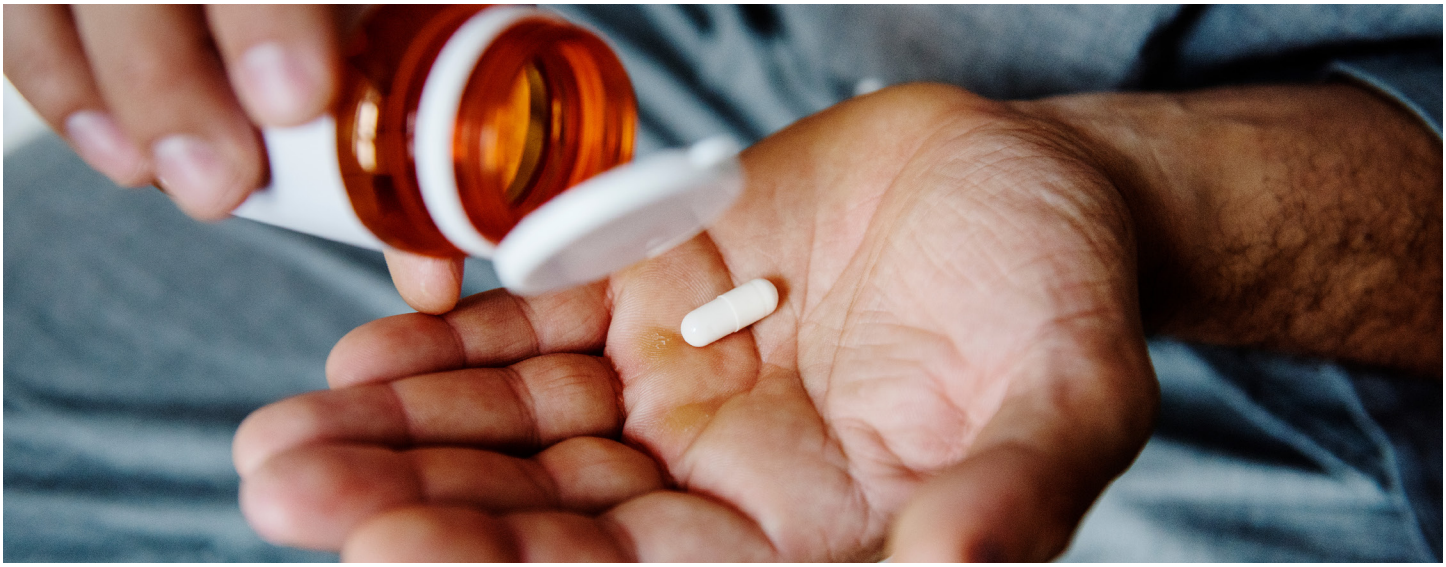
February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND NOT corrected during 30-day period	$68,928 min. $2,067,813 max. $2,067,813 annual cap	$71,162 min. $2,134,831 max. $2,134,831 annual cap
Failure to provide the Summary of Benefits and Coverage (“SBC”)	$1,362 per day	$1,406 per day
Penalty for an employer or other entity to offer financial or other incentive to individual entitled to Medicare/Medicaid benefits not to enroll under a group health plan that would be primary	$11,162	$11,524
Penalty for entity serving as insurer, TPA, or fiduciary for a group health plan that fails to provide information to HHS Secretary identifying when the GHP was primary payer to Medicare	$1,428	$1,474

Employer Action

Covered Entities must ensure proper application and compliance with HIPAA’s Privacy and Security Rules.

Employers should avoid using incentives to discourage Medicare/Medicaid eligible employees from enrolling in the employer’s health plan.

Employers should be aware of the SBC disclosure requirement and ensure employees receive SBCs in a timely fashion (e.g., in connection with open enrollment).



2025 Part D Changes and Employer Sponsored Group Health Plans

Issued date: 09/03/24

Employers are required to notify participants and beneficiaries who are Medicare Part D eligible individuals and the Centers for Medicare and Medicaid Services ("CMS") of the creditable or non-creditable status of the group health plan prescription drug plan(s).

Prescription drug coverage is creditable when the coverage is as good as (or better than) Medicare Part D. Coverage that is not as good as Medicare Part D is considered non-creditable.

As previously reported, the Inflation Reduction Act of 2022 ("IRA") changed aspects of the Medicare Part D program to enhance and improve Medicare Part D coverage. The changes include:

- A newly defined standard Part D benefit design consisting of three phases: annual deductible, initial coverage, and catastrophic coverage;
- A lower annual out-of-pocket ("OOP") threshold of $2,000;
- The sunset of the Coverage Gap Discount Program ("CGDP") and establishment of the Manufacturer Discount Program ("Discount Program"); and
- Changes to the liability of enrollees, Part D sponsors, manufacturers, and CMS in the newly defined standard Part D benefit design.

