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2024 YEAR IN REVIEW

Compliance Digest

COMPLIANCE BULLETINS

RELEASED JANUARY - DECEMBER

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State Health Coverage Reporting Requirements for Calendar Year 2023

Issued date: 01/10/24

Five states (California, Massachusetts, New Jersey, Rhode Island, and Vermont) and the District of Columbia have already enacted individual health insurance mandates with their own requirements for:

- Furnishing information regarding health insurance coverage to residents of the state, and
- Filing that information with certain state agencies.

These requirements and deadlines may (or may not) align with the federal requirements. As described below, satisfying the federal requirements may not satisfy the applicable state obligations. It is important to ensure both federal and state requirements (as applicable) are met.

The following chart summarizes important deadlines related to 2023 state individual mandate reporting.

State	Deadline to Furnish Statements to Employee Residents	Deadline to File Statements with State Agency
California	January 31, 2024. However, no penalty is imposed for failing to furnish by this deadline.	March 31, 2024. No penalties will be assessed if filed by May 31, 2024.
District of Columbia	March 1, 2024	April 30, 2024 (30 days after federal deadline)
Massachusetts	January 31, 2024	January 31, 2024
New Jersey	March 1, 2024	April 2, 2024
Rhode Island	March 1, 2024	April 1, 2024
Vermont	N/A	N/A

It should be noted that the state reporting deadlines are subject to change if the states update their reporting information. This information is current as of the date of publication.

Important issues to consider regarding furnishing and filing state-level health coverage information are as follows:

- **State residents —** Employers with employees and other covered individuals residing in states with health coverage mandates should ensure the state-level health insurance distribution and state-level filing requirements are satisfied. Penalties may arise for late or incorrect filings with the state.

- **Forms**

  - California, the District of Columbia, New Jersey, and Rhode Island use the federal Forms 1094/1095 (B, C) for the state's individual mandate reporting requirements.

  - Massachusetts requires MA Form 1099-HC to be furnished to Massachusetts residents and filed with the state by January 31. In addition, Massachusetts requires employers with at least 6 employees residing in Massachusetts to file the Health Insurance Responsibility Disclosure ("HIRD") form.

- **Employers with fully insured plans**

  - Carriers issuing policies in California, Massachusetts, New Jersey, and Rhode Island are generally obligated to issue health coverage statements to plan members residing in the respective state and to file the required health coverage information to that state agency.

  - The District of Columbia requires employers that sponsor a fully insured group health plan with at least 50 full-time employees, including at least one employee who is a resident of the District, to file information returns with the Office of Tax and Revenue ("OTR").

  - It should be noted that a carrier may not automatically furnish a member statement and file with a state agency for plan members residing outside of the policy issue/situs state.

- **Employers with fully insured plans issued out-of-state —** Employers should confirm that the carrier will adhere to the required state distribution and filing obligations for plan members that reside in a state with individual mandate reporting obligations.

- **Employers with self-funded plans —** Employers should confirm with their third-party administrator ("TPA") or ACA form preparation vendor that the required state distribution and filing obligations for plan members that reside in a state with an individual mandate will be satisfied and whether any additional fees will be assessed.

For employers with fully insured plans that are written outside of a state with an individual mandate or a self-funded health plan, if the carrier or TPA will not furnish or file the forms with state residents or the applicable state agency, the employer may be required furnish and/or file. This may require involvement with your payroll provider or other ACA reporting vendor to coordinate.

Employer Action

Employers with employees and/or plan members residing in a state (and/or the District of Columbia) with individual mandate reporting requirements should confirm state reporting requirements with their carrier, TPA or ACA vendor to ensure federal as well as state-level reporting obligations will be met.

FDA Clears Way for Florida's State Programs to Import Drugs

Issued date: 01/12/24

On January 5, 2024, the U.S. Food and Drug Administration ("FDA") approved Florida's drug importation program under the Federal Food, Drug, and Cosmetic Act ("FD&C Act") Sec. 804 which provides a pathway for states and tribes to develop and apply for approval to import drugs from Canada under a Sec. 804 Importation Program ("SIP").

Below you will find a high-level summary:

- Applicability. The program is limited to state programs including Medicaid, the prison system, and facilities run by the Department of Children & Families ("DCF"). Private sector employer group health plans are not eligible to create a SIP. Public employers such as cities and counties are likewise not eligible to create a SIP.
- Term. Florida's SIP is authorized for two years from the date the FDA is notified of the first shipment of drugs to be imported.
- Start date/process. Importation will not begin immediately. Before drugs can be imported, Florida's Agency for Health Care Administration must do all of the following:
    - Submit additional drug-specific information for the FDA's review and approval.
    - Ensure that the drugs Florida seeks to import have been tested for, among other things, authenticity and compliance with the FDA-approved drugs' specifications and standards.
    - Relabel the drugs to be consistent with the FDA-approved labeling.
    - Set up a distribution center.
    - Submit a quarterly report to the FDA that includes information about the imported drugs, cost savings and any potential safety and quality issues.

Note that the onerous administrative requirements may offset expected savings.

- Challenges. Pharmaceutical Research and Manufacturers of America ("PhRMA"), the pharmaceutical industry's largest lobbying group, is expected to sue Florida regarding the program. In addition, there appear to be accessibility concerns as (1) some drug manufacturers have agreements that prohibit exporting prescription drugs out of the country and (2) Canada has taken steps to limit/prohibit exporting when their supply is low, as reiterated in a statement from Health Canada issued on January 8, 2024. Note that Canada's population is 40 million, Florida's population is 22 million, and the U.S. market is nearly 10 times bigger than Canada's.

According to the proposal, Florida will begin by providing prescription drugs in a small number of drug classes which will include maintenance medications to help individuals who have chronic health conditions such as HIV/AIDS, mental illness, prostate cancer, and urea cycle disorder. These drugs will be for individuals who are under the care of the Agency for Persons with Disabilities ("APD"), DCF, Department of Corrections ("FDC"), and Department of Health ("DOH"). The program will then expand to include providing imported prescription drugs for Medicaid members across the state. The submitted cost savings estimate for importing prescription drugs from Canada is up to $183 million per year once the program is fully implemented.

Other states, including Colorado, Vermont, and New Mexico are seeking approval for similar programs.

It is important to note that the SIP program is only allowed to import drugs from Canada. Importation of drugs from other countries (e.g., Turks and Caicos, Australia, and Turkey) is not allowed. Employers should understand that, currently, the approval of this program does not change the importation rules as they exist with respect to private sector employer plans or local state employers. Drug importation is still generally illegal and employers should be wary of vendors indicating otherwise and carefully evaluate the compliance risks associated with these programs.

We will keep you apprised of developments.

DOL Increases Penalties For 2024

Issued date: 01/16/24

The Department of Labor ("DOL") has published the annual adjustments for 2024 that increase certain penalties applicable to employee benefit plans.

Annual Penalty Adjustments for 2024

The following updated penalties are applicable to health and welfare plans subject to ERISA.

Description	2023 Penalty (Old)	2024 Penalty (NEW)
Failure to file Form 5500	Up to $2,586 per day	Up to $2,670 per day
Failure of a MEWA to file reports (i.e., M-1)	Up to $1,881 per day	Up to $1,942 per day
Failure to provide CHIP Notice	Up to $137 per day per employee	Up to $141 per day per employee
Failure to disclose CHIP/Medicaid coordination to the State	$137 per day per violation (per participant/beneficiary)	$141 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,362 per failure	Up to $1,406 per failure
Failure to furnish plan documents (including SPDs/SMMs) to DOL on request	$184 per day $1,846 cap per request	$190 per day $1,906 cap per request
Genetic information failures	$137 per day (per participant/beneficiary)	$141 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$3,439 minimum	$3,550 minimum
Failure to meet genetic information requirements – not de minimis failures	$20,641 minimum	$21,310 minimum
Cap on unintentional failures to meet genetic information requirements	$688,012 maximum	$710,310 maximum

Employer Action

Private employers, including non-profits, should ensure employees receive required notices timely (SBC, CHIP, SPD, etc.) to prevent civil penalty assessments. In addition, employers should ensure Form 5500s are properly and timely filed, if applicable. Finally, employers facing document requests from EBSA should ensure documents are provided timely, as requested.

Medicare Part D CMS Notification Reminder

Issued date: 01/17/24

Employers sponsoring a group health plan (whether insured or self-insured) need to report information on the creditable (or non-creditable) status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services (CMS). In order to provide this information, employers must access CMS's online reporting system at: www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html.

As a reminder, notice must be provided by the following deadlines:

- Within 60 days after the **beginning** date of each plan year;
- Within 30 days after the **termination** of the prescription drug plan; and
- Within 30 days after any **change** in the creditable coverage status of the prescription drug plan.

For example, an employer with a **calendar year plan** (January 1 – December 31, 2024) must complete this reporting **no later than Wednesday, February 29, 2024**.

Additional resources on completing the form are available at:

- www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html
- Disclosure to CMS Form User Guide with screenshots: www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage/downloads/ccuserguide.pdf

Guidance Issued On Contraception Coverage Mandate

Issued date: 01/26/24

On January 22, 2024, the Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") answered a new round of FAQs, providing additional guidance on the Affordable Care Act ("ACA")'s requirement for non-grandfathered medical plans to cover certain preventive services including contraceptives, without cost-sharing. These FAQs answer questions from stakeholders to help people understand the contraceptive coverage mandate and promote compliance by providing an alternate method of compliance. It should be noted that religious employers, certain non-profit religious organizations, and closely held for-profit entities can exclude contraception.

Background

Plans and issuers must cover at least one form of contraception in each of the following categories:

1. Sterilization surgery for women
2. Implantable rods
3. Copper intrauterine devices
4. Intrauterine devices with progestin (all durations and doses)
5. Injectable contraceptives
6. Oral contraceptives (combined pill)
7. Oral contraceptives (progestin only)
8. Oral contraceptives (extended or continuous use)
9. Contraceptive patch
10. Vaginal contraceptive rings
11. Diaphragms
12. Contraceptive sponges
13. Cervical caps
14. Condoms
15. Spermicides
16. Emergency contraception (levonorgestrel)
17. Emergency contraception (ulipristal acetage)

Plans must also cover any additional contraceptives approved, cleared, or granted by the FDA (including newer contraceptive products) so long as the individual's attending provider determines such care as medically appropriate and necessary. Plans may apply reasonable medical management techniques for newer products and procedures only if there exists at least one other substantially similar product or service available and medically appropriate, and that similar product or service is covered without cost sharing.

If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a recommended preventive service, then the plan or issuer may use reasonable medical management techniques to determine any such coverage limitations. To the extent not specified in a recommendation or guideline, a plan or issuer may rely on the relevant clinical evidence base and established reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage of a recommended preventive item or service.

The Departments are aware of reports that plans and issuers continue to apply unreasonable medical management techniques and exclusions that present barriers to access contraceptive care without cost sharing. Examples of potentially unreasonable medical management techniques and other problematic practices include actions by plans that:

- require individuals to satisfy step therapy protocols (a medical management technique also known as "fail first") using numerous other services or FDA-approved, -cleared, or - granted contraceptive products within the same category of contraception before the plan or issuer will approve coverage for the contraceptive service or FDA-approved, -cleared, or -granted contraceptive product that is medically necessary for the individual, as determined by the individual's attending health care provider;

- apply age-related restrictions for a contraceptive service or product that is medically necessary for the individual, as determined by the individual's attending health care provider;

- impose unduly burdensome administrative requirements as part of an exceptions process, such as onerous documentation requirements or multiple levels of processes (such as one to cover an excluded drug that is medically necessary and another to remove cost-sharing requirements), that result in denials of coverage or imposition of a cost-sharing requirement for contraceptive services or products that are medically necessary for the individual, as determined by the individual's attending health care provider; and

- require cost sharing for services provided that are integral to the preventive service provided (regardless of whether the items and services are billed separately), such as anesthesia, pregnancy tests needed before the provision of certain forms of contraceptives, or other pre and post-operative items and services integral to the furnishing of sterilization surgeries including tubal ligation.

In response to such reports, the Departments are clarifying how plans and issuers can remain compliant while applying medical management techniques, as summarized below.

Therapeutic Equivalence

As an alternative to complying with prior guidance, a plan may provide coverage consistent with the therapeutic equivalence approach outlined in these FAQs. Specifically, with respect to FDA-approved contraceptive drugs and drug-led devices, if a plan utilizes medical management techniques within a specified category described in the HRSA-supported Guidelines (or group of substantially similar products that are not included in a specified category), the Departments will generally consider such medical management techniques to be reasonable if the plan covers all FDA-approved contraceptive drugs and drug-led devices in that category (or group of substantially similar products) without cost sharing, other than those for which there is at least one therapeutic equivalent drug or drug-led device that the plan or issuer covers without cost sharing.

The Departments will determine whether a drug or procedure is therapeutically equivalent using the FDA's "Orange Book." Forms of contraception that are not FDA-approved drugs or drug-led devices are not listed in the Orange Book. Therefore, the therapeutic equivalence approach described above does not apply to such other forms of contraception.

Exceptions Process

Regardless of approach, and even if a plan covers a substantially similar product or service in a given category, the plan must also have in place an exceptions process that would allow the individual to access the medically necessary product or service without cost sharing; the individual's provider determines medical necessity.

Example: Within the category of "oral contraceptives (combined pill)," a plan covers all FDA-approved oral contraceptives (combined pill) products without cost sharing, other than those for which there is a therapeutic equivalent that is covered without cost sharing. Specifically, the plan covers Pill A, Pill B, and generic Pill D without cost sharing. Neither Pill A nor Pill B has a therapeutic equivalent product according to the Orange Book. Pill W, Pill X, and Pill Y, as well as Pill Z (which is a more expensive brand name product) are all classified in the Orange Book as therapeutic equivalents to Pill D and are not covered by the plan without cost sharing. However, the plan provides an easily accessible, transparent, and sufficiently expedient exceptions process that is not unduly burdensome on an individual or their provider (or other individual acting as the individual's authorized representative). The plan's exceptions process allows an individual to receive coverage without cost sharing for a therapeutic equivalent to Pill D (i.e., Pill W, Pill X, Pill Y, or Pill Z) if the therapeutic equivalent product is determined to be medically necessary with respect to the individual, as determined by the individual's attending provider.

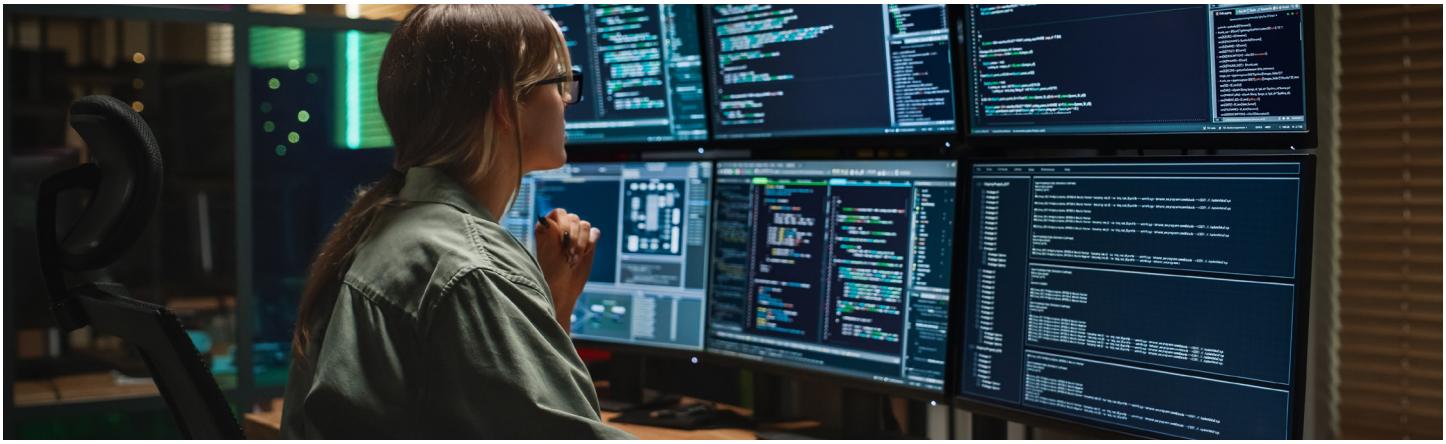
Conclusion: The plan's medical management techniques with respect to the category of "oral contraceptives (combined pill)" are generally reasonable. However, the plan's medical management techniques could be considered unreasonable if the plan imposes additional medical management techniques that are problematic, such as those highlighted earlier in this article.

Reporting Noncompliance

The FAQ provides contact information at relevant state and federal agencies that individuals with concerns about their plan's compliance with the contraceptive coverage requirements should contact.

Employer Action

It is important for plan sponsors to understand that the Departments do not view this set of FAQs as adding any additional requirements to health plans and plan designs that were compliant before the publication of this guidance remain compliant. Groups that have a fully insured plan can defer to the insurance carrier to deploy reasonable medical management techniques and designs. For groups that are self-insured, it is recommended to review the plan design and any medical management techniques with their third-party administrators in order to ensure compliance with the ACA's contraceptive care requirements.



New Cybersecurity Breach Notice Requirement

Issued date: 01/30/24

A recent amendment to 23 NYCRR Part 500, commonly referred to as the "Cybersecurity Regulation," now requires entities and individuals licensed under the New York Insurance Law to notify the New York Department of Financial Services ("DFS") within 72 hours after learning of a cybersecurity incident that has occurred at a third-party service provider. Although the original regulation required notice within 72 hours, the updated regulations require notice where a third-party service provider has a cybersecurity incident. These changes to the notice and reporting provisions went into effect on December 1, 2023.

Background

DFS enacted the Cybersecurity Regulation in 2017 establishing cybersecurity requirements that apply to, among others, any entity or individual who is required to be licensed under the New York Insurance Law. The Cybersecurity Regulation was amended in 2020, and again more recently in November 2023 (the "Amendment"). Insurance agents, producers and brokers who are licensed (or should be licensed) to sell life and health insurance in New York are Covered Entities under the Cybersecurity Regulation and are required, among other things, to provide timely notice of a cybersecurity incident to DFS.

Changes Under the Amendment

While the Cybersecurity Regulation has been around since 2017, the Amendment made some notable changes to the definition of a cybersecurity incident and to the notice provisions that apply to Covered Entities. It should be noted that this Bulletin does not discuss the Cybersecurity Regulation in its entirety, as it has existed for some time; rather its focus is to provide you with important changes that were made under the Amendment. In short, agents, producers and brokers must (as of December 1, 2023) notify DFS of a cybersecurity incident even if that incident took place at one of their vendors.

Definition of Cybersecurity Incident

The Amendment changes the definition of a cybersecurity incident. Under Section 500.17, a cybersecurity incident is now defined as an event that has occurred at the Covered Entity, its affiliates, or a third-party service provider that:

1. Impacts the Covered Entity and requires the Covered Entity to notify any government body, self-regulatory agency or any other supervisory body;

2. Has a reasonable likelihood of materially harming any material part of the normal operation(s) of the Covered Entity; or

3. Results in the deployment of ransomware within a material part of the Covered Entity's information systems.

Notification of Cybersecurity Incident

While Covered Entities were already required to notify the Superintendent of Financial Services electronically through the DFS Portal of a cybersecurity incident as promptly as possible, but in no event later than 72 hours after determining that a cybersecurity incident has occurred, the Amendment now requires Covered Entities to provide this notice if the cybersecurity incident occurred at the Covered Entity, its affiliates, or a third-party service provider. Thus, if a breach occurs at an insurance carrier or other third-party administrator or vendor, and such breach would be considered a cybersecurity incident, agents, producers and brokers must now notify DFS. This is true even if the third-party service provider is also providing notice to DFS. Covered Entities must also promptly provide DFS with any information requested regarding the incident and update DFS with material changes or new information previously unavailable.

Notification of Extortion Payment

DFS continues to discourage making extortion payments. Under the Amendment, Covered Entities must:

a. Notify DFS within 24 hours of any extortion payment made; and

b. Within 30 days of a payment, provide DFS with a written description of the reasons payment was necessary, alternatives to payment considered, diligence performed to find alternatives to payment and to ensure compliance with applicable regulations, including those of the Office of Foreign Assets Control.

Certification of Compliance

In addition to notifying DFS of the above, beginning April 15, 2024, every year Covered Entities must electronically submit a certification of material compliance with Part 500 or acknowledgment of noncompliance to DFS. If the Covered Entity did not comply, its written acknowledgment must:

a. Acknowledge that, for the prior calendar year, the Covered Entity did not materially comply with all the requirements of Part 500;

b. Identify all sections of the Cybersecurity Regulation that the Covered Entity has not materially complied with and describe the nature and extent of such noncompliance; and

c. Provide a remediation timeline or confirmation that remediation has been completed.

The Covered Entity's certification of compliance or acknowledgment of noncompliance must be submitted electronically in the form set forth on the department's website and must be signed by the Covered Entity's highest ranking executive and its Chief Information Security Officer ("CISO"). If the Covered Entity does not have a CISO, the certification or acknowledgment must be signed by the highest-ranking executive and by the senior officer responsible for the cybersecurity program of the Covered Entity.

Action

All Covered Entities, which include agents, producers and brokers, should review the Amendment and evaluate their obligations under all applicable laws. In the event a Covered Entity determines a cybersecurity incident has occurred at the Covered Entity, its affiliate, or at a third-party service provider, such as an insurance carrier, third-party administrator or other vendor, or is notified of same, the Covered Entity must report same to DFS within 72 hours. Each Covered Entity must provide a certification of material compliance or acknowledgment of noncompliance to DFS before April 15, 2024.

Resources

NYS DFS Cybersecurity Resource Center:
https://www.dfs.ny.gov/industry_guidance/cybersecurity

For a copy of the Amendment:
https://www.dfs.ny.gov/system/files/documents/2023/10/rf_fs_2amend23NYCRR500_text_20231101.pdf

DFS Portal:
https://myportal.dfs.ny.gov/

Instructions for Reporting A Cybersecurity Incident:
https://www.dfs.ny.gov/system/files/documents/2023/11/reporting-cybersecurity-incidents.pdf

Instructions for Reporting an Extortion Payment:
https://www.dfs.ny.gov/system/files/documents/2023/11/instruct_reporting_extortion_payments.pdf

2023 RxDC Reporting Instructions Released

Issued date: 02/12/24

The Centers for Medicare and Medicaid Services ("CMS") recently released updated Prescription Drugs Data Collection ("RxDC") reporting instructions related to reporting 2023 data. There are some notable changes.

Background

As previously reported, plan sponsors of group health plans (typically, employers) must submit information annually about prescription drugs and health care spending ("RxDC reporting") to CMS. The first deadline was December 27, 2022 (extended to January 31, 2023) for reporting on calendar years 2020 and 2021. For reporting on calendar year 2023, the next deadline is June 1, 2024, which is a firm date even though it falls on a Saturday. It should be noted that carriers, pharmacy benefit managers ("PBMs"), and third-party administrators ("TPAs") assisting with the reporting may have earlier deadlines for employers to respond to them with certain data points (e.g., plan name, average monthly premiums).

RxDC reporting consists of uploading to CMS a total of nine spreadsheets, consisting of a plan list (P2 is used for group health plans) and eight data files (D1 through D8), plus a "narrative response." In some situations, a TPA or PBM will not handle the full filing. This often requires the employer to file at least the D1 file, and occasionally the D2 file. A P2 list file must accompany all "D" filings.

New Instructions

The following are the most notable changes for reporting for the 2023 reference year compared to the prior year:

- Changes providing clarification about what should be reported in D1:
    - Now simplified, determine the "average monthly premium" calculation by taking total annual premiums, or premium equivalents for self-insured plans, and dividing by 12, rather than dividing by "member-months" as in prior years. The calculation is done for the "average monthly premium paid by members" and the "average monthly premium paid by employers," respectively.
    - Include under premiums or premium equivalents paid by members:

    - Member payments for COBRA coverage, including the 2% administrative fee
    - Spousal and tobacco surcharges
    - Amounts paid for coverage of an owner of an S-Corporation or Partnership if the owner works for the business and pays their premium out of personal funds
  - Now optional for premium equivalents, report on a cash basis (i.e., when claims are paid) or on a retrospective basis (i.e., when claims are incurred)
- Change providing clarification about what should be reported in D2:
  - Include information for pharmaceutical supplies, medical devices, nutritional supplements, and OTCs in the appropriate spending category in D2 if the products are covered under a plan's medical benefit
- Change related to the P2 list:
  - Provide specific language in Column C as to the specific type of carve-out benefit being reported, which is mandatory for the 2023 reference year:
    - Pharmacy only
    - Medical only
    - Behavioral health only
    - Fertility only
    - Specialty drugs only
    - Hospital only
    - Other
- Other changes generally clarifying or otherwise impacting mainly issuers, TPAs or PBMs:
  - Exclude medical devices, nutritional supplements, and over the counter (OTC) drugs from prescription drug lists (D3, D4, D5, D7, D8) unless the NDC for the product is on the CMS Drug and Therapeutic Class Crosswalk
  - Follow instructions on how to submit data when plan list or data files exceed the maximum allowable size limit in HIOS – should be quite rare at the employer level
  - Follow aggregation restrictions, which will be enforced starting with the 2023 reference year

- Data can generally be submitted on an aggregated basis – generally by state and by market segment, then at the reporting entity level, which will generally be the:
    - Employer level,
    - Issuer level, or
    - TPA level
- This is generally dictated by what is submitted on a D2 file, and employer level reporting is considered the most "granular"
- The level of aggregation applied on the D2 must be applied at the same, or more granular, level to the data in D1 and D3 to D8 – examples:
    - Data submitted in D2 is aggregated according to the employer EIN, the data in D1 and D3 to D8 must also be aggregated according to the employer EIN
    - Data submitted in D2 is aggregated according to the TPA EIN, then the reporting entities for D1 and D3 to D8 may choose to aggregate at the TPA level or to aggregate according to the plan sponsor EIN. The reporting entities for D1, D3, D4, D5, D6, D7, and D8 do not have to make the same decision. For example, if D2 is at the TPA level, the reporting entity for D1 could aggregate at the plan sponsor level and the reporting entity for D4 could aggregate at the TPA level
- Ideally for self-insured plans, D2 data will be submitted by the TPA, which will dictate the aggregation levels for D3 to D8 data. An employer will still be able to submit D1 data at the employer level

HIOS Guidance

The HIOS RxDC User Manual and RxDC HIOS Access Guide have not changed since their last updates of July 2023 and March 2023, respectively. If an employer needs to submit one (or more) of the "D" files (e.g., D1) on behalf of the group health plan because a TPA or PBM is not handling the full filing, the employer must sign up for a HIOS account.

Employer Action

With respect to these new instructions, employers should:

- Identify which of the above changes will impact their filing this year.
- Work with carrier partners, TPAs, PBMs and other vendors, as appropriate, to submit the requisite 2023 data.

The instructions themselves are very helpful and answer questions about the filing requirement and provide relevant examples when appropriate.

Additional guidance and/or relief could be issued before the June 1, 2024, filing deadline. We will continue to monitor and inform you of any applicable changes.

Pharmacy Costs Under Scrutiny In Recent Litigation

Issued date: 02/16/24

A class action lawsuit was filed in federal court by participants, alleging that their employer, Johnson & Johnson ("J&J"), and group health plan fiduciaries breached their fiduciary duties under ERISA.

Briefly, the plaintiffs allege that J&J mismanaged its group prescription drug benefits program, costing its employees millions of dollars in the form of higher payments for prescription drugs, higher premiums, higher deductibles, higher coinsurance, higher copays, and lower wages or limited wage growth. The plaintiffs challenge the plan and its fiduciaries' processes for evaluating, selecting, and monitoring the pharmacy benefit manager ("PBM"). This is supposedly most evident in the prices it agreed to with its PBM for generic-specialty drugs.

The complaint includes multiple examples of alleged overpayment for prescription drugs in the J&J plan. One such example shows that someone with a 90-pill prescription could fill that prescription, without even using their insurance, at multiple pharmacies for prices that ranged from $28.00 – $77.00. Defendants, however, agreed to make their ERISA plans and their beneficiaries pay over $10,000 for each 90-pill prescription of the same drug.

This case has garnered a significant amount of attention in the benefits community. The following summarizes the complaint and provides some high-level considerations for group health plan fiduciaries.

Background

An ERISA fiduciary is held to a very high standard of behavior, which requires more careful decision-making and more disclosure to plan participants and beneficiaries than would be required in a normal business relationship. The relevant principal duties of ERISA fiduciaries are:

- to act solely in the best interest of plan participants and beneficiaries (the duty of undivided loyalty);
- to use plan assets for the exclusive purpose of paying plan benefits or reasonable expenses of plan administration (the exclusive benefit rule);

- to act with the care, skill, prudence and diligence that a prudent person in similar circumstances would use; and
- to act in accordance with the documents and instruments governing the plan so long as those documents are consistent with ERISA.

Selection of service providers is an important fiduciary responsibility because service providers work on behalf of plan participants and beneficiaries and often are paid with plan funds. Fiduciaries should periodically monitor their selected providers' performance.

Specific Allegations in the Lawsuit

The detailed complaint alleges various breaches by the group health plan fiduciaries regarding the pharmacy benefits in the group health plan. Below are highlights of some of the core issues of the plaintiff's arguments.

Plan Design

- The classification of a generic drug as a "specialty" drug can have a major impact on the price the plan will be required to pay. Because there is no definitive set of objective factors to determine whether any given drug is a specialty drug, the classification of a drug as "specialty" should have been the subject of negotiations between plan fiduciaries and PBMs.
- Prudent fiduciaries will replace brand-name drugs on the formulary when lower-cost, FDA-approved generics become available. Alternatively, prudent fiduciaries will add the generics to the formulary at lower prices and then incentivize plan beneficiaries to obtain these lower-cost generics instead of the more expensive brand-name drugs.
- Prudent fiduciaries are aware of the conflicts of interest that PBMs have in making formulary decisions.
- J&J should not have steered beneficiaries toward the PBM's mail-order pharmacy as the prices are routinely higher than amounts retail pharmacies charge for the same drugs.
- An arrangement in which a plan's members are incentivized or required to obtain "specialty" drugs only from the PBM's own "specialty" pharmacy provides powerful incentives for PBMs to designate generic drugs as "specialty" drugs and/or to inflate the prices of specialty drugs.

Choosing and Monitoring Service Providers

- J&J should have used its bargaining power to obtain better rates from their own PBM or another traditional PBM; could have moved all or parts of their prescription-drug plan to a "pass-through" PBM that bases its prices on actual pharmacy acquisition costs rather than inflated and manipulable benchmarks, etc.
- Prudent fiduciaries conduct open RFP processes to obtain competitive bids for PBM services at regular intervals and ensure that the rates and terms to which they agree continue to reflect the best rates and terms available in light of the plan's size, bargaining power, and other characteristics. The plaintiffs allege J&J did not have an open RFP process and did not consider the full range of available options for PBM services.
- Prudent fiduciaries should evaluate service providers, like consultants, for potential conflicts of interest including whether the service provider may have a financial interest in steering a plan toward certain PBMs or including certain provisions in PBM contracts that do not correlate to the financial or other interests of plan participants and beneficiaries.

Failure to Provide Plan Documents

- The plaintiff alleges the fiduciaries of the group health plan failed to comply with a request for plan documents. Under ERISA, fiduciaries must furnish participants and beneficiaries with plan documents upon request. Penalties of up to $110/day may apply to these failures.

Requested Relief

The plaintiff's request:

- Recovery of any losses of plan assets and any profits (or disgorgement of profits) as a result of the breaches.
- Injunctive and equitable relief including removal of the current fiduciary and appointment of an independent fiduciary.
- $110/day in penalties beginning on January 19, 2024, for failure to provide plan documents upon request.

J&J Response

J&J has not responded to the complaint filed against the group health plan. J&J is expected to file a response that will likely counter the multiple claims filed by the plaintiff and offer potential defenses.

Employer Action

This appears to be the first case by plan participants alleging a fiduciary breach tied to pharmacy costs under the plan. Employers offering group health plans should monitor developments in this case.

In addition, employers may take this opportunity to review fiduciary best practices as it relates to group health plans, including:

- Who are the ERISA group health plan fiduciaries?
- Are plan documents in place and provided upon request to participants and beneficiaries?
- How are service providers monitored and are conflicts of interest identified?
- How are fees and plan expenses evaluated for reasonableness?
- Has the ERISA group health plan obtained the required compensation disclosure under ERISA 408(b)(2) from service providers who are providing brokerage and consulting services? This is a recent requirement that was part of the Consolidated Appropriations Act of 2021 ("CAA-21").
- Is the group health and welfare plan (and its fiduciaries) covered by a fiduciary liability insurance policy?

We will continue to follow this litigation and will monitor developments.

New Attention On IVF Benefits

Issued date: 03/11/24

On February 16, 2024, the Alabama Supreme Court (“the Court”), the highest court in the state, ruled that the destruction of human embryos created through in vitro fertilization (“IVF”) violates the state’s Wrongful Death of a Minor Act (“the Act”). The Court determined that there is no exception to the Act based on an embryo’s location within or outside of a biological uterus. This has sparked a national discussion around IVF, which may impact employers offering fertility benefits.

While many fertility clinics in Alabama initially stopped IVF services, a recent legislative change may allow some IVF service providers to resume services. However, as discussed below, the legislative fix may not be enough to resume full services for all providers in the state.

Background

The plaintiffs in this case had embryos created through IVF being stored at a fertility clinic operated by the Center for Reproductive Medicine, P.C. (“the Center”). The embryos were artificially gestated and placed into a “cryogenic nursery.” A cryogenic nursery is a facility designed to keep extrauterine embryos alive at a fixed state of development, which is done by keeping them at an extremely low temperature.

In December 2020, a patient in the local hospital where the Center is located entered the cryogenic nursery and removed several embryos resulting in their destruction.

Lawsuit

The plaintiffs allege that the Center was obligated to keep the cryogenic nursery secured and monitored at all times and brought two lawsuits against the Center and the Hospital. Two sets of parents filed the first suit jointly, and the third set of parents filed the second suit. The suits claimed (1) wrongful death under the Act, and (2) common-law negligence claims if the court ruled an embryo was not a child.

The trial court granted the defendants' motions to dismiss on the basis that the IVF embryos involved in the case did not meet the definition of a person or a child, and therefore could not give rise to a wrongful death claim. The Alabama Supreme Court overturned the dismissal finding that embryos created through IVF should be considered children, the Act can apply when embryos are destroyed, and the plaintiffs may continue with their lawsuit. Based on this finding, the Court ruled that the negligence claims were moot.

Why is this Important?

The most immediate impact of the Court's decision is that many fertility clinics in Alabama have halted their IVF services as they attempt to address the impact of this decision on their IVF practices. In particular, these clinics are concerned with the civil and potential criminal liability that their entities, physicians, and patients may face as a result of the Court's determination that the Act applies to IVF embryos.

On March 6, 2024, the governor signed into law a bill to restore access to IVF treatment in the state. The bill has a retroactive effect and provides for civil and criminal immunity for "death or damage" to an embryo as part of IVF services. However, some practitioners have expressed concern that the legislation may be ambiguous and does not go far enough to protect access to IVF. Some providers may not resume services until issues are further resolved.

Additionally, defendants in the lawsuit filed an application with the Court to rehear the case. Rehearing is not common and the Court may decide to deny the application.

Implications for Benefits

Many employers offer fertility benefits, including IVF, as part of a comprehensive benefits package. Some state insurance laws require coverage for certain fertility benefits. While there appear to be some immediate concerns for IVF providers and facilities in Alabama, at this time it is unclear how the Court's decision will impact employee benefits programs.

This case has ignited a national discussion around IVF with state and federal governments, considering legislation to protect IVF providers from liability. We are in a "wait and see" period as outcomes could range from additional protection for IVF providers in some states, with other states considering further regulation that may limit accessibility to IVF.

Employer Action

Employers offering fertility benefits within Alabama may want to discuss with their carriers or fertility services vendor to confirm the current state of fertility benefit availability. Some IVF providers may begin to resume services as a result of the state's legislative action. Employers may consider adding or enhancing travel benefits to allow employees continued access to fertility benefits if unavailable in the employee's state of residence.

As for employees residing outside Alabama, it's possible that other state governments (or courts) could take similar action with respect to IVF. As such, employers outside of Alabama should monitor developments at their state level. This issue is rapidly changing across the country as federal and state governments evaluate next steps. We will continue to monitor this topic to keep you informed as this issue develops.

IRS Addresses Nutrition Wellness And General Health Expenses

Issued date: 03/18/24

The Internal Revenue Service ("IRS") is reminding taxpayers that expenses related to nutrition, wellness, and general health are not likely to qualify as reimbursable medical expenses under Internal Revenue Code ("Code") section 213. In a news release and frequently asked questions ("FAQs"), the IRS:

- Clarifies the requirement that reimbursable medical expenses must be related to a targeted diagnosis-specific activity or treatment; and
- Cautions employers about companies who are misrepresenting the circumstances in which food and wellness expenses can be paid or reimbursed by a tax favored plan.