As a result of these changes, some employer sponsored prescription drug coverage may no longer qualify as creditable for the 2025 plan year. This will likely happen with certain high deductible health plans ("HDHPs") (with or without a Health Savings Account ("HSA") component) that may have been creditable before, but due to the change no longer are. It should be noted that many of these plans have been non-creditable in the past and there is no change due to the IRA.

Employers will need to be aware of any change in the creditable status of their prescription drug coverage and provide timely notification to participants and CMS. The following Q&As, which focus on compliance issues related to employers sponsoring group health plan coverage for active employees (and not for retirees) are intended to help employers understand the changes and obligations and serve as a refresher to current requirements.

Why does this change matter to employers?

All group health plans that offer prescription drug coverage are required to notify Medicare Part D eligible individuals (and CMS) of the creditable status of their group health plan coverage. Nothing has changed with respect to group health plans being required to notify Medicare Part D eligible individuals and CMS of creditable status, but these changes may cause certain plan options offered by employer (e.g., some HDHPs) that were creditable in a prior year to no longer be creditable for the first plan year in 2025.

Do employers have to offer a creditable prescription drug program?

No, it's not required and there are no penalties on the employer for not offering one. However, it's important to note that Medicare Part D eligible individuals who delay Medicare Part D enrollment and go without creditable coverage for 63 days will face higher prescription drug premiums when they later enroll in a Medicare Part D prescription drug plan.

When do these changes take effect?

The changes to the Part D program take effect in 2025 and employers should review whether the prescription drug plans are creditable or non-creditable for plan years that begin on or after January 1, 2025. For non-calendar year plans, the redetermination occurs effective with the first plan year that begins in 2025 (e.g., June 1, 2025, for a June 1 – May 31 plan year).

If the creditable status of the prescription drug coverage is changing, it's important to promptly communicate this to plan participants. Even if there is no change in the creditable (or non-creditable) status of the prescription drug coverage, there are still notification requirements that must be met each year.

How do we know if the coverage is creditable?

For fully insured plans, the carrier will typically disclose whether coverage is creditable or non-creditable.

For self-funded plans (including level-funded plans), the TPA or PBM may provide this information or offer tools to help support this determination. Note that some may charge for this service and some TPAs and PBMs will not help.

It is important to note that a determination of creditable coverage must be made for each benefit option. For example, you may offer a PPO plan that has creditable coverage and a HDHP/HSA option that provides non-creditable coverage.

How is creditable coverage determined?

A health plan's prescription drug coverage is considered creditable if the average value of prescriptions paid by the plan meets or exceeds the average value of those paid under standard Medicare Part D prescription drug coverage. CMS rules provide two methods to determine creditable coverage: the simplified method and an actuarial determination.

Simplified method

- Some plans may use the simplified determination of creditable coverage status to annually determine whether coverage is creditable or not. However, an HDHP/HSA plan cannot use the simplified method. Additionally, employers who participate in the Retiree Drug Subsidy Program cannot use this method.
- The simplified method remains available for 2025; however, this will be reevaluated by CMS for 2026.
- Under the simplified method, a prescription drug plan is deemed to be creditable if:
    - It provides coverage for brand and generic prescriptions;
    - It provides reasonable access to retail providers;
    - The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
    - It satisfies at least one of the following:
    - The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000;
    - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual; or
    - For entities that have *integrated health coverage*, the integrated health plan has:
        - No more than a $250 deductible per year,
        - No annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000, and
        - No less than a $1,000,000 lifetime combined benefit maximum.

    Integrated health coverage is any plan of benefits where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

    - A combined plan year deductible for all benefits under the plan,
    - A combined annual benefit maximum for all benefits under the plan, and/or
    - A combined lifetime benefit maximum for all benefits under the plan.

Actuarial determination

Generally, this can be determined through an actuarial equivalency test, requiring an actuary to be hired (but an actuarial certification is not required). Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general, this is determined by measuring whether the expected total of paid claims under the employer's drug program is at least as much as what is expected under the standard Part D program.

Who do we need to notify of creditable status?

Employers need to notify both participants and CMS.

Participants

Employers that provide prescription drug benefits are required to notify Medicare Part D-eligible individuals annually as to whether the employer provided benefit is creditable or non-creditable so that these individuals can decide whether or not to delay enrollment in a Medicare Part D prescription drug plan. Since most employers won't know who is a Part D eligible individual, employers should provide the notice to all plan participants.

Medicare Part D eligible individuals who go without creditable coverage for 63 days will face higher prescription drug premiums when they later enroll in a Medicare Part D prescription drug plan.

CMS

At least annually, employers must notify CMS as to whether prescription drug coverage is creditable or non-creditable.

When do we provide the participant notice?

Group health plans must notify Medicare Part D eligible individuals at the following times:

- Prior to (but no more than 12 months before) October 15th each year (or next working day);
- Prior to (but no more than 12 months before) an individual's Initial Enrollment Period for Part D (three months before the month of the person's 65th birthday);
- Prior to (but no more than 12 months before) the effective date of coverage for any Medicare eligible individual under the plan;
- Whenever prescription drug coverage ends or changes so that it is no longer creditable, or it becomes creditable; and
- Upon a beneficiary's request.

If the disclosure notice is provided to all plan participants annually, CMS will consider the first two bullet points satisfied. Many employers provide the notice in connection with the annual group plan enrollment period or immediately following the start of the plan year.

To satisfy the third bullet point, employers should also provide the participant notice to new hires and newly eligible individuals under the group health plan.

How do we notify participants?

There is flexibility in the form and manner employers can provide notices to participants. An employer may provide a single disclosure notice to a participant and his or her family members covered under the plan; however, the employer is required to provide a separate disclosure notice if it is known that a spouse or dependent resides at an address different from the address where the participant's materials were provided.

Mail: Mail is the recommended method of delivery and the method CMS initially had in mind when issuing its guidance.

Electronic Delivery: The employer may provide the notice electronically to plan participants who have the ability to access the employer's electronic information system on a daily basis as part of their work duties (consistent with DOL electronic delivery requirements).

If this electronic method of disclosure is chosen, the plan sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare-eligible dependents covered under the group health plan.

In addition to having the disclosure notice sent electronically, the notice must be posted on the entity's website, if applicable, with a link to the creditable coverage disclosure notice.

It is important to note that sending notices electronically may not always work for COBRA qualified beneficiaries who may not have access to the employer's electronic information system on a daily basis. Mail is generally the recommended method of delivery in such instances.

Open enrollment materials: If an employer chooses to incorporate the Part D disclosure with other plan participant information, the disclosure must be prominent and conspicuous. This means that the disclosure portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded or offset on the first page of the provided information. CMS provides model notice letters that can be used to disclose the creditable or non-creditable coverage status of the plan per the requirements. Such letters, including Spanish versions, can be found at:

https://www.cms.gov/medicare/employers-plan-sponsors/creditable-coverage/model-notice-letters

When do we provide notice to CMS?

Employers also need to electronically notify CMS as to the creditable status of the group health plan prescription drug coverage. This notice must be provided by the following deadlines:

- Within 60 days after the beginning date of the plan year (March 1, 2025, for a 2025 calendar-year plan);
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status (January 31, 2025, for a 2025 calendar year plan with a change in creditable status).

It is important to note that if there is a change in the creditable coverage status that applies to the coverage effective in the new plan year, the employer should provide CMS notice within 30 days (not 60 days). While there is no penalty for late notice, it appears that the 30-day deadline applies. A calendar year plan that changed from creditable to non-creditable coverage
(or vice versa) should notify CMS by January 31, 2025.

How do we notify CMS?

Notice must be submitted electronically by completion of a form found at:
https://www.cms.gov/medicare/employers-plan-sponsors/creditable-coverage/disclosure-form

What happens if one of the plans we offer is creditable for 2024 but not for 2025?

For example, if an employer offers both a PPO plan and an HDHP/HSA plan and both prescription drug plans provide creditable coverage for the 2024 plan year, but the HDHP/HSA will not be creditable for the 2025 plan year and the PPO remains creditable, below are steps an employer should consider:

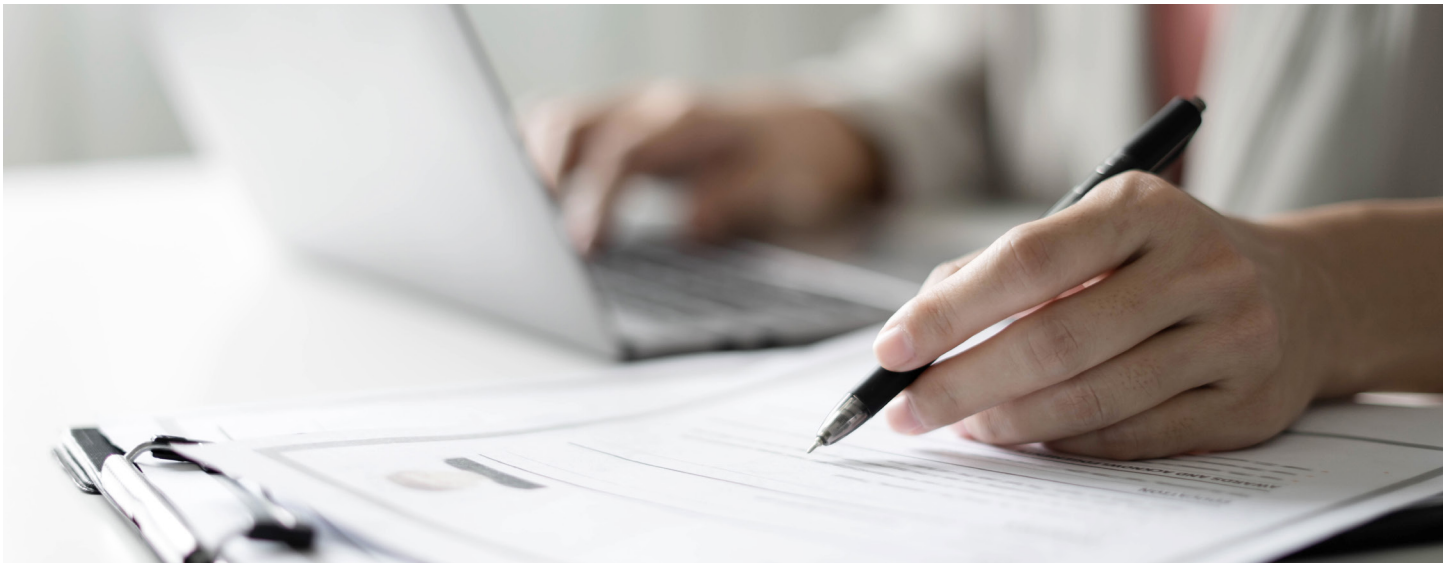
- Offer non-creditable coverage. Decide whether to offer the HDHP/HSA plan with non-creditable prescription drug coverage. There is no penalty for offering a non-creditable coverage. Employers may want to consider whether the arrangement could be made creditable and, if so, how much it would cost.