Background

Qualified medical expenses under Code section 213(d) can be reimbursed on a tax-favored basis by a health savings account ("HSA"), health flexible spending account ("FSA"), or a health reimbursement arrangement ("HRA"). Generally, amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure of function of the body are included under this definition. These expenses can include costs for legal medical services rendered by physicians, surgeons, dentists, and other medical practitioners. They include costs for equipment, supplies, and diagnostic devices needed for medical care. They also include costs for medicines and drugs prescribed by a physician or purchased over the counter. Medical expenses do not include personal expenses that are merely beneficial to general health.

IRS News Release

The IRS has expressed concern that taxpayers may be misinformed about the circumstances in which food or wellness expenses can be medical expenses. On March 6, 2024, the IRS issued a press release to remind taxpayers that personal expenses are not reimbursable on a tax-favored basis through FSAs, HSAs, or HRAs.

The IRS also warned taxpayers about companies that are misleading taxpayers into believing nutrition, wellness, or general health expenses can be reimbursable simply by obtaining a note from a doctor that can be submitted with a claim for reimbursement. These companies offer to provide doctor's notes to taxpayers for a fee. In this news release, the IRS cautions documentation or a note from a doctor based on self-reported health information cannot convert personal expenses into medical expenses.

The IRS directs taxpayers to FAQs that provide examples of medical expenses that can qualify for reimbursement.

Examples of expenses that are not reimbursable as medical expenses include:

- Cost of exercise such as swimming or dancing lessons or memberships,
- Cost of weight loss programs that do not treat a specific disease diagnosed by a physician,
- Cost of food or beverages for weight loss that satisfies normal nutritional needs,
- Cost of food or beverages that does not alleviate or treat an illness,
- Cost of food or beverages that is not prescribed by a physician,
- Cost of drugs that aren't prescribed by a physician,
- Cost of nutritional supplements that are not recommended as treatment for a specific medical condition diagnosed by a physician.

The proper treatment of medical expenses is required for an employer benefit plan that provides benefits through an FSA or HRA. FSA and HRA plans that reimburse expenses that are not eligible can risk the tax qualified status of the entire plan.

The IRS has also recently emphasized the high standards for FSA claim substantiation. The failure to meet substantiation requirements can result in the employee losing their tax benefits under the plan or the employer's entire plan losing its tax-favored status.

Employer Action

Employers that sponsor benefit plans that reimburse medical expenses should confirm with their service providers that the plans only reimburse qualified medical expenses and that all claims processed are properly substantiated prior to reimbursement. This could require plan sponsors to review how claims are substantiated for reimbursement when paid by a debit-card or other point of sale reimbursement.

Employers should closely evaluate vendors who promote programs that use pre-tax dollars for nutritional or other wellness expenses and, for a fee, provide doctor's notes in an attempt to substantiate these claims.

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Paid Leave Oregon Updates

As previously reported, leave and wage replacement benefits under Paid Leave Oregon ("PLO") became available on September 3, 2023. Recently, the definition of safe leave was expanded to include bias crimes. Additionally, the Oregon Employment Department ("ED") announced a delay in the first annual reporting requirement for equivalent plans.

Background

PLO took effect January 1, 2023 and began providing benefits to covered individuals on September 3, 2023. PLO is funded by employer and employee contributions deducted from employee paychecks. ED administers PLO and sets the benefit amounts and contribution limits. Alternatively, employers may self-administer a PLO equivalent plan provided by insurance or self-funded to comply with PLO requirements.

Safe Leave Expansion

During the 2023 legislative session, the Oregon legislature passed, and the Governor signed House Bill 3443 (HB 3443) that amended the definition of safe leave to include leave for victims of bias crimes. According to PLO:

- Bias is a prejudice in favor of or against one thing, person, or group compared with another, usually in a way considered to be unfair.
- A bias crime is motivated in part or whole by bias against another person's race, color, disability, religion, national origin, sexual orientation, or gender identity.

The changes in HB 3443 became effective on January 1, 2024. This means that, as of that date, PLO and any equivalent plan should be approving safe leave requests for employees that are victims of bias crimes in addition to leave for reasons related to domestic violence.

Equivalent Plan Reporting Delay

Equivalent plans are required to submit annual aggregate benefits usage reports and aggregate financial information to PLO due no later than the January 31 for the prior year. The reporting period is the calendar year. The aggregate benefit usage report must include for the reporting period:

- the number of benefit applications received and the qualifying leave purpose.
- the number of benefit applications approved, the qualifying leave purpose, and the total amount of leave.

- the number of benefit applications denied, the qualifying leave purpose, the number of denials appealed, and the outcome of the appeals.
- If the equivalent plan is funded by employee contributions, a separate annual report for the same reporting period is required to report the following:
- the total amount of employee contributions withheld.
- total plan expenses paid including benefit amounts and total administrative costs.
- The balance of employee contributions held in trust at the end of the reporting period.

Both the annual aggregate benefit report and financial information reports may require additional information and the employer should respond within ten calendar days of a notice from ED requesting information about the equivalent plan.

The reporting period for equivalent plans that were effective in 2023 is the period between the effective date of the plan and December 31, 2024. The reporting period for equivalent plans that were effective in 2024 is the period between the effective date of the plan and December 31, 2024. This means that the first annual reporting for all equivalent plans that became effective in 2023 or 2024 will be due by January 31, 2025.

Equivalent Plan Reapproval

Equivalent plans are required to apply for reapproval annually for the first three years that they offer PLO benefits to employees. The application is due 30 days before the anniversary of the effective date of the plan. Equivalent plans that were effective Sept. 3, 2023, must submit their reapproval applications no later than August 3, 2024.

Employer Action

Employers sponsoring equivalent plans should confirm their carriers or administrators have incorporated the expanded definition of safe leave into their approval process.

Equivalent plan sponsors should also confirm their carriers or administrators are preparing the information required for the annual reporting and they will timely provide the information before the reporting deadline.

Employers should also confirm their carriers or administrators will provide the required equivalent plan information needed to timely submit the application for reapproval.

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San Francisco HCSO Reporting Due May 3 2024 Reminder

Issued date: 04/03/24

As a reminder, employers covered under the San Francisco Health Care Security Ordinance ("HCSO") need to submit the 2023 Employer Annual Reporting Form by May 3, 2024. The form is completed and submitted online at www.sf.gov/submit-employer-annual-reporting-form-olse.

It is important to note that this annual reporting includes the reporting requirement associated with San Francisco's Fair Chance Ordinance ("FCO"), which is not addressed in this article. You can access more information on the FCO on the FCO website of the San Francisco Office of Labor Standards Enforcement ("OLSE").

Employer Annual Reporting Form

Under the HCSO, covered employers must make minimum health care expenditures for each hour worked by covered employees in San Francisco.

Covered employers must also submit an online Employer Annual Reporting Form each year that summarizes how they complied with the HCSO.

The Form is normally due on April 30th of the following year, but the OLSE has announced that the deadline to submit the 2023 Form has been extended to May 3, 2024. According to FAQs emailed from the OLSE, no submission will be accepted after that date. The penalty for failing to timely submit the Employer Annual Reporting Form is $500 per quarter.

An employer that was not covered by the HCSO and/or the FCO in any quarter of calendar year 2023 does not need to submit the Form. To determine whether the Form is required, an employer will answer the short survey on the first page of the online Form. Employers that were not covered by the HCSO or the FCO in 2023 will be directed to a webpage indicating that they do not need to submit the Form, and no further action is required. Covered employers will be directed to the appropriate online Form.

The OLSE has posted a sample of the 2023 Form for employers who wish to preview the Form before completing it online (www.sf.gov/sites/default/files/2024-03/2023%20ARF%20PDF%20Preview.pdf). It has also published instructions for completing the 2023 Form (/www.sf.gov/sites/default/files/2024-03/2023 ARF Instructions_0.pdf).

HCSO Notice for Employers

If they haven't already, covered employers should make sure to post the official 2024 HCSO Notice in a conspicuous place at any employer workplace or job site where covered employees work. The Notice should also be mailed or emailed to employees who do not work at an employer workplace or job site, such as employees working from home. The Notice is available in several languages at /www.sf.gov/sites/default/files/2023-12/2024 HCSO poster_1.pdf.

Massachusetts Releases 2025 MCC Amounts

Issued date: 04/04/24

The Commonwealth Health Insurance Connector Authority ("Health Connector") recently published Administrative Bulletin 02-24 to provide annual guidance regarding certain provisions of the Minimum Creditable Coverage ("MCC") regulation. Specifically, this Bulletin describes the calculation of the deductible limits and out-of-pocket maximums for 2025 and provides those respective dollar amounts.

Background

On July 1, 2007, the Massachusetts Health Care Reform Act became effective. A component of this Act included an individual mandate, requiring Massachusetts residents aged 18 and older to have MCC or pay a penalty on their state income tax return. MCC requirements apply to individuals, not health insurance plans or employers. While employers are not required to provide health plans that meet MCC, their Massachusetts resident employees must enroll in MCC to avoid significant penalties.

Deductible Limits

The 2007 regulations mandated a $2,000/$4,000 deductible limit and a separate prescription deductible limit of up to $250/$500 for in-network covered services. Subsequent regulations required indexing the deductible limits to the annual out-of-pocket maximum ("OOPM") adjustment percentage under federal law, rounded down to the next $50.

Administrative Bulletin 02-24 sets the 2025 maximum MCC deductibles as $2,950/$5,900. If the plan has a separate prescription drug deductible, the amounts cannot exceed $360/$720 and the total maximum deductible applies. These deductible limits are unchanged from 2024.

OOPMs

In 2017, the Health Connector published Administrative Bulletin 02-17, tying the indexed OOPMs under MCC to the federally indexed OOPMs that apply to non-grandfathered plans.

For 2025, the OOPMs under MCC will be $9,200/$18,400. It should be noted that the 2005 federally indexed OOPMs that apply to non-grandfathered plans have not been released.

Effective Dates

Administrative Bulletin 02-24 takes effect immediately; the changes applicable to employer-sponsored plans will be incorporated with plan years beginning on or after January 1, 2025.

Pennsylvania Aligns Dependent Care Benefits With Federal Tax Rules

Issued date: 04/04/24

The Commonwealth of Pennsylvania recently enacted Act 34, Section 202.3 (HB 1300) ("The Act"), which, among other things, amended Pennsylvania law to allow for employer-provided dependent care assistance, including a Section 125 Dependent Care Assistance Program ("DCAP"), to be excluded from an employees' income for state income tax purposes. The Act is effective retroactively back to January 1, 2023.

Exclusion from Income Taxation

The Act aligns Pennsylvania's tax code with Section 129 of the Internal Revenue Code by allowing employees to exclude dependent care assistance provided by their employers from their personal income tax. For purposes of this exclusion, "dependent care assistance" is considered:

- the fair market value of daycare facility benefits provided by an employer;
- an amount paid directly by the employer to a daycare facility or reimbursed to the employee to subsidize the benefit; and
- benefits from the pre-tax contributions made by the employee under a Section 125 DCAP flexible spending account.

Correcting Inaccurate Form W-2s

Because the Act is effective retroactively, it is likely that employers withheld tax for employer-provided dependent care assistance for the 2023 tax year. This could create issues for employees when they file their 2023 state income tax return. In published guidance, the Pennsylvania Department of Revenue ("DOR") has provided steps to address this issue:

- If an employer has already filed their W-2s with the DOR, they should file corrected W-2s with the dependent care assistance excluded. Employees can exclude up to the federal maximum annual limit ($5,000 for 2024).

The employee(s) should also be provided with a corrected W-2.

- If an employer has not yet filed their W-2s with the DOR, they can file updated W-2s in which the dependent care benefits reported in Box 10 are not included in Box 16 (State Wages). The updated W-2 should also be provided to the applicable employee(s).

- Employers should not file amended W-3s and Annual Withholding Reconciliation Statements (REV-1667s) to remove withholding for dependent care assistance. Only W-2s should be amended.

Employer Action

Employers should file amended W-2s for any applicable employees according to the DOR's guidance. In addition, withholding for dependent care assistance benefits should be stopped as soon as possible. Payroll systems should be adjusted to ensure that dependent care assistance benefits are excluded from employees' taxable wages and are not included in their 2024 Form W-2.

Finally, any employee communications or plan documents which reference the prior taxation of dependent care assistance benefits in Pennsylvania should be updated to remove this language.

Change On The Horizon For Prescription Drugs And EHBs

Issued date: 04/30/24

According to a recent FAQ, the Departments of Labor, the Treasury, and Health and Human Services ("HHS") (collectively, "the Departments") intend to issue guidance that would require large insured group health plans and self-funded plans to treat all prescription drugs as essential health benefits ("EHBs").

Background

Generally, employers who offer large insured group health plans and self-funded group health plans are not required to cover EHBs. However, if the plan covers EHBs, the plan:

- May not impose annual or lifetime dollar limits on EHBs; and
- For non-grandfathered plans, cost-sharing for EHBs is counted toward the annual out-of-pocket maximum ("OOPM").

Prescription drugs are listed as an EHB.

In recent years, some programs have been designed to designate only certain prescription drugs as "EHBs" and other prescription drugs as "non-EHBs." This practice is often seen in connection with programs that utilize drug manufacture coupons or other copay assistance.

HHS finalized the 2025 Benefit and Payment Parameters regulation. Notably, the rule codifies current policy that prescription drugs that a plan covers in excess of those covered by a state's EHB-benchmark plan are considered EHBs, unless the coverage of the drug is mandated by state action. This rule applies to the individual and small group insured market. It does not apply to large insured group health plans and self-insured group health plans.

FAQ 66 – Proposed Change for Large Insured Plans and Self-Funded Plans

At the same time the final rule was issued, the Departments announced in FAQ 66 their intent to issue rulemaking that would require large insured group health plans and self-funded group health plans to treat all prescription drugs covered by the plan as EHBs, effectively aligning the rules across markets.

As a result:

- Annual and lifetime dollar limits on any covered prescription would be prohibited; and
- Cost-sharing would accumulate to the out-of-pocket maximum in a non-grandfathered plan.

Employer Action

Employers should await further guidance from the regulators on this issue. Employers that have large insured group health plans or self-funded plans that have designated certain prescription drugs as non-EHBs may need to make changes to their plan design when guidance is issued.

IRS Addresses Tax Treatment Of Work-Life Referral Services

Issued date: 05/03/24

In a recent Fact Sheet FAQ, the Internal Revenue Service ("IRS") clarified the tax treatment of certain work-life referral ("WLR") services provided by employers. The FAQ explains that where the WLR services are incorporated into an employee assistance program ("EAP") or otherwise bundled with other types of services, the value of the WLR services may be excluded from employees' income as a de minimis fringe benefit.

Background

WLR Programs

As described in the FAQ, a WLR program is an employer-funded fringe benefit that provides WLR services to eligible employees. WLR services are defined as informational and referral consultations that assist employees with identifying, contracting, and negotiating with life-management resources for solutions to a personal, work, or family challenge. These services are sometimes referred to as caregiver or caretaker navigation services. Examples of WLR services include:

- Identifying appropriate education, care, and medical service providers
- Choosing a child or dependent care program
- Navigating eligibility for government benefits
- Evaluating and using paid leave programs
- Locating home services professionals for family members with special needs
- Navigating private and public service programs
- Connecting employees with local retirement and financial planning professionals

De Minimis Fringe Benefits

In general, for federal tax purposes, a fringe benefit provided by an employer to an employee is presumed to be income to the employee unless it is specifically excluded by a section of the Internal Revenue Code ("Code").

The Code excludes from gross income and employment taxes any fringe benefit that qualifies as de minimis fringe. A de minimis fringe benefit is defined as any property or service, the value of which is (after taking into account the frequency with which similar fringes are provided to employees) so small as to make accounting for it unreasonable or administratively difficult. The Code requires the employer to establish the frequency with which it provides fringe benefits to individual employees (employee-measured frequency). If the employer can establish that it is administratively difficult to determine employee-measured frequency, it may instead reference the frequency by which it provides fringe benefits to the workforce as a whole (employer-measured frequency).

It is important to note that cash and cash equivalents (such as gift cards) do not qualify as de minimis fringes.

Application to WLR Programs

In the FAQ, the IRS explains that the value of employer-provided WLR services can be excluded from employees' gross income as a de minimis fringe benefit, and thus not subject to U.S. income and employment taxes.

The IRS only addressed WLR services when they are incorporated into an EAP or otherwise bundled with other types of services offered by the employer. The FAQ expressly declined to address the direct or indirect payment for life-management services or other non-WLR services offered through an EAP or that may be bundled with a WLR program.

Employer Action

The IRS notes that the Fact Sheet FAQ is intended to provide general information and will not be relied on to resolve any cases. However, if the FAQs turn out to be an inaccurate statement of the law, taxpayers who reasonably relied on them in good faith will not be subject to a penalty that provides a reasonable cause standard for penalty relief.

Employers who offer WLR services through an EAP or bundled with other services may continue to do so without including the value of the services in employees' gross income. However, there may be tax concerns if life-management services are purchased directly through a vendor and provided to employees, or if employees are reimbursed for life-management services that they receive outside of an employer-provided program.

Many vendors promoting life management programs offer benefits that go beyond the WLR services described in this FAQ. Employers offering these benefits should work carefully with their vendor to ascertain the scope of the services offered. Employers may need to consult with their tax advisor to determine the tax implications of offering these benefits.

Annual Out-of-Pocket Maximum Adjustments Announced For 2025

Issued date: 05/07/24

The Department of Health and Human Services ("HHS") published the "payment parameters" portion of its Annual Notice of Benefit and Payment Parameters for 2025. For purposes of employer-sponsored health plans, the guidance includes the limits on annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) for non-grandfathered group medical plans for plan years that begin in 2025.

Change to the Out-of-Pocket Maximums

The out-of-pocket maximum for non-grandfathered group medical plans will be decreased for plan years beginning on or after January 1, 2025, as follows:

- $9,200 for self-only coverage (down from $9,450 for 2024)
- $18,400 for coverage other than self-only (down from $18,900 for 2024).

It is important to note that the out-of-pocket maximum limits for non-grandfathered group medical plans are different (and generally higher) than the out-of-pocket maximum limits required for high-deductible health plans ("HDHPs") that are compatible with health savings account ("HSA") eligibility.

Employer Action

Non-grandfathered group medical plans should update out-of-pocket limits for plan years beginning on or after January 1, 2025.

New York Provides Paid Prenatal Leave And Sunsets COVID-19 Sick Leave

Issued date: 05/17/24

On April 20, 2024, Governor Kathy Hochul signed the 2025 state budget that includes an amendment to the New York Paid Family Leave ("NYPFL") law requiring employers to provide 20 hours of paid prenatal care. This "first-in-the-nation" prenatal leave effective January 1, 2025, makes available additional paid, protected leave for pregnant employees for prenatal care in addition to existing paid leave entitlements.

In addition, the separate New York COVID-19 paid sick leave law will sunset as of July 31, 2025.