  Individuals who are enrolled in Medicare can no longer make contributions to their HSA account, so Medicare Part D eligible individuals may be more likely to elect a coverage option that is not an HDHP/HSA. Some individuals eligible for Medicare may be able to delay enrollment in Medicare (and therefore not a Part D eligible individual). These individuals would be allowed to enroll in HDHP coverage and to make HSA contributions. If the prescription coverage is not creditable, the individual would not necessarily face higher prescription drug premiums when they later enroll in Medicare Part D. However, this will generally not be an option for those who have begun receiving Social Security benefits since Medicare enrollment is automatic for those taking Social Security benefits (no delay available).

- Advance notice of the change. Provide advance notice that the HDHP/HSA plan will be considered non-creditable coverage for the 2025 plan year and what this may mean for Part D eligible individuals. This can be done in an email to plan participants or other form of communication.

- Required Participant Notification. Timely provide the required Medicare Part D participant notice for the PPO plan (creditable coverage) and the HDHP/HSA plan (non-creditable coverage). The notice should be provided to all plan participants, including COBRA qualified beneficiaries and can be provided with the 2025 open enrollment materials, or just after the start of the plan year. It must be provided annually before October 15 each year. Because the prescription drug coverage in the HDHP plan changed from creditable to non-creditable, the notice should be provided within 60 days of the change (if not earlier).

- Required CMS Notification. Timely notify CMS of the creditable status of prescription drug coverage for the 2025 plan year. Because the HDHP/HSA plan is changing from creditable to non-creditable, notice should be provided within 30 days of the change, or by January 31, 2025. You can also timely disclose the creditable status of the prescription drug coverage for the PPO plan at this time.



IRS Announces 2025 ACA Affordability Indexed Amount

Issued date: 09/18/24

The IRS recently announced that the Affordable Care Act ("ACA") affordability indexed amount under the Employer Shared Responsibility Payment ("ESRP") requirements will be 9.02% for plan years that begin in 2025. This is a significant increase from the 2024 percentage amount (8.39%) but remains below the original 9.5% threshold.

Background

IRS Revenue Procedure 2024-35 establishes the indexed "required contribution percentage" used to determine whether an individual is eligible for "affordable" employer-sponsored health coverage under Section 36B (related to qualification for premium tax credits when buying ACA Marketplace coverage). However, the IRS explained in IRS Notice 2015-87 that a percentage change under Section 36B will correspond to a similar change for affordability under section 4980H ESRP requirements.

Determining Affordability in 2025

An employer will not be subject to a penalty with respect to an ACA full-time employee ("FTE") if that employee's required contribution for 2025 meets one of the following safe harbors.

- **The W-2 safe harbor.**
  The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.02% of the employee's W-2 wages (as reported on Box 1 of Form W-2). Application is determined after the end of the calendar year and on an employee-by-employee basis. Box 1 reflects compensation subject for federal income taxes, which would exclude amounts such as employee contributions to a 401(k) or 403(b) plan, and towards other benefits through a cafeteria plan.

- **Rate of pay safe harbor.**
  The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.02% of the employee's computed monthly wages. For hourly employees, monthly wages are equal to 130 hours multiplied by their rate of pay. For salaried employees, monthly wages are equal to their monthly salary.

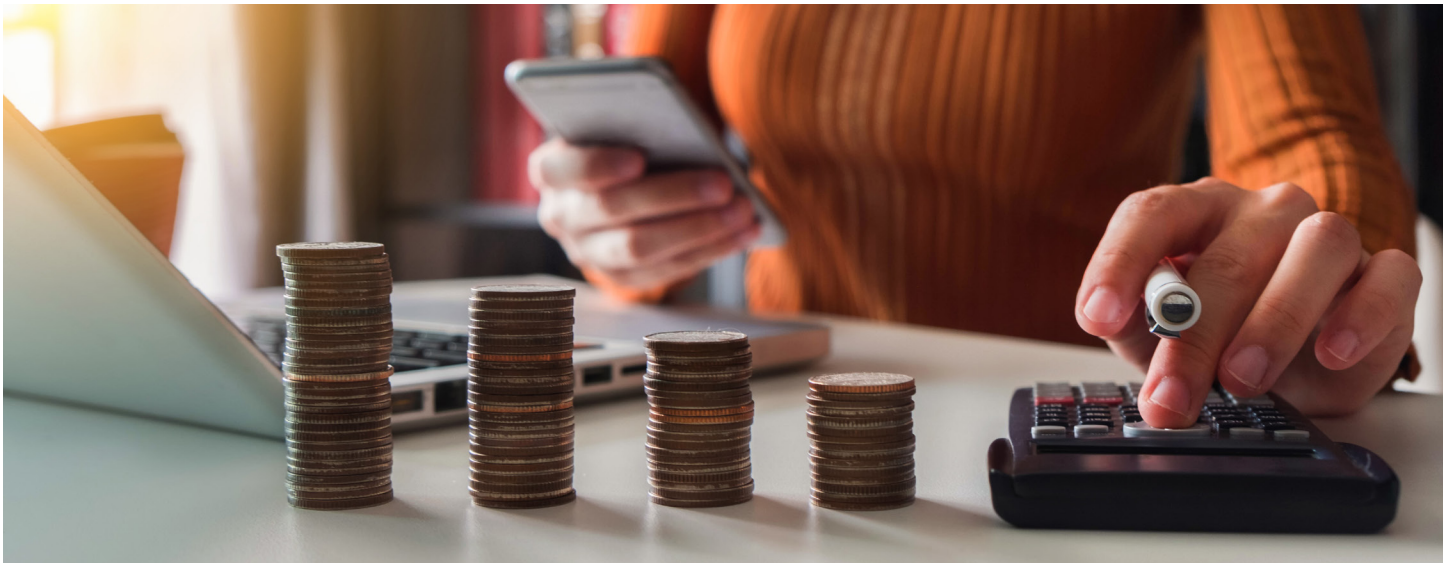
- **Federal Poverty Level ("FPL") safe harbor.**

  Coverage is affordable if it does not exceed 9.02% of the FPL.

  For a 2025 calendar year plan, coverage is affordable under the FPL safe harbor if the employee monthly cost for self-only coverage in the lowest cost plan that provides minimum value is not more than $113.20 (48 contiguous states), $141.38 (Alaska), or $130.11 (Hawaii). Note, this amount may increase (or decrease) when the 2025 FPL guidelines are issued.

Employer Action

Employers budgeting and preparing for the 2025 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.



2024 MLR Rebate Checks to Be Issued Soon to Fully Insured Plans

Issued date: 09/18/24

As a reminder, insurance carriers are required to satisfy certain medical loss ratio ("MLR") thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan; it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to employers in the form of a premium credit or check.

If a rebate is available, carriers are required to distribute MLR checks to employers by September 30, 2024.

Importantly, employers must distribute any amounts attributed to employee contributions to employees and handle the tax consequences (if any).

This does not apply to self-funded plans.

What To Do with this MLR Rebate Check?

The rules around rebates are complex and require careful review with ERISA counsel. Among other things, an employer receiving a rebate as a policy holder will need to determine:

- who receives a rebate (e.g., current participants v. former participants);
- the form of the rebate (e.g., premium reduction v. cash distribution);
- the tax impacts of any such rebate (on both the employer and participants receiving the rebate); and
- what, if any, communication to provide participants regarding the rebate.

The following questions and answers are designed to provide information as to what employer action may be necessary.

What will the rebate amount be?

Carriers determine MLR on a state basis by market segment (individual, small group, or large group). Carriers do not disaggregate by type of plan within these markets (e.g., PPO v. HMO v. HDHP) or by policyholder so the carrier will have to let you know the amount.

A carrier is not required to provide a rebate to an enrollee if the total rebate owed is less than $20 per subscriber ($5.00 when a carrier pays the rebate directly to each subscriber). This rule regarding de minimis amounts only applies to the carrier, not to employers refunding amounts to participants.

Will there be any communication?

Yes.

For each MLR reporting year, at the time any rebate of premium is provided, a carrier must provide the policyholder and each current enrollee who was also enrolled in the MLR reporting year in a form prescribed by HHS.

Employers do not have to notify employees, but they may want to address the notices being distributed by the carriers. Language similar to the following provides a starting point for such a notice:

Employees should have received a notice of rebate from [carrier]. In short, [Employer] received a rebate check in the amount of $_____. Amounts attributable to participant contributions will be used to [reduce premium amounts] for [currently enrolled employees] in accordance with legal requirements. These amounts will be reflected in the [September ___] paychecks.

What will the form of rebate to the employer be?

Carriers may issue rebates in the form of either a premium credit (i.e., reduction in a premium owed), a lump-sum payment, a lump-sum reimbursement to the account used to pay the premium if an enrollee paid the premium using a credit card or direct debit, or a "premium holiday," if this is permissible under state law.