Paid Prenatal Personal Leave

New York employers will be required to provide 20 hours of Paid Prenatal Personal Leave ("prenatal leave") during any 52-week calendar period that can be taken by the employee for pregnancy-related health care services including:

- physical examinations,
- medical procedures,
- monitoring and testing, and
- discussions with a health care provider related to pregnancy.

Prenatal leave may be taken in hourly increments with employees paid at their regular rate of pay, or the applicable minimum wage whichever is greater. An employer is not required to pay an employee for unused prenatal leave at an employee's termination, resignation, retirement, or separation from employment.

Prenatal leave is in addition to leave entitlements provided by other New York leave laws including paid sick leave and NYPFL. Some employees may also qualify for unpaid leave under the Family and Medical Leave Act ("FMLA") for serious health conditions.

Employers shall not retaliate against an employee for exercising their rights to prenatal leave and employees must be restored to their position of employment prior to any prenatal leave with the same pay and other terms and conditions of employment.

Employer Action

New York employers should review and be prepared to update, communicate, and coordinate existing leave policies and paid leave requirements with the new paid prenatal personal leave provisions that become effective January 1, 2025.

Employers should also be prepared for the sunsetting of the COVID-19 paid sick leave, effective July 31, 2025.

2025 Inflation Adjusted Amounts For HSAs HDHPs And EBHRAs

Issued date: 05/20/24

The IRS released the inflation adjustments for health savings accounts ("HSAs") and their accompanying HSA-compatible high deductible health plans ("HSA-compatible HDHPs") effective for calendar year 2025, and the maximum annual amount that may be made available under excepted benefit health reimbursement arrangements ("EBHRAs"). All limits increased from the
2024 amounts.

HSA Annual Contribution Maximum

For calendar year 2025, the maximum HSA contribution amount for an individual with coverage under an HSA-compatible HDHP is:

- $4,300 for self-only coverage (up from $4,150 for 2024)
- $8,550 for coverage other than self-only (up from $8,300 for 2024)

It should be noted that Individuals who are age 55 or older and covered by an HSA-compatible HDHP may make an additional HSA catch-up contribution of $1,000 each year until they enroll in Medicare. This catch-up contribution amount has not increased since 2009.

HSA-Compatible High Deductible Health Plan

For calendar year 2025, an HSA-compatible HDHP is a health plan:

- for which the maximum annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed:

- $8,300 for self-only coverage (up from $8,050 for 2024)
- $16,600 for coverage other than self-only (up from $16,100 for 2024), and

- with a minimum annual deductible that is not less than:
  - $1,650 for self-only coverage (up from $1,600 for 2024)
  - $3,300 for coverage other than self-only (up from $3,200 for 2024)

If family HDHP coverage includes an embedded individual deductible, for 2025 that embedded individual deductible cannot be less than $3,300 (the statutory minimum deductible for family HDHP coverage).

Non-calendar year plans: In cases where the HSA-compatible HDHP renewal date is after the beginning of the calendar year (e.g., a fiscal year plan), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date.

Excepted Benefit HRA Adjustment

For plan years beginning in 2025, the maximum amount that may be made newly available for the plan year for an EBHRA is $2,150 (up from $2,100 in 2024).

2024 PCOR Fee Filing Reminder For Self-Insured Plans

Issued date: 06/11/24

The Patient-Centered Outcomes Research ("PCOR") fee filing deadline is **July 31, 2024**, for all self-funded medical plans and some HRAs (including individual coverage HRAs ("ICHRAs")) for plan years (including short plan years) ending in 2023. Carriers are responsible for paying the fee for insured policies.

The plan years and associated PCOR fee amounts due July 31, 2024, are as follows:

Plan Year END Date	PCOR Fee Amount
January 31, 2023	$3.00/covered life/year
February 28, 2023	$3.00/covered life/year
March 31, 2023	$3.00/covered life/year
April 30, 2023	$3.00/covered life/year
May 31, 2023	$3.00/covered life/year
June 30, 2023	$3.00/covered life/year
July 31, 2023	$3.00/covered life/year
August 31, 2023	$3.00/covered life/year
September 30, 2023	$3.00/covered life/year
October 31, 2023	**$3.22/covered life/year**
November 30, 2023	**$3.22/covered life/year**
December 31, 2023	**$3.22/covered life/year**

Employers with self-funded health plan years ending in 2023 should use the 2nd quarter Form 720 to file and pay the PCOR fee by July 31, 2024. The information is reported in Part II.

IRS Form 720 is a quarterly form that is used to report and pay many different taxes, including fuel and other transportation excise taxes. The IRS has adapted the Form 720 to be used for this annual reporting requirement. Each year, the PCOR section is updated with the fee rates in June for the July 31st due date (the 2nd quarter form).

Please note, Form 720 is a tax form (not an informational return form such as Form 5500), and as such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third-party administrators, cannot report or pay the fee.

Resources

For a copy of Notice 2023-70, visit: www.irs.gov/pub/irs-drop/n-23-70.pdf.

For a copy of the regulations, visit: www.gpo.gov/fdsys/pkg/FR-2012-12-06/pdf/2012-29325.pdf

For additional information, please visit the following IRS sites:

- Form 720, Quarterly Federal Excise Tax Return – instructions and forms: www.irs.gov/forms-pubs/about-form-720
- Patient-Centered Outcomes Research Trust Fund Fee, Questions and Answers: www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee
- PCOR Filing Due Dates and Applicable Rates Chart: www.irs.gov/affordable-care-act/patient-centered-outreach-research-institute-filing-due-dates-and-applicable-rates

Updated Instructions For Gag Clause Attestations

Issued date: 06/14/24

The Departments of Labor, the Treasury, and Health and Human Services (collectively, "the Departments") recently issued the updated Annual Submission Instructions and User Manual to facilitate the Gag Clause Prohibition Compliance Attestation ("GCPCA") for 2024.

Background

Briefly, group health plans and health insurance carriers are prohibited from entering into an agreement with a health care provider, network or association of providers, third-party administrators ("TPAs"), or other service provider offering access to a network of providers, that directly or indirectly restricts the plan or carrier from:

- disclosing cost or quality of care information or data, and certain other information, to:
  - active or eligible participants, beneficiaries, and enrollees of the plan or coverage,
  - the plan sponsor, or
  - referring providers.
- electronically accessing de-identified claims and encounter information or data for each participant or beneficiary in the plan
  or coverage, upon request and consistent with the relevant privacy regulations, or
- sharing such information with a business associate, consistent with applicable privacy regulations.

A group health plan or carrier must annually attest that, for the period of the attestation, it has not entered into any agreements that violate the gag clause prohibition. The annual attestation is submitted through the Centers for Medicare and Medicaid Services ("CMS") via a webform on the GCPCA homepage. The first attestation was due by December 31, 2023. The next attestation is due by December 31, 2024.

What's New?

There are a handful of changes made to the information as follows:

- In a separate section of the instructions, the agreements that are subject to an attestation of compliance are clarified to include agreements between group health plans (fully insured or self-funded) and carriers (offering group or individual health insurance coverage) with:
    - health care providers,
    - a network or association of providers,
    - TPAs, or
    - other service providers (including vendors) offering access to a network of providers.
- The term "Reporting Entity" has been changed to "Responsible Entity;" however, the definition remains the same.
    - The Responsible Entity is defined as the plan or issuer that has (directly or indirectly) entered into agreements, usually through a TPA or another vendor (like a pharmacy benefit manger ("PBM") or behavioral health manager ("BHM"), with health care providers, a network or association of providers, TPAs or other service providers offering access to a network of providers.
- The terms "Attestation Period" and "Attestation Year" have been clarified.
    - The Attestation Period begins on the day immediately following the date of the prior attestation and extends to the date of the current attestation.
- The year in which the attestation is submitted is the Attestation Year.
- The list of Responsible Entities (those required to attest) has been updated to include Tribal health plans that qualify as ERISA plans or state or local government plans. In addition, a footnote has been added to address who is the Responsible Entity in a Multiple Employer Welfare Arrangement ("MEWA").
- The instructions clarify that a single group health plan with multiple benefit packages (e.g., a single plan using a single ERISA plan number that offers a PPO and an HDHP health plan option) is a single Responsible Entity and may submit one attestation. However, if there are multiple group health plans (such as a PPO plan that uses ERISA plan number 501 and a separate HDHP plan that uses ERISA plan number 502) the Responsible Entity will need to file an attestation for each separate plan.
- Additional changes to the webform submission and GCPCA user manual.

Employer Action

Employers should begin to prepare for compliance with the gag clause attestation for Attestation Year 2024, due no later than December 31, 2024.

For fully insured group health plans, the carrier is responsible for submitting the attestation. The employer should confirm that the carrier will submit on behalf of the plan.

For self-funded group health plans (including level-funded plans), the plan sponsor (the employer) is responsible for compliance and remains legally responsible for the attestation. In many cases, the employer will need to act as the Responsible Entity and submit the annual attestation on behalf of the plan.

In some cases, the TPA or other third party will submit the attestation on behalf of the plan. Employers looking to have a TPA or other third party submit the attestation on the plan's behalf should confirm this in writing with the applicable vendor.

Further, if there are carved out vendors (e.g., PBMs, BHMs) with a contract subject to this provision, employers should confirm no gag clauses exist and either, through written agreement, have the vendor submit the attestation on behalf of the plan or prepare to file on the carve-out portion of the arrangement.

A reminder on the Gag Clause Attestation will be sent out closer to the December 31, 2024, due date.

2024 State-Based Compliance: Quarter Two

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Kentucky Legislation Regulates PBM Pricing and Provider Networks

On April 4, 2024, the Kentucky Governor signed Senate Bill 188 into law titled "An Act relating to Patient Access to Pharmacy Benefits" ("the Act"), which created new sections of the Kentucky Revised Statutes ("KRS") to address what is described as an unfair playing field between independent pharmacies and pharmacy benefit managers ("PBMs") and to provide expanded access and lower costs for patients and rural clinics. The new Act will regulate the pricing that a PBM charges to pharmacies and costs, fees, and financial benefits received by PBMs. Additionally, the Act attempts to regulate the provision of pharmaceutical providers made available by PBMs and health plans. The new Act will go into effect for new contracts or policies delivered, executed, amended, adjusted, or renewed on or after January 1, 2025.

Network Access, Contract Regulation, and Minimum Reimbursement

The Act sets requirements around what a PBM can charge pharmacies for prescription medication and certain financial incentives that a PBM can receive. While the regulations are broad in scope, there are several points that will be of relevance to group health plans:

- Requires reasonably adequate and accessible network of pharmacies that are not mail-order pharmacies with convenient access within a reasonable distance from the insured's residence, but in no event more than 30 miles of an insured's residence, to the extent that pharmacy services are available.
- Prohibits a PBM or plan from denying a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services that meet the terms and requirements set forth by the insurer under the policy or plan;
- Requires equal access and incentives to all pharmacies within the network;
- Requires identical reimbursement terms to be offered to all pharmacies located in the health plan's geographic coverage area;
- It sets a minimum dispensing fee or floor of $10.64 to fill a prescription for retail independent pharmacies until a study of national average dispensing costs is completed by the Kentucky Department of Insurance (available only to independent pharmacies, not chain pharmacies); and
- Requires annual reporting with the insurance commissioner.

Freedom of Patient Choice

The Act specifically requires that consumers have the freedom of choice related to the provision of pharmacy benefits by prohibiting a PBM or health plan from doing the following:

- Prohibiting or limiting any covered individual from selecting a pharmacy or pharmacist of his or her choice who has agreed to participate in the plan according to the terms offered by the insurer;
- Imposing cost-sharing or other conditions that are greater or more restrictive than what would be imposed if the patient used a mail-order pharmacy;
- Requiring patients to obtain their drugs through mail order or direct patients to a pharmacy owned by the PBM or reimbursing a pharmacy that it owns at a higher rate than a community pharmacy;
- Steering insureds to the PBM preferred pharmacy;
- Preventing a community pharmacy from filling a 90-day prescription for a maintenance drug; and
- Penalizing a community pharmacy for sharing information with patients on the least expensive option to pay for a prescription.

These provisions have the effect of declaring Kentucky as an "any willing provider" state. States that fall under this characterization require insurance carriers, PBMs, and health plans to allow healthcare providers to become members of the carriers' networks of providers if certain conditions are met. In the case of the Kentucky Act, a PBM or health plan will be required to allow a pharmaceutical provider to participate in their network if that provider is able to provide the services required and if they agree to the terms under the policy or plan, including the terms of reimbursement.

In addition to the "any willing provider" provisions, the Act will also prohibit a PBM or benefit plan from steering a participant toward certain providers at the expense of other network providers. Specifically, the applicable parties are not permitted to impose a monetary benefit or penalty (which includes a higher copayment or a reduction in reimbursement for services) to influence a beneficiary's utilization of one provider or method of provision over another.

Which Plans is this Applicable to?

In general, fully insured plans whose policies or contracts are issued by an insurance carrier registered in the Commonwealth of Kentucky will be covered by the provisions under the Act. This will likely be limited to only those health plans situsued in the Commonwealth of Kentucky.

ERISA-covered self-funded health plans are generally excluded from coverage by state insurance regulations through the doctrine of ERISA preemption. Any provision of the Act determined to be preempted by ERISA will not apply to ERISA-covered self-funded plans. ERISA preemption does not apply to fully insured plans. However, the Act defined insurers as including self-funded plans, government plans, church plans, and multiemployer plans, with the stated intent that the Act cover such plans. Moreover, the Act amended provisions of Kentucky law applying to pharmacies, pharmacists, and PBMs to address these provisions.

The U.S. Supreme Court held in Rutledge v. Pharmaceutical Care Management that federal ERISA preemption does not apply to a state regulation that amounts to mere cost regulation. Conversely, the court ruled that ERISA preemption exists where state law impermissibly connects to ERISA through such actions as "require providers to structure benefit plans in particular ways," "bind plan administrators to specific rules for determining beneficiary status," or create economic effects that "force an ERISA plan to adopt a certain scheme of coverage."

In the case of the Kentucky Act, it seems likely that the provisions related to provider adequacy are preempted by ERISA as they force ERISA-covered health plans to administer their benefits in a certain way. On the other hand, the provisions related to the pricing regulation of PBMs are likely not preempted as they appear to be cost regulations and applicable to all PBMs.

The Act does not apply to self-insured health plans provided by a hospital or health system for its employees where the hospital or health system owns a pharmacy.

The Act does not apply to Medicare Part D plans or to fully insured Kentucky student health plans.

Employer Action

Fully insured plans should coordinate with their carriers to ascertain what impacts these regulations will have on any upcoming renewals.

Self-funded plans should work with independent counsel to determine whether they are subject to ERISA preemption. To the extent they are not subject to preemption, or the provisions of the regulations are not, plans should work with their TPAs and PBMs to determine the impact that the regulations will have on plan costs and to plan and budget accordingly.

Employers should watch for updates as additional regulations are expected.

Maine Publishes Proposed PFML Regulations

The Maine Department of Labor ("Department") has recently published proposed regulations for the Maine Paid Family and Medical Leave ("PFML") program. The proposed regulations provide additional details including program eligibility, how the benefit may be used, and applying for benefits.

The Basics

On June 11, 2023, Maine Governor Janet Mills signed into law the state's budget bill which established a PFML program. The program provides 12 weeks of wage replacement benefits for employees taking family or medical leave. Contribution withholdings under the state program begin January 1, 2025, and claims processing begins May 1, 2026. Employers can opt out of the state program and offer a private plan if certain conditions are met.

Below you will find highlights of new and clarifying information contained in the proposed regulations.

Employer Coverage

All private and public employers who employ one or more employees in Maine are required to provide paid family and medical leave. A "covered individual" is defined as an employee who earned at least 6 times the State Average Weekly Wage during the first 4 of the last 5 completed calendar quarters immediately preceding the first day of an individual's benefit year.

The program does not apply to the federal government. Self-employed individuals and tribal governments can opt-in to the program. In addition, the program does not apply to any employer or employee subject to the Railroad Unemployment Insurance Act, incarcerated persons earning wages in a Maine correctional facility or detention facility, and students that are earning wages as part of the Federal Work-Study Program and are enrolled in any University of Maine system, a community college, or any private higher educational institution in the State of Maine.

Uses and Types of Leaves

Covered individuals may take their full 12 weeks of leave in a variety of ways:

- Continuous leave occurs in blocks of consecutive days or weeks.
- Intermittent leave provides for varying periods of leave and returning to work throughout a period of approved covered leave time. Intermittent leave may be planned (e.g., for routine appointments) or unplanned (e.g., for a flare-up of a serious health condition).

- Reduced schedule leave reduces an employee's typical number of days per workweek, or hours per workday, on a planned and consistent basis.

Partial weeks or partial days of leave will be prorated against the employee's scheduled workweek.

Eligibility to Receive Benefits

To receive PFML benefits, a covered individual must:

- Be a covered employee;
- Submit an application for benefits in a manner approved by the Department (which may be submitted online), no more than 60 days before the anticipated start date of family leave and medical leave and no more than 90 days after the start date of family leave and medical leave;
- Have not been declared ineligible due to fraud; and
- Satisfy one of the qualifying reasons under the PFML program.
- Additional provisions regarding eligibility to take leave include:
- The combined medical and family leave may not exceed the 12-week maximum of family and medical leave within a benefit year.
- The 12 weeks of aggregate PFML may be reduced by amounts taken under FMLA or state FMLA unless the leaves are taken concurrently.
- A covered individual taking family leave to care for an individual with whom they have an affinity relationship is limited to one such designated individual per benefit year.

Employee Notice to Employer

Absent an emergency, illness, or other sudden necessity for taking leave, an employee must give reasonable notice (e.g., 30 days) to the employee's supervisor of the intent to use leave. If the request for leave is not foreseeable, an employee must make a good faith effort to provide written notice to the employer of the employee's intent to use leave as soon as possible. Notice provided on behalf of the employee by a family member or health care provider is considered notice provided by the employee.

An employer claiming an undue hardship with respect to the scheduling of foreseeable leave has the burden to prove the undue hardship. "Undue hardship" means a significant impact on the operation of the business or significant expenses, considering the financial resources of the employer, the size of the workforce, and the nature of the industry.

Amount of Benefit

The weekly benefit amount paid to employees and self-employed individuals on family or medical leave is calculated based on a tiered wage system. The calculation is as follows:

- 90% of Average Weekly Wage up to 50% of the State Average Weekly Wage (Tier 1) plus 66% of Average Weekly Wage in excess of 50% of the State Average Weekly Wage (Tier 2).
- The weekly benefit cannot exceed the State Maximum Weekly Benefit.

Premiums

The employer's premium amount and contribution report must be remitted quarterly on or before the last day of the month following the close of the quarter for which premiums have accrued. Beginning January 1, 2025, the premium is set at no more than 1% of wages.