When will the rebate be issued?

Rebates must be paid by **September 30** each year. A carrier that fails to timely pay any rebate must additionally pay the enrollee interest at the current Federal Reserve Board lending rate or 10% annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due.

Do employers have to give some or all of the rebate to participants?

Yes, unless they paid 100% for all tiers of coverage.

Carriers will generally send rebate checks to employers and employers must mete out any amounts attributed to employee contributions to employees and handle the tax consequences.

There is no one formula for employers to use, but guidance has been provided to aid employers.

ERISA-covered group health plans

To the extent that rebates are attributable to participant contributions, they constitute plan assets. Plan assets must be handled in accordance with the fiduciary responsibility provisions of Title I of ERISA.

If the employer is the policyholder, determining the plan's portion, if any, may depend on provisions in the plan or the policy or on the manner in which the plan sponsor and the plan participants have shared in the cost of the policy. If the plan or its trust is the policyholder, in the absence of specific plan or policy language to the contrary, the entire rebate would constitute plan assets, and the policyholder would be required to comply with ERISA's fiduciary provisions in the handling of rebates that it receives.

The HHS regulations and related DOL guidance for ERISA plans leave to the policyholder the decision as to how to use the portion of a rebate that constitutes plan assets, subject to ERISA's general standards of fiduciary conduct. The DOL notes that, in choosing an allocation method, "the plan fiduciary may properly weigh the costs to the plan and the ultimate plan benefit as well as the competing interests of participants or classes of participants provided such method is reasonable, fair and objective." An allocation does not necessarily have to exactly reflect the premium activity of policy subscribers. A plan fiduciary may instead weigh the costs to the plan and the competing interests of participants or classes of participants when fashioning an allocation method, provided the method ultimately proves reasonable, fair, and objective. If the fiduciary finds that the cost of passing through the rebate to former participants would exhaust most of those rebates, the proceeds can likely be allocated to current participants.

Guidance does not address how to handle an MLR rebate where the amount is inconsequential (e.g., a dollar per participant). Taking a cue from DOL Field Assistance Bulletin No. 2006-01, a fiduciary may be able to conclude, after analyzing the relative costs, that no allocation is necessary, when the administrative costs of making correction far exceed the amount of the allocation.

If a plan provides benefits under multiple policies, the fiduciary is instructed to allocate or apply the plan's portion of a rebate for the benefit of participants and beneficiaries who are covered by the policy to which the rebate relates provided doing so would be prudent and solely in the interests of the plan according to the above analysis. But, according to the DOL, "the use of a rebate generated by one plan to benefit the participants of another plan would be a breach of the duty of loyalty to a plan's participants."

Plans that are neither covered by ERISA nor are governmental plans (e.g., church plans)

With respect to policyholders that have a group health plan but not a governmental plan or a plan subject to ERISA, carriers must obtain written assurance from the policyholder that rebates will be used for the benefit of current subscribers or otherwise must pay the rebates directly to subscribers.

The final rule issued on February 27, 2015, provides that subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates within three (3) months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do.

When do rebates need to be made to participants?

As soon as possible following receipt and, in all cases, within 3 months of receipt.

What is the form of rebate to participants?

There is no one way to determine this, but guidance has been provided to aid employers.

Reductions in future premiums for current participants is probably the best method.

If proceeds are to be paid to participants in cash, the DOL is likely to require that payments go to those who participated in the plan at the time the proceeds were "generated," which may include former employees. An option that may be easier to administer is to keep the proceeds in the plan and provide a "premium holiday" (suspension of required premiums) or a reduction in the amount of employee-paid premiums.

The interim final regulations for non-ERISA governmental plans require that rebates be used to reduce premiums for all health plan options for subscribers covered when the rebate is received, to reduce premiums for current subscribers to the option receiving the rebate, or as a cash refund to current subscribers in the option receiving the rebate. In each case, the regulations allow the rebate to be allocated evenly or in proportion to actual contributions to premiums. Note that the rebate is to be used to reduce premiums for (or pay refunds to) employees enrolled during the year in which the rebate is actually paid (rather than the MLR reporting year on which the rebate was calculated).

To recap, here are some options to consider:

- Reduce future premiums for current plan participants. This is administratively easy with limited tax issues with respect to participants.

- Cash payments to current participants. This is administratively burdensome and results in tax consequences to participants.

- Cash payments to former participants. This is administratively burdensome and results in tax consequences to former participants.

The employer could also consider, with counsel, whether providing benefit enhancements or payment of reasonable plan expenses would be considered permissible.

What are the federal tax implications to employees?

Pre-Tax Premium Payments

When employees pay their portion of the premiums for employer-sponsored health coverage on a pre-tax basis under a cafeteria plan, MLR rebates will be subject to federal income tax and wages. Briefly:

- For rebates that are distributed as a reduction in premium (thus reducing an individual's pre-tax premium payment during the year), there is a corresponding increase to the employee's taxable salary that is also wages taxable for employment tax purposes.