- An employer with 15 or more employees may only deduct up to 50% of the required premium from an employee's wages and must remit 100% of the combined premium contribution to the Paid Family and Medical Leave Insurance Fund ("Fund") (i.e., the required premium may be equally shared between the employee and employer).
- An employer with fewer than 15 employees may only deduct up to 50% of the required premium from an employee's wages and must remit 50% of the premium to the Fund as businesses with fewer than 15 employees are exempt from paying into the state plan.
- The Program caps the amount of an employee's earnings subject to contributions at the same amount of earnings subject to Social Security taxes.

The employer size for the purposes of determining premium liability for calendar year 2025 is determined by the number of covered employees employed for the employer in the State of Maine on October 1, 2024. The number of employees includes full-time, part-time, seasonal, and temporary employees. On October 1, 2025, and October 1 of each year thereafter, the employer must calculate its size for the purpose of determining premium liability for calendar year 2026 and each calendar year thereafter.

The proposed regulations clarify that an employer's determination as to whether to deduct premiums from employees' wages must apply to all employees. If an employer changes that determination, the employer must provide notice to all employees in writing at least 7 days prior to the employees' first affected paycheck.

Employers must include in the employee's pay statement that a premium deduction for PFML has been deducted from the employee's wages.

Approved Private Plan

Employers may apply for a private plan exemption after January 1, 2026, but an exemption may not be effective prior to April 1, 2026. Applications for substantially equivalent private plans must be submitted on a form provided by the Department and may be accepted on a rolling basis. An application fee set by the Department must be included with the submission of the application.

An approved private plan is effective on the first day of the first quarter following approval of the application. The employer is responsible for premiums provided under the PFML program and the regulations until the effective date of substitution. An approved private plan is valid for a period of 3 years.

Employers approved for a private plan may not request cancellation of their private plan prior to the private plan's expiration date except by a demonstration to the Department of good cause. Good cause includes, but is not limited to, evidence of a premium increase. If the Department approves the employer's request for cancellation, the employer may not re-apply for another private plan for three years from the date of cancellation.

Employers must notify the Department of any material changes to an approved private plan at least 60 days in advance of the effective date of the changes and must obtain written approval from the Department regarding the changes.

Employer Action

Employers should review all the available information from the Department and work with employment counsel, leave vendors, payroll processors and any other related business advisors to make sure they are compliant with the PFML program by the requisite dates. In addition, employers should monitor the PFML website for additional guidance and regulations. We will continue to keep employers updated on new PFML program developments as applicable.

Maryland's Paid Family and Medical Leave Delayed Again

As previously reported, Maryland passed the Time to Care Act of 2022 ("the Act"), which mandates that covered employers provide paid family and medical leave to their employees in Maryland. On April 25, 2024, the Maryland General Assembly passed SB 485 which further delays the implementation of the Act. In addition to delaying implementation of the Act, the new legislation also provides clarification on the definition of "wages" and allows the Maryland Department of Labor ("MDOL") to set certain fees applicable to private plans.

Legislative Changes and Updates

Employers participating in the State Plan must begin making payroll contributions on July 1, 2025, with benefits beginning on July 1, 2026.

The definition of "wages" now aligns with the definition under Maryland's Unemployment Insurance statute. This alleviates the need to calculate different sets of wages under the two statutes.

The MDOL is permitted to assess application and renewal fees for employers that establish a private plan that satisfies the Act's requirements. Future rulemaking should further address these fees.

Employer Action

Employers should:

- Review and examine their existing paid leave policies (and employee handbooks) to determine whether they will want to utilize these policies to satisfy, or supplement, their requirements under the Act.
- Contemplate whether to participate in the state program or offer a private program (e.g., substitute existing leave or purchase a private insurance policy). Note, employers will need to apply for approval from the MDOL to offer an alternative plan. Guidance on this process is expected in the future.
- Provide written notice to all covered employees of their rights and duties under the Act.
- Ensure that payroll is prepared to begin contributions on July 1, 2025.
- Await future regulations that are expected.

Paid Leave Oregon Benefit and Contribution Amount Adjustments

December 21, 2023 Update: The Social Security wage cap has been released for 2024. The "Contribution Limit" section below includes several updates to reflect this and additional related information.

As previously reported in August 2021, leave and benefits under Paid Leave Oregon ("PLO") will become available on September 3, 2023. Recently, the Oregon Employment Department ("ED") announced the adjusted weekly wage replacement benefit amounts based on the State Average Weekly Wage. Additionally, the Oregon Legislature modified PLO to align the wage cap for employee contributions with the social security wage limit.

Background

PLO took effect January 1, 2023 and will begin providing benefits to covered individuals on September 3, 2023. PLO is funded by employer and employee contributions deducted from employee paychecks. ED administers PLO and sets the benefit amounts and contribution limits.

Wage Replacement

On June 1, 2023, ED announced the weekly benefit amounts for PLO effective July 1, 2023, through June 30, 2024. The minimum and maximum weekly benefit amounts are adjusted annually based on the Oregon State Average Weekly Wage set by ED. The State Average Weekly Wage ("SAWW") increased to $1,269.69 from $1,224.82. The minimum weekly benefit under PLO is 5% of the SAWW and the maximum is 120% of the SAWW.

	Minimum weekly benefit amount	Maximum weekly benefit amount
July 1, 2023 – June 30, 2024	$63.48	$1,523.63

Contribution Limit

The total contribution amount of 1% of eligible wages is split between employees and employers. Employees pay 60% and employers pay 40%. For example, $1,000 in wages would equal $10 in premiums paid to PLO of which, the employee would pay $6, and the employer would pay $4.

Employers that do not sponsor approved equivalent plans are required to deduct PLO premiums from employee paychecks and remit those premiums to the Paid Family and Medical Leave Insurance Fund. ED annually sets the maximum wage limit from which employers deduct premiums. Initially, the wage limit was set at $132,900. Recently Oregon enacted SB 913 which aligned the PLO wage cap with the Social Security wage cap beginning January 1, 2024. The Social Security cap has been announced for 2024 and is set at $168,600. ED is required to announce the adjusted contribution limit by November of each year for the following calendar year.

Paid Leave Oregon Website

The PLO website provides extensive information for employers including program information, employer resources, printable forms, employee contribution calculators, and FAQs. Employers can also access program guidebooks, checklists, and guidance and tools related to administering equivalent plans.

Employer Action

Employers should plan to update their 2024 employee payroll deductions to the adjusted amount starting for payroll dates on or after January 1, 2024.

Paid Leave Oregon Updates

As previously reported, leave and wage replacement benefits under Paid Leave Oregon ("PLO") became available on September 3, 2023. Recently, the definition of safe leave was expanded to include bias crimes. Additionally, the Oregon Employment Department ("ED") announced a delay in the first annual reporting requirement for equivalent plans.

Background

PLO took effect January 1, 2023 and began providing benefits to covered individuals on September 3, 2023. PLO is funded by employer and employee contributions deducted from employee paychecks. ED administers PLO and sets the benefit amounts and contribution limits. Alternatively, employers may self-administer a PLO equivalent plan provided by insurance or self-funded to comply with PLO requirements.

Safe Leave Expansion

During the 2023 legislative session, the Oregon legislature passed, and the Governor signed House Bill 3443 (HB 3443) that amended the definition of safe leave to include leave for victims of bias crimes. According to PLO:

- Bias is a prejudice in favor of or against one thing, person, or group compared with another, usually in a way considered to be unfair.
- A bias crime is motivated in part or whole by bias against another person's race, color, disability, religion, national origin, sexual orientation, or gender identity.

The changes in HB 3443 became effective on January 1, 2024. This means that, as of that date, PLO and any equivalent plan should be approving safe leave requests for employees that are victims of bias crimes in addition to leave for reasons related to domestic violence.

Equivalent Plan Reporting Delay

Equivalent plans are required to submit annual aggregate benefits usage reports and aggregate financial information to PLO due no later than the January 31 for the prior year. The reporting period is the calendar year. The aggregate benefit usage report must include for the reporting period:

- the number of benefit applications received and the qualifying leave purpose.
- the number of benefit applications approved, the qualifying leave purpose, and the total amount of leave.

- the number of benefit applications denied, the qualifying leave purpose, the number of denials appealed, and the outcome of the appeals.
- If the equivalent plan is funded by employee contributions, a separate annual report for the same reporting period is required to report the following:
- the total amount of employee contributions withheld.
- total plan expenses paid including benefit amounts and total administrative costs.
- The balance of employee contributions held in trust at the end of the reporting period.

Both the annual aggregate benefit report and financial information reports may require additional information and the employer should respond within ten calendar days of a notice from ED requesting information about the equivalent plan.

The reporting period for equivalent plans that were effective in 2023 is the period between the effective date of the plan and December 31, 2024. The reporting period for equivalent plans that were effective in 2024 is the period between the effective date of the plan and December 31, 2024. This means that the first annual reporting for all equivalent plans that became effective in 2023 or 2024 will be due by January 31, 2025.

Equivalent Plan Reapproval

Equivalent plans are required to apply for reapproval annually for the first three years that they offer PLO benefits to employees. The application is due 30 days before the anniversary of the effective date of the plan. Equivalent plans that were effective Sept. 3, 2023, must submit their reapproval applications no later than August 3, 2024.

Employer Action

Employers sponsoring equivalent plans should confirm their carriers or administrators have incorporated the expanded definition of safe leave into their approval process.

Equivalent plan sponsors should also confirm their carriers or administrators are preparing the information required for the annual reporting and they will timely provide the information before the reporting deadline.

Employers should also confirm their carriers or administrators will provide the required equivalent plan information needed to timely submit the application for reapproval.

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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.

Updated Guidance on Minnesota's Paid Leave Law

Issued date: 07/09/24

As previously reported, Minnesota's Paid Leave Law ("PLL") goes into effect January 1, 2026. PLL requires employers to provide covered employees with up to 20 weeks of paid leave to care for themselves or their family members. PLL will be paid for by payroll taxes and premium payments from both employers and employees. The first premium payment is due on or before April 30, 2026. A private plan option will be available and is required to be the same or more generous than the PLL requirements.

Minnesota's Department of Employment and Economic Development ("MN DEED")

MN DEED recently released new guidance for employers and employees.

For employees, the guidance addresses the two types of available state-funded leaves – family leave and medical leave. Employees will be eligible for up to 12 weeks per benefit year for each type of leave, but limited to a maximum of 20 weeks of paid leave per benefit year. Employees that have the PLL qualifying event of acquiring a new child either through birth, adoption, or foster care in 2025 will still be eligible to apply for family leave under the PLL in 2026 if the leave is used within the first 12 months of acquiring the new child.

For employers, MN DEED's updated guidance requires covered employers to register with MN DEED's Unemployment Insurance Division ("UID") and establish a "Paid Leave Only" employers account by October 31, 2024. October 31, 2024 is also the due date for the first wage detail report submission and should cover wages paid between July 1, 2024 and September 30, 2024. Subsequent wage detail report submissions will be due on a fiscal quarterly basis. Employers who already submit wage detail reports to UID will not need to provide a second report for PLL purposes. Finally, starting November 1, 2025, employers will be required to provide a workplace notice of the employees' PLL rights. MN DEED has yet to provide a model notice for this purpose.

Approved PLL Amendments

Additionally, new PLL amendments have recently been signed into law and are summarized as follows:

Premiums

- Based upon actuarial guidance, the original 0.7% payroll tax on employers will most likely increase to 0.88%; up to half of this amount may be shared with employees. In response to the actuary's findings, MN DEED's commissioner was provided with the power to annually adjust the premium rates contingent upon actuarial results.

- Employers that have 30 or fewer employees and pay an average weekly wage to employees that is equal to or less than 150% of Minnesota's average weekly wage ($1,337 per week as of October 1, 2023) can pay a smaller employer premium rate of 0.75%, with the employer's portion of the contribution capped at 0.1875% (1/4th of the 0.75%). These smaller employers may also apply for assistance grants from MN DEED.

- Employers and employees will have 30 calendar days from the MN DEED or private plan administrator decision date regarding an awarded PLL benefit to request an administrative review of the decision. MN DEED will then issue a hearing notice to the parties and a hearing officer will hold a recorded, private hearing and provide a written decision, including their reason for the decision and findings of fact. A request for reconsideration can be filed by either party and a subsequent hearing will be heard before the same hearing officer. Upon completion of the reconsideration hearing, either party can appeal the decision with the Minnesota Court of Appeals.

Definitions

- For employer's participating in the MN DEED's state program, "benefit year" is defined as the 52 calendar weeks beginning the effective date of the leave. However, private plans can have their own definition of a "benefit year," such as calendar year, any fixed 12-month period, a 12-month period measured forward from the employee's first day of leave, or a rolling 12-month period backwards from the employee's first day of leave.

- Independent contractors and self-employed individuals can opt into coverage for paid leave benefits. MN DEED's commissioner will need to develop procedures to allow this option.

- The definition of "family member" is expanded to include the child of a domestic partner. This joins the current list of potential family members: spouse or domestic partner, child (biological, adopted, foster, stepchild, child in loco parentis, guardianship, or de facto custodian), applicant's parent or legal guardian, sibling, grandchild, grandparent or spouse's grandparent, son or daughter-in-law, and an individual who has a personal relationship with the applicant that creates an expectation and reliance that applicant care for the individual without compensation.

Intermittent Leave

A covered individual's initial paid week occurs when they take a combination, either consecutively or non-consecutively, of seven leave days. Intermittent leave must be taken in increments consistent with the employer's existing leave policy and have a minimum increment of one calendar day of leave.

Calculation of Benefits

- The amendment changes the benefits calculation from an examination of whether the person receives an hourly rate or salary to benefit payments based upon the average hours the covered employee worked during the two quarters prior to filing the application for benefits. The final benefit amount will be based upon the percentage of the applicant's average weekly wage.

- Employers can supplement the employee's wages on top of their PLL benefits. But if the employee receives more than their usual income, they must return such excess supplemental payments to their employer.

Retroactive Benefits

- Benefits take effect on the Sunday of the calendar week when a benefit application is filed. Applicants that are incapacitated or fail to timely apply for benefits through no fault of their own can request retroactive payment of benefits longer than the seven days prior to the Sunday when their application was filed. The amendment also stipulates that employees unable to work due to incarceration or while receiving unemployment insurance will not be able to utilize PLL benefits for the affected time.

Reinstatement

- The amendment requires that when the employee can return to work, they must be put back into a position with the same overtime pay rate and overtime hour opportunities as the position that they worked prior to receiving the leave. If overtime opportunities changed for similarly classed employees, this reinstatement requirement does not apply.

Employer Plan Changes

- If an employer switches from the MN DEED program to a private plan or vice versa, the prior plan stays in effect until the request is approved. Extensions or change requests that are made during the transition period will apply to the new plan. Terminated employees must receive coverage the earlier of 26 weeks following termination or until they secure another job.

Data Privacy

- The amendments require that, in general, information collected for PLL purposes, such as recorded testimony or exhibits for benefits determination, must be kept private. Disclosure of such information will usually require a court order. However, state and federal agencies, employers, and healthcare providers may be able to access certain permitted information based upon the applicable need.

Employer Action

To incorporate this new guidance and changes in the PLL, employers should:

- Register with MN DEED and establish "Paid Leave Only" employers account by October 31, 2024. All employers that are subject to the PLL, including those that will eventually choose to go with a private plan, must take this course of action.

- By October 31, 2024, determine if the first wage detail report is due to MN DEED and, if applicable, submit.

- Recognize requirements that will apply in 2025, such as posting in the workplace and updating employee handbooks or any other leave related policies. It may be prudent to provide additional leave language for a child newly acquired in 2025 but eligible for PLL benefits in 2026.

- Recalculate the premium amount that will be due starting in 2026 with the higher required contribution amount. This may require updating payroll and other electronic systems with the updated amounts.

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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Departments Issue Final MHPAEA Regulations

Issued date: 10/04/24

On September 9, 2024, the Departments of Health and Human Services , Labor, and the Treasury (collectively, the "Departments") released final rules pertaining to the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") with the aim of ensuring that individuals who seek treatment for mental health ("MH") or substance use disorder ("SUD") reasons do not face greater burdens than they would face when seeking coverage for medical/ surgical reasons. The final rules amend certain provisions of the existing MHPAEA regulations and add new regulations to set forth content requirements and timeframes.

Background

Briefly, MHPAEA:

- Provides that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on MH/SUD benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits in a classification.

- Prohibits separate treatment limitations that apply only to MH/SUD benefits.

- Provides that non-quantitative treatment limitations ("NQTLs") may not be imposed on MH/SUD benefits in any classification unless they are comparable and applied no more stringently for MH/SUD benefits than for medical/ surgical benefits under the terms of the plan (or health insurance coverage) as written and in operation. Examples of NQTLs include prior authorization and medical management requirements. The focus here is not on whether the final result is the same for MH/SUD benefits as for medical/surgical benefits, but rather on whether the underlying processes, strategies, evidentiary standards, and other factors are in parity.

- Imposes certain disclosure requirements, including a requirement that group health plans conduct a comparative analysis of all NQTLs imposed on MH/SUD benefits and make that analysis available to the Departments and participants and beneficiaries (including their authorized representatives) upon request.

MHPAEA applies to:

- Employers with at least 51 employees offering a group health plan that provides coverage for any MH/SUD benefits; and
- Small employers with fully insured group health plans that are required to provide all essential health benefits, including MH/SUD benefits.

The Final Rules

The following summarizes some of the highlights applicable to employers sponsoring group health plans subject to MHPAEA.

Terms

The final rules amend the definitions of the terms "medical/surgical benefits," "mental health benefits," and "substance use disorder benefits" by removing a reference to state guidelines. The definition of whether a condition or disorder is a MH condition or SUD must follow the most current version of the International Classification of Diseases or Diagnostic and Statistical Manual of Mental Disorders. If generally recognized independent standards of current medical practice do not address how to treat a condition, disorder, or procedure, plans and carriers may define it in accordance with applicable federal and state law.

The regulations reinforce that the following conditions are MH conditions:

- eating disorders, such as anorexia nervosa, bulimia nervosa, and binge-eating disorder;
- autism spectrum disorder; and
- gender dysphoria.

Additionally, the final rules add new definitions for the following terms: evidentiary standards, factors, processes and strategies.

Requirements for NQTLs

Under the final regulations, a plan or carrier may not impose any NQTL with respect to MH/SUD benefits in any classification that is more restrictive, as written or in operation, than the predominant NQTL that applies to substantially all medical/surgical benefits in the same classification. For this purpose, a plan or carrier must satisfy two sets of requirements:

1. The design and application requirements; and
2. The relevant data evaluation requirements.

Design and Application Requirements

The general rule of the design and application requirements requires an examination of the processes, strategies, evidentiary standards, and other factors used in designing and applying an NQTL to MH/SUD benefits in the classification to ensure they are comparable to, and are applied no more stringently than, those used in designing and applying the limitation with respect to medical/surgical benefits in the same classification.

The final regulations also prohibit the use of discriminatory factors and evidentiary standards to design an NQTL to be imposed on MH/SUD benefits.

Whether information, evidence, sources, or standards are considered to be biased is based on all the relevant facts and circumstances and whether they systematically disfavor or are specifically designed to disfavor access to MH/SUD benefits as compared to medical/surgical benefits. Historical plan data/information from a time when the plan or coverage was not subject to or was not in compliance with MHPAEA is generally biased if it systematically disfavors access or is specifically designed to disfavor access to MH or SUD benefits as compared to medical/surgical benefits, and the plan has not taken the steps necessary to correct, cure, or supplement the data or information. Generally recognized independent professional medical or clinical standards and carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH/SUD benefits are not biased.

Relevant Data Evaluation Requirements

To ensure an NQTL applicable to MH/SUD benefits in a classification is no more restrictive than the predominant NQTL applied to substantially all medical/surgical benefits in the same classification, plans and carriers must collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on relevant outcomes related to access to MH/SUD benefits and medical/surgical benefits and must carefully consider the impact. For NQTLs related to network composition standards, a plan or carrier must collect and evaluate relevant data in a manner reasonably designed to assess the NQTLs' aggregate impact on relevant outcomes related to access to MH/SUD benefits and medical/ surgical benefits.

As the relevant data for any given NQTL will depend on the facts and circumstances, the final rules provide flexibility for plans and carriers to determine what should be collected and evaluated, as appropriate.

The Departments may also request other data in addition to what a plan or carrier determines to be relevant data for any particular NQTL included in their comparative analyses.

If the evaluated relevant data suggest that the NQTL contributes to material differences in access to MH/SUD benefits as compared to medical/surgical benefits, it will be considered a strong indicator of a MHPAEA violation. Differences in access are material if, based on all relevant facts and circumstances, the difference in the data suggests that the NQTL is likely to have a negative impact on access to MH/SUD benefits as compared to medical/surgical benefits.

Differences in access to MH/SUD benefits are not treated as material if they are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect, prevent, or prove fraud and abuse. If material differences in access exist, the plan or carrier must take reasonable action, as necessary, to address them to ensure compliance with MHPAEA in operation.

Examples of possible actions that a plan or carrier could take to comply with the requirement to take reasonable action, as necessary, to address any material differences in access with respect to NQTLs related to network composition include, but are not limited to:

1. Strengthening efforts to recruit and encourage a broad range of available MH and SUD providers and facilities to join the plan's or carrier's network of providers, including taking actions to increase compensation or other inducements, streamline credentialing processes, or contact providers reimbursed for items and services provided on an out-of-network basis to offer participation in the network;

2. Expanding the availability of telehealth arrangements to mitigate any overall MH and SUD provider shortages in a geographic area;

3. Providing additional outreach and assistance to participants and beneficiaries enrolled in the plan or coverage to assist them in finding available in-network MH and SUD providers and facilities; and

4. Ensuring that provider directories are accurate and reliable.

Meaningful Benefits Standard

If a plan provides any benefits for a MH condition or SUD in any benefits classification, it must provide meaningful benefits for that condition or disorder in every classification in which meaningful medical/ surgical benefits are provided. Whether the benefits provided are meaningful is determined in comparison to the benefits provided for medical/surgical conditions in the same classification. Meaningful benefits require coverage of a core treatment (standard treatment or course of treatment by generally recognized independent standards of current medical practice) for that condition or disorder in each classification in which the plan or coverage provides benefits for a core treatment for one or more medical conditions or surgical procedures.

Comparative Analysis

Content

The final regulations require a comparative analysis of the design and application of each applicable NQTL. The analysis, at a minimum, must contain the following six content elements:

1. A description of the NQTL, including identification of benefits subject to the NQTL;

2. Identification and definition of the factors and evidentiary standards used to design or apply the NQTL;

3. A description of how factors are used in the design or application of the NQTL;

4. A demonstration of comparability and stringency, as written;

5. A demonstration of comparability and stringency, in operation, including the required data, evaluation of that data, explanation of any material differences in access, and description of reasonable actions taken to address such differences; and

6. Findings and conclusions.

Each plan (or carrier) must prepare and make available to the Secretary, upon request, a written list of all NQTLs imposed under the plan. For ERISA covered plans, this list must be provided to the named fiduciaries of the plan.

For plans subject to ERISA, the comparative analysis must include a certification by one or more named fiduciaries confirming the fiduciary's engagement in a prudent process to select one or more qualified service providers to perform and document a comparative analysis in connection with the imposition of any NQTLs that apply to MH/SUD benefits, as well as satisfaction of the duty to monitor those service providers.

Request and Review Process

The final regulations set forth the steps the Departments will follow to request and review a plan's or carrier's comparative analysis of an NQTL.

1. After an initial request for a comparative analysis, the plan or carrier must submit it to the relevant Secretary within 10 business days (or an additional period of time specified by the relevant Secretary).

2. If the Secretary determines the comparative analysis is insufficient, the Secretary will specify the additional information necessary, which must be provided by the plan or carrier within 10 business days (or an additional period of time specified by the relevant Secretary).

3. If the Secretary makes an initial determination of noncompliance, the plan or carrier has 45 calendar days to specify the actions it will take to comply and provide additional comparative analyses.

4. If the Secretary makes a final determination of noncompliance, the plan or carrier must notify all participants, beneficiaries, and enrollees enrolled in the plan or coverage not later than 7 business days after the Secretary's determination. The final rules set forth specific content for this notice and require that a copy of the notice be provided to the Secretary and relevant service providers and fiduciaries.

Plans and carriers must make a copy of the comparative analysis available when requested by any applicable state authority, a participant or dependent who has received an adverse benefit determination related to MH/SUD benefits. ERISA-covered plans must provide the analysis to participants and dependents within 30 days of a written request.

If a plan receives a final determination that an NQTL is not in compliance with the comparative analysis requirements, including because the plan has not submitted a sufficient comparative analysis to demonstrate compliance, the relevant Department may direct the plan to stop applying the NQTL until the plan is compliant, which could result in increased claim costs and additional fees from the plan's service providers. Not impose the NQTL with respect to MH/SUD benefits unless and until the plan or carrier demonstrates compliance or takes appropriate action to remedy the violation.

Sunset of MHPAEA Opt-Out

The final rules implement the sunset provision for self-funded non-federal governmental plans to opt out of compliance with MHPAEA effective June 27, 2023.

Effective Dates

The final rules generally apply to group health plans and group health insurance coverage on the first day of the first plan year beginning on or after January 1, 2025. This includes the new fiduciary certification requirement.

However, the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related requirements in the provisions for comparative analyses apply on the first day of the first plan year beginning on or after January 1, 2026.

Until the applicability date, plans and carriers are required to continue to comply with the existing requirements, including the CAA amendments to MHPAEA.

Employer Action

Plan sponsors should:

- Note that compliance with MHPAEA rules as they currently exist remains ongoing and is an enforcement priority of the Departments.

- Continue to carefully evaluate their health plans for compliance with MHPAEA, especially in light of new requirements, and be prepared to respond to requests by the Departments for this information. Notably, this will include an analysis of network adequacy. Coordination with carriers, TPAs and other service providers will be essential.

- Review their plan's current limits on MH/SUD and the plan's written comparative analysis to determine whether changes are required in light of recent enforcement efforts.

- Evaluate whether to make plan design changes beginning in 2025. (The meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related requirements in the provisions for comparative analyses apply on the first day of the first plan year beginning on or after January 1, 2026.)

It is important to note that, while all plan sponsors have the above responsibilities, in a fully insured arrangement, plan sponsors will not generally have flexibility as to plan design changes and carrier compliance will be crucial. For self-funded plans (including level-funded) it will be important that TPAs are able to support MHPAEA compliance.

Pennsylvania Regulates PBMs

Issued date: 10/04/24

On July 17, 2024, Governor Josh Shapiro signed House Bill 1993 ("the Bill") into law. The Bill seeks to further regulate pharmacy benefit managers ("PBMs") by, among other things, requiring pass-throughs for drug manufacturer rebates, requiring provider freedom of choice, and enacting provider network requirements.

The Bill is effective on November 14, 2024, and could have significant impacts on the prescription drug coverage offered under fully insured group health plans covering residents of the Commonwealth of Pennsylvania.

Applicability

The Bill amended the existing Pharmacy Audit Integrity and Transparency Act, with the amended statute now called the Pharmacy Benefit Reform Act ("the Act"). The Act applies to fully insured health plans offering prescription drug coverage in the Commonwealth. Importantly, self-insured ERISA plans, non-federal governmental plans, church plans, and Indian tribal government plans are not covered by the Act.

Impact of the Bill on Fully Insured Group Health Plans

The Bill is intended to regulate contracts between a pharmacy or PBM and a health insurer or health benefit plan. As a whole, the Act regulates a wide variety of PBM operations; however, specific to group health plans, the Bill imposes the following requirements on PBMs operating in the Commonwealth:

- **Pass-through of Drug Manufacturer Rebates.** If the health plan designates negotiation of a drug manufacturer rebate to a PBM, the PBM is required to pass through to the health plan at least 95% of any rebate received by the PBM on behalf of the health plan.

- **Freedom of Choice.** Provided that the provider agrees to the terms and conditions of the PBM's contract, an individual covered under the health plan must be permitted to select an in-network pharmacy or pharmacist of their choice and a PBM cannot:

- require the use of a mail order pharmacy or PBM retail pharmacy affiliate,
- transfer a covered individual's prescription from an in-network pharmacy to another pharmacy unless the individual requests it, or
- auto-enroll an individual in mail-order pharmacy services.

In addition, a PBM is prohibited from "steering" a covered individual to a PBM-affiliated retail pharmacy by using financial incentives.

- **Prohibition on Clawbacks.** Health plans, health insurers, and PBMs are prohibited from collecting the difference in the cost-sharing that a covered individual pays to a pharmacy and the applicable cost-sharing as defined by the health plan.
- **Network Adequacy.** A PBM is required to establish a provider network that allows for convenient access to providers within a reasonable distance from a covered individual's residence. In doing so, the PBM must adhere to the following requirements:
  - The network cannot be limited to only pharmacies affiliated with the PBM, and
  - The network must meet the requirements for pharmacy networks related to Medicare Part D drug coverage.

Beginning April 1, 2026, PBMs must file an annual network adequacy report with the Pennsylvania Insurance Department ("the Department").

- **Effects of Spread Pricing.** "Spread pricing" is where a PBM charges a health plan or health insurer a contracted price for prescription drugs, but that contracted price differs from the amount the PBM directly or indirectly pays the pharmacy for prescription drugs. The Department is permitted to request data from a PBM to analyze the impact of, among other things, spread pricing and steering on the cost of prescription drugs in the Commonwealth.

Employer Action

Employers sponsoring fully insured group health plans which cover residents of Pennsylvania should review their contracts with their carrier and/or PBM to ensure that they are compliant and amend them as necessary.

Final 2024 ACA Reporting Instructions And Forms Issued

Issued date: 10/04/24

The IRS released final instructions and forms for calendar year 2024 ACA reporting, including Forms 1094-C, 1095-C, 1094-B, and 1095-B. As a reminder, it is important to ensure the forms are accurate, timely furnished to participants and filed with the IRS as good faith relief from penalties is no longer available.

There are no significant changes to the 2024 forms.

Forms 1094-C/1095-C

Applicable large employers ("ALEs") must furnish Form 1095-C to full-time employees and file Form 1094-C and all 1095-Cs with the IRS. ALEs offering a self-insured group health plan (including level-funded arrangements and individual coverage health reimbursement arrangements ("ICHRAs") must also furnish Forms 1095-C to covered employees or other primary insured individuals in the self-funded health plan (e.g., covered part-time employees, COBRA qualified beneficiaries).

The calendar year 2024 Form 1095-C must be furnished to full-time employees and other individuals by March 3, 2025. The Form 1094-C and all Forms 1095-C must be filed with the IRS electronically by March 31, 2025.

ALEs, in coordination with their payroll or other reporting vendors, should have records to determine each employee's status as an ACA FTE or not an ACA FTE for each month during 2024 in preparation to complete, furnish and file these forms for 2024.

Forms 1094-B/1095-B

Employers that are not ALEs and offer self-funded group health plan coverage, including level-funded plans and ICHRAs, must furnish and file forms regarding minimum essential coverage. Specifically, as the provider of the self-funded plan, the employer reports to the IRS and all covered individuals (e.g., employees, COBRA qualified beneficiaries, spouses, dependents) the coverage they had during the calendar year. To meet this requirement, employers use Forms 1094-B and 1095-B.

The calendar year 2024 Form 1095-B must be furnished to covered individuals by March 3, 2025. The Form 1094-B and all Forms 1095-B must be filed with the IRS electronically by, March 31, 2025.

Employers should coordinate with payroll or other reporting vendors to assist in this process.

What's New?

There are no significant changes to the 2024 forms; however, the penalties for failures have increased.

2024 Penalties

The instructions reiterate that all ALEs and other employers that sponsor self-funded group health plans that fail to comply with the information reporting requirements may be subject to the general reporting penalty provisions for failure to file correct information returns and failure to furnish correct payee statements. *Good faith relief is no longer available*. However, penalties may be waived if the failure is due to reasonable cause and not willful neglect.

For 2024, the following penalties may apply:

- Failure to file a correct return is $330/statement (total calendar year penalty not to exceed $3,987,000).
- Failure to furnish a correct statement is $330/statement (total calendar year penalty not to exceed $3,987,000).

An employer that fails to both file and furnish a correct statement is subject to a combined penalty of $660/statement with a maximum penalty of $7,974,000.

Electronic Filing Required (10+ Forms)

Employers required to file 10 or more information returns (e.g., Forms W-2, 1094-C, 1095-C, 1094-B, 1095-B) during the year must file these forms electronically with the IRS on or after January 1, 2024. Previously, the IRS allowed employers filing fewer than 250 returns to file hard-copy (paper) forms.

The IRS also encourages employers filing fewer than 10 returns to consider electronic filing.

Employer Action

It is important to identify vendors, like payroll or other reporting administrators, to assist in this process especially as most employers will be required to file forms electronically with the IRS. A health plan carrier typically does not prepare this reporting.

ALEs should begin preparing and ensure that Form 1095-C is furnished to full-time employees and other individuals by March 3, 2025. Form 1094-C and all Forms 1095-C should be electronically filed with the IRS by March 31, 2025.

Employers that are not ALEs but offer self-funded group health plan coverage should ensure a process is in place for furnishing and filings Forms 1094-B and 1095-B. Form 1095-B must be furnished to covered individuals by March 3, 2025, and all forms 1095-B along with Form 1094-B must be electronically filed with the IRS by March 31, 2025.

Employers should be certain the statements are complete and accurate since good faith relief is no longer available.

Employers may have additional reporting obligations for employees residing in states with an individual mandate (California, Massachusetts, New Jersey, Rhode Island, Vermont, Washington D.C.). Ensure vendors will assist with state reporting obligations.

San Francisco HCSO Expenditures and Reporting Update for 2025

Issued date: 10/04/24

The San Francisco Health Care Security Ordinance ("HCSO") minimum expenditure rates for 2025 have been released, and the HCSO Annual Reporting Form for calendar year 2024 is due on April 30, 2025.

2025 Minimum Expenditure Rates

Under the HCSO, covered employers must make minimum health care expenditures at the following rates for each hour worked by covered employees in San Francisco:

Employer Size	Number of Employees	2024 Health Care Expenditure Rate	2025 Health Care Expenditure Rate
Large	All employers with 100 or more employees	$3.51 per hour payable	$3.85 per hour payable
Medium	Businesses with 20-99 employees Nonprofits with 50-99 employees	$2.34 per hour payable	$2.56 per hour payable
Small	Businesses with 19 or fewer employees Nonprofits with 49 or fewer employees	Exempt	Exempt

The hours payable under the HCSO for each employee are capped at 172 hours per month. Therefore, for 2025 the maximum required health care expenditure for a covered employee of a large employer is $662.20 per month ($3.85/hour x 172 hours). For a medium-sized employer, the maximum required expenditure for a covered employee is $440.32 per month ($2.56/hour x 172 hours).

Managerial, supervisory, or confidential employees who earn more than a specified amount are exempt from the minimum health care expenditures requirement under the HCSO. For 2024, the earnings threshold for these employees to be exempt from the HCSO is $121,372 per year (or $58.35 per hour). As of January 1, 2025, the new threshold will be $125,405 per year (or $60.29 per hour).

Annual Reporting Form

Covered employers must submit an online report each year that summarizes how they complied with the HCSO. The web-based HCSO Annual Reporting Form for the prior calendar year is typically available on the San Francisco Office of Labor Standards Enforcement ("OLSE") HCSO website by April 1 and must be submitted by April 30. For example, the HCSO Annual Reporting Form for calendar year 2024 is expected to become available on the HCSO website by April 1, 2025, and is due by April 30, 2025.

Employer Action

Covered employers should ensure that they will be making the required minimum health care expenditures in 2025 at the new rates for employees in San Francisco and maintain records showing compliance with the HCSO requirements.

The 2025 version of the HCSO poster, which must be posted in all workplaces with covered employees, is expected to become available by December 2024. Covered employers should monitor the San Francisco HCSO website (linked below) to obtain and post the 2025 version of the poster by January 1, 2025.

https://www.sf.gov/information/health-care-security-ordinance

Covered employers should also be prepared to submit the HCSO Annual Reporting Form for calendar year 2024 no later than April 30, 2025.

Cybersecurity Guidance Applies To Health And Welfare Benefits

Issued date: 10/16/24

The Employee Benefits Security Administration ("EBSA") of the U.S. Department of Labor confirmed in Compliance Assistance Release No. 2024-01 that cybersecurity guidance issued in 2021 applies to all ERISA-covered health and welfare plans. This guidance goes beyond what is required under HIPAA for health plans, and includes "Tips for Hiring a Service Provider," "Cybersecurity Program Best Practices," and "Online Security Tips," which were updated to reflect this clarification.

Background

In April 2021, EBSA issued cybersecurity guidance for benefit plan fiduciaries and service providers, regarding best practices for maintaining cybersecurity. Recognizing that ERISA requires plan fiduciaries to take appropriate precautions to mitigate cybersecurity risks, EBSA's guidance came in three forms, directed at benefit plan sponsors, fiduciaries, record keepers, and participants.

The language in the original guidance led to confusion as to whether the guidance applied solely to retirement plans. With this new guidance, EBSA clarifies that its cybersecurity guidance does, in fact, also apply to ERISA-covered health and welfare plans.