- Rebates that are distributed as cash will result in an increase in taxable income that is also wages subject to employment taxes.

The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

After-Tax Premium Payments

When employees pay their portion of the premiums on an after-tax basis, MLR rebates generally are not subject to federal income tax or employment taxes. This applies when the rebate is provided as a reduction in premiums or as a cash. The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

What are the tax implications to employer?

Employers should review the tax implications of a rebate with tax advisors. Generally, amounts used for benefits (e.g., to pay premiums with respect to insured plans) should not be taxable.

When employees pay premiums on a pre-tax basis, does reducing a participant's premiums mid-year allow them to make election changes?

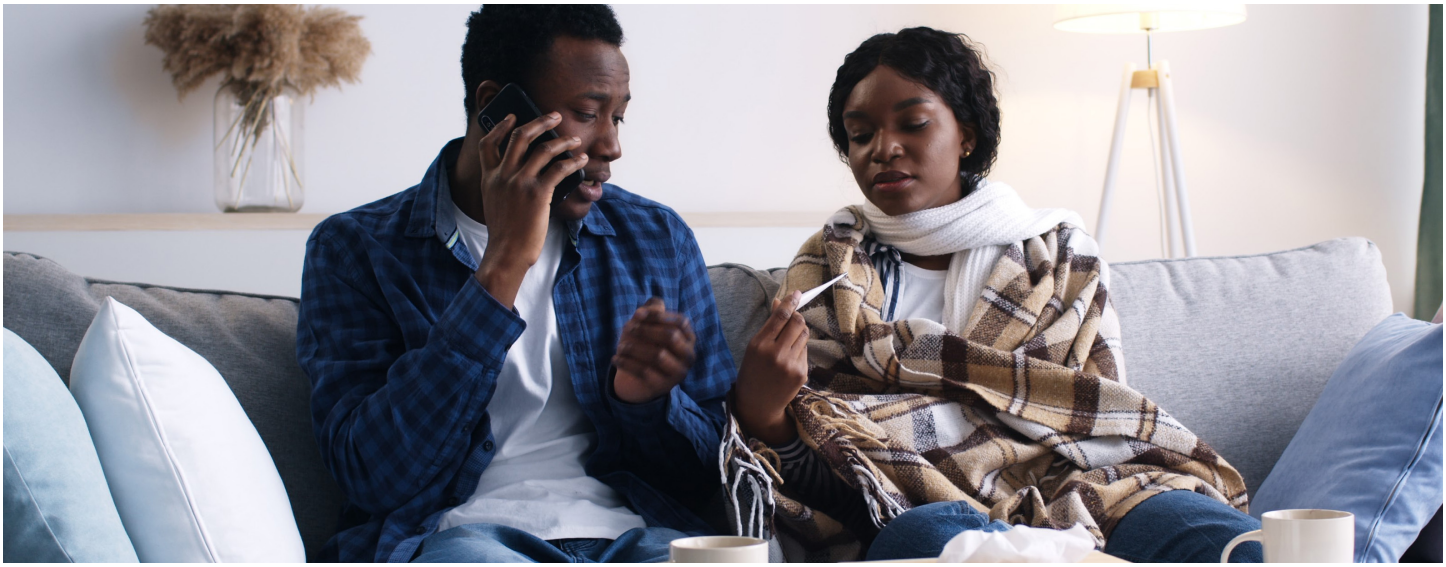
Probably not.

If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

If the plan incorporates the permitted election change rules, the relevant issue is whether this change in cost is permitted under the regulations.

- If there is an insignificant decrease, there can be an automatic adjustment.
- If there is a significant decrease, employees may make a corresponding change including commencing participation in the cafeteria plan for the first time for the option with a decrease in cost.

Generally, MLR rebates are expected to be fairly low dollar amounts and may not rise to the level of a significant change. Employers should consider either taking the position that the cost change is insignificant or that the cost change is significant, and the "corresponding change" is to simply allow the reduction or increase. The cafeteria plan document should be consistent with the employer's position.



Michigan 2025 Changes to Paid Leave

Issued date: 09/23/24

On July 31, 2024, in *Mothering Justice v. Attorney General*, the Michigan Supreme Court ruled that a process and procedure used by the legislature to amend two ballot initiatives was unconstitutional. By ruling the amendments unconstitutional, the Improved Workforce Opportunity Wage Act ("Wage Act") and the Earned Sick Time Act ("ESTA") revert to the original provisions approved on the 2018 ballot. This means higher minimum wage and increased sick leave for employees starting on February 21, 2025.

Most Michigan employers will now be required to offer 72 hours of sick leave annually to employees.

- An employee is now broadly defined with only one exception for individuals employed by the federal government. This replaces the definition of employee under Paid Medical Leave which excluded from the definition of employees: employees that are exempt from the overtime requirements under the Fair Labor Standards Act, employees covered by a collective bargaining agreement, federal employees, and employees working 25 weeks or less in a calendar year.

- Employees include seasonal, temporary, part-time, leased, full-time and any other employee classification created by the employer. There is no minimum age for an employee to accrue hours; this does apply to minors.

- Regarding paying employees for this time, there is a distinction between employers with fewer than ten employees and those with more than ten employees. The Department has not issued final guidance regarding counting of employees for out-of-state employers, but anticipates the number of employees will be based on all employees on payroll and is not limited to counting employees located in Michigan. However, only Michigan employees are entitled to the benefits.

    - Have a reasonable relationship to the business of the employer, or

    - Are required as part of a degree program.

- Employees accrue one hour of sick time for every 30 hours worked. There is no limit to the number of hours an employee can accrue. Employees can carry over all accrued but unused sick time; however, an employer is not required to allow the employee to use more than 72 hours each year.

- Employers do not have to pay out accrued and unused sick time upon termination, resignation, retirement, or any other type of separation from employment.

The ESTA also includes anti-retaliation provisions if an employee uses sick leave. Employees will be able to file civil actions against employers for any violations of the ESTA and potentially recover payment for the sick leave, payment of back wages, rehiring or reinstatement in previous role, and attorney's fees. The ESTA also imposes notice and record-keeping requirements as detailed below in the next steps. Failure to comply with ESTA could result in the Director of Licensing and Regulatory Affairs:

- Imposing civil penalties (amounts vary depending upon the violation and are also at discretion of Director)

- Requiring payment of earned sick time

- Awarding compensatory damages including back wages

- Bringing a civil lawsuit against the employer

Beginning February 21, 2025, the Court has ordered a phased-in approach to the Wage Act and the minimum wage requirements plus phasing out the tip credit. The current minimum wage of $10.33 will increase to an amount above $12 to account for the inflation adjustment. The tip credit will also be phased out until eliminated starting February 21, 2029. Currently, the tipped employee hourly rate is $3.93 which is 38% of the minimum wage.

Date	Minimum Wage	Tip Credit Rate
February 21, 2025	$10.00 plus inflation adjustment	48% of minimum wage
February 21, 2026	$10.65 plus inflation adjustment	60% of minimum wage
February 21, 2027	$11.35 plus inflation adjustment	70% of minimum wage
February 21, 2028	$12.00 plus inflation adjustment	80% of minimum wage

Employer Action

Employers should:

- Amend eligibility provisions for sick leave based upon the definition of employee.

- Review sick leave policies to ensure that accrual periods are calculated correctly.

- Ensure that sick leave policies allow employees a minimum of 72 hours of sick leave annually.

- Prepare written notices of the sick leave policy and distribute the notice in English, Spanish, and any other language that is spoken by 10% of the employer's workforce.

- Amend document retention policies to maintain sick leave records for at least three years.
- Update hourly rates when the State's Treasurer releases the new minimum wage adjusted for inflation.
- Review health plan affordability as an increase in wages may permit an applicable large employer to increase employee contributions for health insurance and still comply with the affordability provisions of the ACA.

Telehealth Relief for HSAs Expiring

Issued date: 09/25/24

For plan years beginning on or after January 1, 2025, employers that took advantage of temporary relief to offer free (or reduced cost) telehealth or other remote care services to participants in a high-deductible health plan ("HDHP") before the minimum IRS deductible is satisfied should discontinue doing so in order to preserve HSA eligibility.

Background

To be HSA-eligible, in part, individuals cannot have access to first-dollar healthcare coverage (with a few limited exceptions such as for preventive care items and services).

During the COVID-19 pandemic, the federal government enacted a series of laws to encourage the use of telehealth and other remote care services. The last in this series of federal laws, the Consolidated Appropriations Act of 2023, provided that for an HDHP's plan years beginning before January 1, 2025:

- a plan shall not fail to be a high deductible health plan if free or reduced cost telehealth or other remote care services are offered before satisfaction of the IRS minimum deductible; and
- coverage for telehealth or other remote care services is disregarded for purposes of determining HSA eligibility.

The relief has been optional; employers have not been required to offer free or reduced cost telehealth or other remote care services as part of an HDHP's plan design. However, for employers that continued to offer such first dollar coverage, this relief will expire with the first plan year on or after January 1, 2025. It's not likely that this relief will be extended again. Earlier efforts to make the relief permanent or extend it again did not gain much traction.

Under a somewhat related topic, as a reminder, telehealth (and other remote care services) should only be offered to medical plan participants.

Employer Action

Employers with an HSA-compatible HDHP that currently offers free or reduced cost telehealth or other remote care services should:

- Ensure the arrangement is HSA-compatible for the first plan year that begins on or after January 1, 2025.
    - When there is a separate telehealth (or remote care services) vendor, this will include charging the fair market value for any non-preventive services provided before the minimum deductible is satisfied.
    - When telehealth (or remote care services) is part of the medical plan, this will include charging the full contracted rate for any non-preventive services provided before the minimum deductible is satisfied.
- Communicate the change to participants in connection with open enrollment.

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