Details of the Guidance

Cybercrime is a constant and growing risk across the globe, and employer-based benefit plans have not escaped falling victim to these crimes. Health and welfare benefit plans carry some risk of financial loss to plan sponsors and participants, but they generally carry significantly more risk of disclosure of personally identifiable information ("PII") and sensitive health information of plan members, as well as their covered family members, over multiple benefits and across multiple service providers.

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") is designed to, among other things, impose extensive privacy and security requirements to employer-provided group health plans to secure protected health information ("PHI") and electronic PHI secure. Plan sponsors, fiduciaries, and business associates of group health plans, such as third-party administrators ("TPAs"), who take significant steps in ensuring compliance with HIPAA, will have already made strides in complying with EBSA's ERISA cybersecurity guidance. However, it is important to note that various ERISA-covered welfare benefits are not group health plans subject to HIPAA, including group-term life insurance, disability coverage, and accident-only coverage. Such benefits would generally be subject to ERISA and to which the EBSA cybersecurity guidance would apply.

Both the original 2021 guidance and the recent guidance provide links to three separate pieces. The first two are oriented towards plan fiduciaries and service providers, and the degree to which fiduciaries adopt the detailed suggestions may depend on the size and complexity of their plans, particularly the amount of plan assets and data that they may handle.

Tips for Hiring a Service Provider

EBSA provides six tips directed at a plan fiduciary as recommendations to support prudent selection and monitoring of service providers and recommends requesting the following information:

1. information on the service provider's cybersecurity standards and compare against recognized industry standards. Perhaps involve internal IT experts.

2. how provider validates practices.

3. provider's track record, including third party reports on the provider.

4. providers' prior experience with breaches.

5. information on insurance policies covering cybersecurity losses and identity theft breaches.

6. contract terms (to watch for and consider):

    a. attempts to limit service provider's responsibilities;

    b. service provider ideally obtaining annual third-party audit for compliance;

    c. high standards by provider to secure information;

    d. notify plan fiduciary of incidents/breaches promptly and to properly address;

    e. oblige provider to follow all laws (e.g., retention and destruction of information); and

    f. require insurance.

Health and welfare plan fiduciaries should keep these suggestions in mind for all plan service providers. Though this would mainly pertain to an insurer, TPA, or PBM, it extends to consultants, wellness vendors, data analysts, trustees, etc. as well.

Cybersecurity Program Best Practices – Service Provider

EBSA provides a highly detailed summary of best practices for ERISA plan services providers cybersecurity program. Health and welfare benefit plan fiduciaries may also use this piece to evaluate the extent to which such providers are applying best practices. There are twelve different recommendations, including:

1. having a formal, well documented cybersecurity program
2. conducting prudent annual risk assessments
3. having a reliable annual third-party audit of security controls
4. clearly defining and assigning information security roles and responsibilities
5. having strong access control procedures
6. ensuring that any assets or data stored in a cloud or managed by a third-party service provider are subject to appropriate security reviews and independent security assessments.
7. conducting periodic cybersecurity awareness training.
8. implementing and managing a secure system development life cycle ("SDLC") program.
9. having an effective business resiliency program addressing business continuity, disaster recovery, and incident response.
10. encrypting sensitive data, stored and in transit.
11. implementing strong technical controls in accordance with best security practices.
12. appropriately responding to any past cybersecurity incidents.

Online Security Tips

Lastly, the EBSA guidance provides 9 basic rules oriented to plan members when they are accessing online health, welfare, or retirement accounts, specifically:

1. register, set up and routinely monitor your online account.
2. use strong and unique passwords/passphrases.
3. use Multi-Factor Authentication.
4. keep personal contact information current.
5. close or delete unused accounts.
6. be wary of free Wi-Fi.

7. beware of phishing attacks.

8. use antivirus software and keep apps and software current.

9. know how to report identity theft and cybersecurity incidents.

Employer Action

EBSA has made clear that cybersecurity relating to plan assets and PII should be a point of emphasis for ERISA plan sponsors and fiduciaries, as well as plan service providers. This goes beyond the requirements of HIPAA (applies only to group health plans) and applies to all service providers, whether business associates or not. Employers who sponsor ERISA-covered health and welfare benefit plans, should review the EBSA guidance, confirm current safeguards, and implement additional safeguards, as appropriate, primarily to protect data and to include holding service providers to high standards.

Actions to consider, include:

- identifying all current service providers with whom PII and health data may be shared.
- requesting current service providers to provide written representations of steps it takes to secure PII and health data from cyber threats.
- on a periodic basis (perhaps yearly), requesting current service providers to provide written updates on changes and other developments in its cybersecurity efforts.
- posing questions in the request for proposal ("RFP") pertaining to cybersecurity, including confirmation of:
  - a formal cybersecurity program, perhaps with certification (e.g., SOC 1 or SOC 2);
  - access control procedures;
  - cyber insurance, with policy limits;
  - training of relevant employees on cybersecurity awareness;
  - use of secured networks for exchanging confidential information, including by email; and
  - security assurance when using cloud service providers.
- educating plan members with respect to using sound online security practices, perhaps through furnishing members with the EBSA "Online Security Tips."

New York Paid Family Leave 2025 Contributions And Benefits

Issued date: 10/21/24

The New York State Department of Financial Services has announced the contribution rate under the New York Paid Family Leave ("PFL") law effective January 1, 2025, will be set at **0.388%** of weekly wages.

Employee contributions for PFL are calculated as a percentage of an employee's gross wages per pay period up to the maximum contribution based on the *annualized* New York State Average Weekly Wage ("NYAWW"). For 2025:

- NYAWW in effect will be **$1757.19**, an increase of 2.3% from the 2024 NYAWW of $1,718.15. The *annualized* NYAWW is **$91,373.88**.
- The maximum annual employee contribution will be **$354.53** ($333.25 in 2024).

The PFL benefit is **67%** of an employee's Average Weekly Wage (up to the NYAWW) payable for **12 weeks**. For 2025:

- The maximum weekly PFL benefit will be **$1,177.32** ($1,151.16 in 2024).
- The maximum annual PFL benefit payable for 12 weeks will be **$14,127.84** ($13,813.92 in 2024).

The following should be noted:

- The maximum amount of PFL and disability leave under the New York Disability Law ("DBL") that may be taken in a *52-consecutive week period* is limited to 26 weeks.
- If an employee begins continuous leave in 2024 and the leave extends into the 2025, the benefit is based on the rate in effect on the first day of leave (i.e., in 2024) and is not recalculated at the 2025 rate.
- If an employee begins intermittent leave in 2024 and the leave extends into the following year and there is at least a three-month lapse in days taken under New York PFL, the leave is considered a new claim under the law in 2025 and the benefit is calculated at the 2025 rate.

Employer Action

Employers should prepare for the 2025 New York PFL contribution and benefit changes that begin in January. PFL coverage will typically be added as a rider on an employer's existing disability insurance policy, although benefits can be provided through a self-funded plan approved by the New York Workers' Compensation Board.

Annual Out-of-Pocket Maximum Adjustments Announced For 2026

Issued date: 10/21/24

The Department of Health and Human Services ("HHS") published the "payment parameters" portion of its Annual Notice of Benefit and Payment Parameters for 2026. For purposes of employer-sponsored health plans, the guidance includes the limits on annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) for non-grandfathered group medical plans for plan years that begin in 2026.

The Department also published the proposed Annual Notice of Benefit and Payment Parameters rule for 2026. While this annual guidance generally outlines rules and standards that apply to Marketplace coverage, sometimes it includes items that affect employer-sponsored coverage. In this publication, HHS indicates that, along with the Departments of Labor and the Treasury, future rulemaking to address the applicability of drug manufacturer support to the annual limitation on cost-sharing is expected, something that will impact employer-sponsored coverage. At this time, it's not clear when this guidance will be issued or what it will say.

Change to the Out-of-Pocket Maximums

Non-grandfathered group medical plans will see a significant increase in the out-of-pocket maximum for plan years beginning on or after January 1, 2026, as follows:

- $10,150 for self-only coverage (up from $9,200 for 2025)
- $20,300 for coverage other than self-only (up from $18,400 for 2025).

The out-of-pocket maximum limits for non-grandfathered group medical plans are different (and generally higher) than the out-of-pocket maximum limits required for high-deductible health plans ("HDHPs") that are compatible with health savings account ("HSA") eligibility.

Employer Action

For non-grandfathered group medical plans, employers should update out-of-pocket limits for plan years beginning on or after January 1, 2026.

Massachusetts Paid Family Leave 2025 Contributions And Benefits

Issued date: 10/22/24

The Massachusetts Department of Family and Medical Leave ("DFML") has recently announced the contribution rate, the State Average Weekly Wage, and the maximum weekly benefit amount for the Massachusetts Paid Family and Medical Leave ("PFML") program effective January 1, 2025. The DFML has also published the FY2024 Annual Report for the PFML program.

Contributions

The 2025 contribution rate on eligible wages will be **0.88%** (the contribution rate is unchanged from 2024). Individual contributions are capped by the Social Security income limit. The 2025 Social Security income limit is expected to be released later in October and will likely be significantly higher than the 2024 limit which is currently set at $168,600.

If an employer has at least 25 covered individuals (i.e., employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. The employee is responsible for the entire cost of family leave benefits. The following illustrates the PFML contribution breakdown for 2025:

- Medical Leave Contribution: **0.70%** of eligible wages allocated as follows:
    - Employer: At least 60% of the medical leave cost is paid by the employer (0.42%)
    - Employee: No more than 40% of medical leave can be deducted from the employee's wages (0.28%).
- Family Leave Contributions: **0.18%** of eligible payroll deduction
    - May be paid entirely from employee wages (no employer contribution required).

If the employer has fewer than 25 covered individuals in Massachusetts, the employer is not required to contribute toward the medical or family leave portions of the benefit. The employee's 2025 contribution for medical and family leave benefits is 0.46% of eligible wages.

Amount of Benefit

The weekly benefit amount for employees and self-employed individuals on family or medical leave is determined as follows:

- The portion of an employee's or self-employed individual's average weekly wage ("AWW") that is equal to or less than 50 percent of the state average weekly wage ("MAAWW") is replaced at a rate of 80 percent; and
- The portion of an employee's or self-employed individual's AWW that is more than 50 percent of the MAAWW is replaced at a rate of 50 percent, up to the maximum allowed benefit amount.

For 2025:

- The MAAWW will be **$1,829.13**, an increase of 1.8% from the 2024 MAAWW of $1,796.72.
- The maximum weekly PFML benefit will be **$1,170.64,** an increase of 1.8% from the maximum weekly benefit of $1,149.90 in 2024.

FY2024 Annual Report

As required by the Family and Medical Leave Law, the DFML has issued its annual report containing information on benefits, applications, and certain characteristics of applicants during Fiscal Year 2024.

Employer Action

Employers should prepare for the 2025 PFML contribution and benefit requirements by working with payroll processors, approved private plan vendors and employment counsel to ensure their leave policies and procedures are compliant by January 2025. Updated workplace posters and notifications for the 2025 contribution rates and benefit amounts will be available to employers on the PFML website soon.

IRS Guidance Provides Helpful Clarification For HDHPs

Issued date: 10/29/24

On October 17, 2024, the IRS released two key pieces of guidance, Notice 2024-75 and Notice 2024-71, which provide important updates for plan sponsors offering certain tax advantage health plans.

Briefly, the guidance:

- Expands the items and services that may be treated as preventive care in a qualified high deductible health plan ("HDHP") with a health savings account ("HSA") to include:
    - all types of breast cancer screenings;
    - continuous glucose monitors ("CGMs") for individuals diagnosed with diabetes;
    - insulin delivery devices; and
    - over-the-counter ("OTC") oral or emergency contraceptives and male condoms.
- Creates a safe harbor to include condoms as a qualified medical expense under IRS Code Section 213(d).

Below you will find additional details from the guidance.

Definition of Preventive Care for HDHP/HSA Plans Expanded (Notice 2024-75)

Background

An HDHP, in part, is a health plan with a minimum deductible set by the IRS ($1,650 for self-only coverage and $3,300 for coverage other than self-only for 2025). Generally, an HDHP may not provide benefits for any year until the individual satisfies the minimum deductible. However, there is a safe harbor that permits coverage for preventive care prior to meeting the deductible.

Over the years, through statutory amendments as well as IRS guidance, the definition of preventive care has expanded and evolved.

What's New

Notice 2024-75 further expands the items and services that may be considered preventive care in an HDHP.

1. *Breast Cancer Screenings.* The guidance clarifies that all types of breast cancer screening (e.g., mammograms, Magnetic Resonance Imaging ("MRIs"), ultrasounds, and similar breast cancer screening services) are considered preventive care. This change is effective as of the date of the original guidance, April 12, 2004.

2. *Continuous Glucose Monitors.* Earlier guidance permits an HDHP to treat a glucometer as preventive care for an individual who is diagnosed with diabetes for the purpose of preventing or exacerbating the condition or developing a secondary condition. This new guidance clarifies that a CGM is considered preventive care under the same circumstances as other glucometers if the CGM is measuring glucose levels using a similar detection method or mechanism to other glucometers (i.e., piercing the skin). If a CGM has additional functions, each function must be for preventive care for an HDHP to cover any benefits of the CGM before the deductible is satisfied. For example:

    - if the CGM both monitors glucose and provides insulin, it may be treated as preventive care because it is a device delivering insulin.

    - if the CGM provides additional medical or non-medical functions that are not preventive care (other than minor functions, such as clock and date functions), then the HDHP may not cover the CGM before an individual satisfies the minimum annual deductible for an HDHP.

This change is effective as of July 17, 2019.

3. *Insulin.* The Inflation Reduction Act ("IRA") created a statutory safe harbor that permits first-dollar coverage for "selected insulin products" in an HDHP effective for plan years beginning on or after January 1, 2023. IRS Notice 2024-75 confirms that "selected insulin products" is interpreted to include any device used to administer or deliver the selected insulin products. This guidance is effective for plan years on or after January 1, 2023.

4. *OTC oral contraceptives.* The guidance confirms OTC oral contraceptives for a covered individual potentially capable of becoming pregnant, including, but not limited to, OTC birth control pills and emergency contraception, regardless of whether they are purchased with a prescription may be treated as preventive care, effective for plan years that begin on or after January 1, 2023.

5. *Male condoms.* Male condoms (with or without a prescription) may be treated as preventive care regardless of the gender of the individual covered under the HDHP who purchases them, effective for plan years that begin on or after January 1, 2023.

This guidance addresses items that may be treated as preventive care in a HDHP. It does not address (or expand) the requirements under the Affordable Care Act for non-grandfathered group health plans to provide certain preventive care items and services without cost-sharing in-network.

213(d) Safe Harbor Includes Condoms as a Medical Expense (Notice 2024-71)

Background

Under Section 213(d), the IRS allows taxpayers to receive tax advantages for certain medical care. Certain services, such as hospital visits, prescription drugs, and recently certain OTC products like menstrual products are considered medical care under Section 213(d). Over the years, the IRS has expanded the definition of the items and services included in Section 213(d) for purposes of receiving reimbursement from a health plan with a tax advantage, such as health FSAs, HRAs, and HSAs.

What's New

IRS Notice 2024-71 provides a safe harbor and will treat amounts paid for condoms as a Section 213(d) medical expense. This means amounts paid for condoms are treated as an expense for medical care and eligible to be paid (or reimbursed) from an HSA, HRA, or health FSA.

Employer Action

Employers may wish to evaluate their plan offerings to enhance the overall value of their plans and explore opportunities to further support employee health and wellness through preventive services.

Specifically:

- While not required, employers with HDHP/HSAs may consider expanding what is considered preventive care under the HDHP to incorporate items and services in the updated guidance.

- Condoms may be reimbursed (or paid for) through a health FSA, HRA, or HSA on a tax favored basis.

These changes may require plan documents to be updated to accurately reflect changes to the plan. Any changes should be communicated to plan participants timely. Employers should confirm their carriers and TPAs are prepared to implement changes accordingly.

2025 Cost Of Living Adjustments

Issued date: 10/30/24

The IRS has released cost of living adjustments for 2025 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

Annual contribution limitation

For plan years beginning in 2025, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements (health FSAs) increased from $3,200 to $3,300.

The Affordable Care Act (ACA) amended Code Section 125 to place a $2,500 limitation on voluntary employee salary reductions for contributions to health FSA, subject to inflation for plan years beginning after December 31, 2013.

Annual maximum carryover

For cafeteria plans that permit the carryover option, the maximum unused amount from a health FSA plan year that begins in 2025 that can be carried over to the following plan year is $660 (up from $640 in 2024).

In May 2020, the IRS issued Notice 2020-33 to increase the carryover limit for unused amounts remaining in a health FSA as of the end of a plan year from a static maximum of $500 to 20% of the currently indexed heath FSA contribution limit for plans that have adopted the carryover option.

Qualified Transportation Fringe Benefits

For calendar year 2025, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Code Section 132(f)(2)(B)) increased from $315 to $325.

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Highly Compensated

The compensation threshold for a highly compensated employee or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) for calendar year 2025 is $155,000.

Under the cafeteria plan rules, the term highly compensated means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B). Prop. Treas. Reg. 1.125-7(a)(9).

At the time of this Bulletin, the 2026 dollar limitation under Code Section 414(q)(1)(B) concerning the definition of highly compensated employee or participant looking back to 2025 is not available. This Bulletin will be updated with this information when released.

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2025 is $220,000.

For purposes of cafeteria plan nondiscrimination testing, a key employee is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year. Prop. Treas. Reg. 1.125-7(a)(10).

At the time of this Bulletin, the 2026 dollar limitation under Code Section 416(j)(1)(A)(i) concerning the definition of a key employee looking back to 2025 is not available. This Bulletin will be updated with this information when released.

Non-Grandfathered Plan Out-of-Pocket Cost-Sharing Limits

As previously reported, the 2025 maximum annual out-of-pocket limits for all non-grandfathered group health plans are $9,200 for self-only coverage and $18,400 for family coverage.

These limits generally apply with respect to any essential health benefits (EHBs) offered under the group health plan. For coverage other than self-only (e.g., family coverage), the self-only annual out-of-pocket limit applies to each covered individual.

Health Reimbursement Arrangements

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2025, to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) under Code Section 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed $6,350 ($12,800 for family coverage), which increased from $6,150/$12,450 in 2024.

Excepted Benefit Health Reimbursement Arrangements

For plan years beginning in 2025, to qualify as an excepted benefit health reimbursement arrangement (EB HRA) under Treas. Reg. Section 54.9831-1(c)(3)(viii), the maximum amount that may be made newly available for the plan year for an excepted benefit HRA is $2,150 (increased from $2,100 in 2024).

Health Savings Accounts

As previously reported, the inflation adjustments for health savings accounts (HSAs) for 2025 were provided by the IRS in Rev. Proc. 2024-25.

Annual contribution limitation

For calendar year 2025, the limitation on deductions for an individual with self-only coverage under a high deductible health plan is $4,300; the limitation on deductions for an individual with family coverage under a high deductible health plan is $8,550.

HSA-compatible high deductible health plan

For calendar year 2025, an "HSA-compatible high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,650 for self-only coverage or $3,300 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $8,300 for self-only coverage or $16,600 for family coverage. It should be noted that for family HDHP coverage, an individual embedded deductible cannot be less than $3,300.

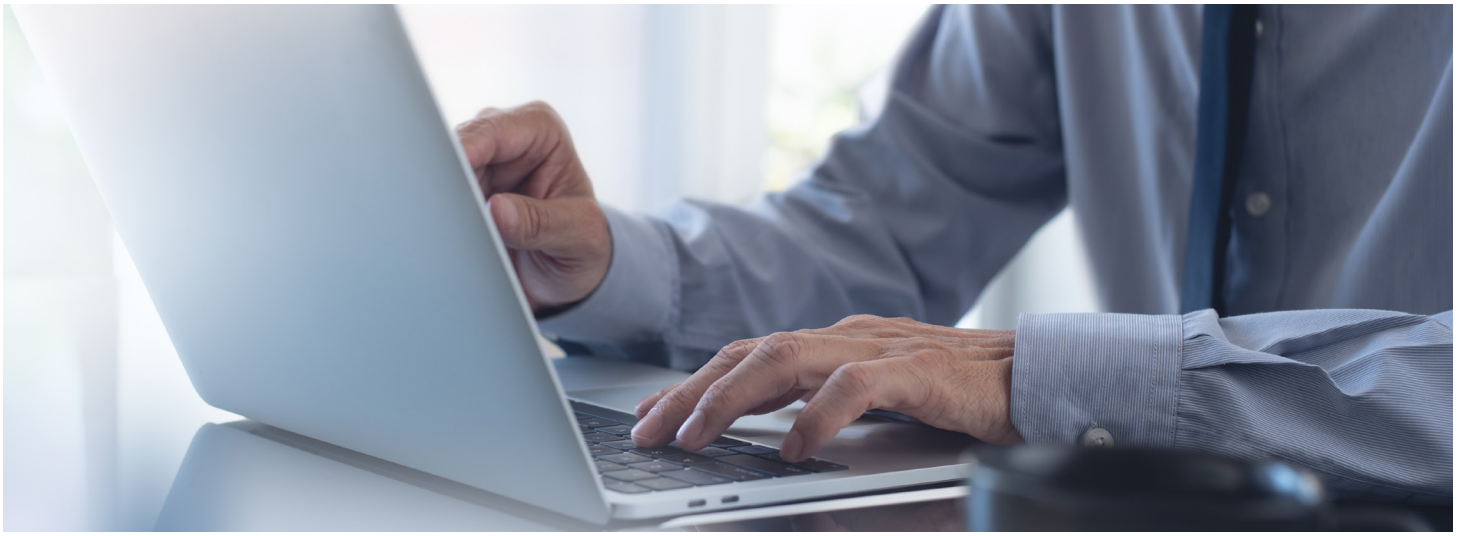
Non-calendar year plans: In cases where the qualifying high deductible health plan renewal date is after the beginning of the calendar year, any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date. See IRS Notice 2004-50, 2004-33 I.R.B. 196, Q/A-86 (Aug.16, 2004).

Catch-up contribution

Individuals who are aged 55 or older and covered by a qualifying high deductible health plan may make additional catch-up HSA contributions each year until they enroll in Medicare. The additional contribution, as outlined in Code Section 223(b)(3)(B), is $1,000 for 2009 and thereafter.

Employer Action

Employer with plan years beginning on or after January 1, 2025 should ensure the correct limits are applied to respective benefit plan options.



Reminder Massachusetts HIRD Reporting Due December 15 2024

Issued date: 11/06/24

As a reminder, Massachusetts employers must file the annual Health Insurance Responsibility Disclosure (HIRD) form through the MassTaxConnect (MTC) web portal. The HIRD reporting will be available to be filed starting November 15th and must be completed by December 15th.

The HIRD form collects employer-level information about employer-sponsored health insurance (ESI) offerings. The HIRD form assists MassHealth in identifying members with access to qualifying ESI who may be eligible for the MassHealth Premium Assistance Program.

State law requires every employer with six or more employees in Massachusetts to annually submit a HIRD form. If you are an employer who currently has (or had) six or more employees in any month during the past 12 months preceding the due date of this form (December 15 of the reporting year), you are required to complete the HIRD form.

- An individual is your employee if you, as the employer, included such individual in your quarterly wage report to the Department of Unemployment Assistance (DUA) during the past 12 months. You are required to complete the HIRD form if you reported six or more employees (includes all employment categories) in any DUA wage report during the past 12 months.

- If you are an out-of-state employer that is not required to file a quarterly wage report to the DUA, an individual is your employee if they are hired for a wage or salary in Massachusetts to perform work, regardless of full-time or part-time status.

For HIRD FAQs, visit: www.mass.gov/info-details/health-insurance-responsibility-disclosure-hird-faqs.

For more information about the Premium Assistance Program and additional employer resources, visit the MassHealth Premium Assistance web page: www.mass.gov/info-details/masshealth-premium-assistance-pa.

California Requires Insured Medical Plans To Provide Fertility Benefits

Issued date: 11/08/24

California has enacted legislation that will require large-group health insurance policies and HMO contracts to cover the diagnosis and treatment of infertility and fertility services, including in-vitro fertilization treatments. Small-group policies and HMO contracts must offer employers the option to cover these same services but are not required to provide the coverage automatically. The new law is generally effective for health insurance policies and HMO contracts that are issued, amended, or renewed on or after July 1, 2025. The new state law does not apply to self-funded plans.

Background

Since 1990, California has required every health insurance carrier and HMO to offer the employer (or other policyholder) the option to cover infertility treatments (except in-vitro fertilization) as part of hospital, medical, or surgery insurance, under the terms and conditions agreed to by the policyholder and the insurance carrier or HMO. Insurance carriers and HMOs are required to communicate the availability of this optional coverage to the employer (or other policyholder) but are not mandated to provide the coverage automatically.

New Requirements

The new state law requires large-group health insurance policies and HMO contracts to cover the diagnosis and treatment of infertility and fertility services, including a maximum of three completed in-vitro fertilization treatments. Small-group health insurance policies and HMO contracts are required to offer the employer (or other policyholder) the option to cover these same services but are not mandated to provide this coverage automatically.

California generally defines “small group” as a plan covering an employer that employs at least one, but not more than 100, full-time equivalent employees on at least 50% of its working days during the preceding calendar quarter or preceding calendar year, the majority of whom were employed in California.

The law prohibits health insurance policies and HMO contracts from excluding or denying coverage of fertility services provided by or to a third party, such as a gestational carrier, a surrogate who enables the intended recipient to become a parent, or the donor of an oocyte, sperm, or embryo. In addition, the new state law prohibits health insurance policies and HMO contracts from including any of the following provisions:

- Any exclusion, limitation, or other restriction on coverage of fertility medications that is different from those imposed on other prescription medications.

- Any deductible, copayment, coinsurance, benefit maximum, waiting period, or other limitation on coverage for the diagnosis and treatment of infertility that is different from those imposed upon benefits for services not related to infertility.

For purposes of the new coverage requirement, the term "infertility" is defined as a condition or status characterized by any of the following:

- A licensed physician's findings;

- A person's inability to reproduce as an individual or with a partner without medical intervention; or

- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular unprotected sexual intercourse.

Effective Date

The new state law is generally effective for health insurance policies and HMO contracts that are issued, amended, or renewed on or after July 1, 2025. However, the new state law does not apply to health plans and policies with CalPERS (the benefit system for state employees) until July 1, 2027.

Exemptions

The law does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, or specialized disability insurance policies.

In addition, it does not apply to:

- A self-funded group health plan subject to ERISA;

- Any health insurance policy or HMO contract maintained by a "religious employer."

Extraterritoriality

The new state law applies to every health insurance policy that is issued, amended, or renewed to residents of California, regardless of the situs of the contract. This provision is identical to the provision under existing law.

Employer Action

Large employers with fully insured plans should be aware of the new fertility requirements that will take effect for plan years beginning on or after July 1, 2025.

Large employers with fully insured policies written outside of California, but providing coverage to California residents, should discuss compliance with the insurance carrier.

Small employers with fully insured plans should determine whether to opt in to the fertility coverage with the first renewal on or after July 1, 2025.

Gag Clause Attestation Due December 31 2024

Issued date: 11/08/24

As previously reported, insurance carriers and plan sponsors of group health plans must submit information annually to the Centers for Medicare and Medicaid Services ("CMS") attesting that their plan(s) do not include prohibited gag clauses by December 31st each year. The next attestation is due by December 31, 2024.

As a reminder, a gag clause is a contractual term that directly or indirectly restricts specific data and information that a plan or issuer can make available to another party. These clauses may be found in agreements between a plan or carrier and any of the following parties:

- a health care provider;
- a network or association of providers;
- a third-party administrator ("TPA"); or
- another service provider offering access to a network of providers.

Carriers and TPAs are notifying clients how they intend to comply with the Gag Clause Prohibition Compliance Attestation ("GCPCA"). Again, it seems there is no uniformity as to how the various carriers/TPAs will address the attestation requirements.

Fully Insured Plans

If the group health plan is fully insured, the plan and the carrier both have the obligation to file an attestation; however, if the carrier submits the attestation on behalf of the fully insured arrangement, no further action should be required by the plan. Plan sponsors should not assume the carrier will submit the attestation on their behalf. The carrier may request information from the employer to enable submission on the employer's behalf or may decline to submit and place the obligation on the employer to file the attestation. It is important to confirm each particular carrier's approach.

Self-funded Plans

A self-funded plan (including level-funded) is responsible for the attestation; however, the plan sponsor may enter into a written agreement with the provider (TPA, PBM) to submit the attestation on behalf of the plan. TPAs may request information from the employer to enable submission on the plan's behalf. It is important to note that some TPAs have indicated they will not submit the attestation for the plan. If that is the case, plan sponsors will need to submit the attestation for their plans and should obtain written confirmation from the TPA and other service providers that the contractual arrangements do in fact satisfy the gag clause prohibition requirements.

Plan sponsors who will need to file an attestation will submit their attestation via the webform by selecting the link for "Gag Clause Prohibition Compliance Attestation" at hios.cms.gov/HIOS-GCPCA-UI.

Plan sponsors should carefully review any communication provided by the carrier or TPA to ascertain what approach they will undertake for the December 31, 2024 submission.

New PCOR Fee Announced

Issued date: 12/12/24

On December 3, 2024, the IRS released Notice 2024-83, announcing that the adjusted applicable dollar amount used to determine the PCOR fee for plan years ending on or after October 1, 2024, and before October 1, 2025, is $3.47.

The PCOR filing deadline is July 31, 2025, for all self-funded medical plans (including level-funded) and some HRAs (including ICHRAs) for plan years (including short plan years) ending in 2024. Carriers are responsible for paying the fee for insured policies.

PCOR fee due July 31, 2025:

Plan Years Ending on	Amount of PCOR Fee
January 31, 2024	$3.22/covered life/year
February 29, 2024	$3.22/covered life/year
March 31, 2024	$3.22/covered life/year
April 30, 2024	$3.22/covered life/year
May 31, 2024	$3.22/covered life/year
June 30, 2024	$3.22/covered life/year
July 31, 2024	$3.22/covered life/year
August 31, 2024	$3.22/covered life/year
September 30, 2024	$3.22/covered life/year
October 31, 2024	**$3.47/covered life/year**
November 30, 2024	**$3.47/covered life/year**
December 31, 2024	**$3.47/covered life/year**

Employer Action

For now, no action by employers with self-funded health plans (or an HRA) is required. We will send a reminder in mid-2025 of the fee and additional information for filing and paying the PCOR fee with the IRS.

It should be noted that we have seen increased enforcement activity from the IRS around missing PCOR fees. Specifically, the IRS is issuing CP161 notices to employers who appear to have missed a prior year PCOR fee filing, requesting payment (including interest and penalties).

New Jersey Releases 2025 Disability And Family Leave Amounts

Issued date: 12/16/24

New Jersey has announced the 2025 contribution rates and benefit level parameters for the Temporary Disability Insurance ("TDI") and Family Leave Insurance ("FLI") programs. Compared to 2024, the 2025 rates and benefit parameters are as follows:

	2025	2024
Maximum TDI and FLI Weekly Benefit	$1,081	$1,055
Alternative Earnings Test Amount for TDI and FLI	$15,200	$14,200
Base Week Amount for TDI and FLI	$303	$283
Taxable Wage Base (employers) for TDI	$43,300	$42,300
Taxable Wage Base (employees) for TDI and FLI	$165,400	$161,400
Employee Contribution Rate for TDI	0.23%	0.00%
Employee Contribution Rate for FLI	0.33%	0.09%

Temporary Disability Insurance 2025

TDI provides benefits to eligible New Jersey workers for non-job-related illness, injury, or other disability that prevents them from working or due to certain public health emergency reasons. To be eligible for TDI, employees must have worked 20 weeks earning at least $303 per week ("Base Week Amount") or have earned a combined total of $15,200 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave. Following a 7-day waiting period (except for certain public health emergencies), the weekly TDI benefit is 85% of an employee's average weekly wage but no greater than $1,081. TDI may be payable for up to 26 weeks in a 52-week period.

Employees typically contribute to TDI; however, in 2023 and 2024, employee contributions were reduced to zero. For 2025, employee contributions have been set at 0.23% of wages. The maximum contribution for 2025 is 0.23% up to the Taxable Wage Base (Employee) of $165,400 equal to $380.42.

Family Leave Insurance 2025

Family Leave Insurance provides benefits to eligible New Jersey workers for (i) the first 12 months following the birth, adoption or foster care placement of a child, or (ii) to care for a seriously ill family member. Similar to TDI, to be eligible for FLI employees must have worked 20 weeks earning at least $303 per week ("Base Week Amount") or have earned a combined total of $15,200 ("Alternative Earnings Test") in the four quarters ("base year") prior to taking leave. The weekly FLI benefit is 85% of an employee's average weekly wage but no greater than $1,081. FLI may be payable for 12 consecutive weeks in a 12-month period, or up to 8 weeks (56 individual days) in a 12-month period, if taking leave intermittently.

Employees contribute 0.33% of wages up to the 2025 Taxable Wage Base (Employee) of $165,400 equal to $545.82 ($145.26 in 2024).

FAQ 68 Addresses Preventive Care And Mastectomy Coverage

Issued date: 12/19/24

On October 21, 2024, the Departments of Labor, Health and Human Services, and the Treasury ("the Departments") issued FAQ Part 68, providing guidance on:

- Pre-Exposure Prophylaxis ("PrEP") as a preventive care service for persons at high risk of HIV;
- Proper coding and claims management for preventive care services; and
- Coverage requirements under WHCRA for mastectomies.

Coverage of PrEP

Under the Affordable Care Act ("ACA"), non-grandfathered group health plans and health insurance carriers must provide certain preventive care services without any cost-sharing requirements. The list of preventive care services is based upon recommendations from various agencies and advisory organizations, including the United States Preventive Services Task Force ("USPSTF"). Plans and carriers are allowed to use reasonable medical management techniques should a preventive care service or item requirement fail to include information on frequency, method, treatment or setting to provide the preventive care service.

In 2019, the USPSTF recommended that clinicians offer PrEP with effective antiretroviral therapy as a preventive care service to persons with a high risk of becoming infected with HIV. This guidance was clarified to include U.S. Food and Drug Administration ("FDA")-approved PrEP antiretroviral medications and specified baseline and monitoring services necessary to the efficacy of PrEP. At that time, the only FDA-approved PrEP formulation was a once-daily oral treatment (TF/FTC, brand name Truvada).

In 2023, two additional FDA-approved PrEP formulations were added:

- Emtricitabine/tenofvir alafenamide (TAF/FTC; brand name Descovy), approved daily oral medication; and

- Cabotegravir (brand name Apretude), a long-acting injectable medication.

FAQ 68 requires that, for plan years beginning on or after August 31, 2024, most health plans must cover without cost-sharing the three FDA approved PrEP formulations. Where necessary, medical management techniques may be used except to direct individuals to use one formulation over another.

Coding and Claims Management

FAQ 68 also reminds plans and carriers about the importance of properly coding claims for preventive care or services. Items or services that are preventive care in nature should be properly coded and processed without cost-sharing unless there is individualized information to determine that the care or service was not preventive care. Participants, beneficiaries or enrollees (or their authorized representatives) have the right to appeal an adverse benefit determination consistent with ERISA's internal appeal and review requirements.

There are industry-standard coding practices to help differentiate preventive care or services from diagnostic, therapeutic or other non-preventive care purposes. For example, the American Medical Association ("AMA") maintains the Current Procedural Terminology ("CPT®") coding system and established "modifier 33" to provide a standard way to communicate that an item or service is recommended preventive care under the ACA. FAQ 68 includes additional examples.

Mastectomy Related Required Coverages

The Women's Health and Cancer Rights Act ("WHCRA") requires health plans to include coverage for mastectomies and certain services related to consultation with the patient and attending physician. These required coverages include all stages of care on the breast on which the mastectomy was performed, surgery and reconstruction of the other breast for symmetrical appearance, prostheses, and treatment of physical complications related to the mastectomy, such as lymphedema.

FAQ 68 clarifies that WHCRA includes coverage of chest wall reconstruction with aesthetic flat closure if chosen by the patient upon consultation with their attending physician in connection with the mastectomy. Further, plan sponsors and carriers may impose deductibles and coinsurance for WHCRA benefits if such costs are deemed appropriate and consistent with costs for other benefits covered by the health plan.

Employer Action

Employers should take the following steps concerning this guidance:

- Confirm that the listed PrEP formulations are identified as preventive care services under their group health plans beginning with plan years on or after August 31, 2024;

- Ensure carriers and TPAs have appropriate practices in place to properly identify whether a service or item should be covered as preventive care;

- Examine mastectomy-related services and care under the group health plan for any exceptions or limitations, including cost sharing provisions; and

- Continue to monitor ongoing litigation that could impact preventive care requirements for group health plans.

2024 State-Based Compliance: Quarter Four

2024 State Bulletins

Idaho

Idaho enacts PBM Law 150

Washington

Washington State PBM Law 153

Idaho Enacts PBM Law

Effective January 1, 2025, Idaho HB 596 (the "Bill") will place new requirements on pharmacy benefit managers ("PBMs") and the plans they service. Idaho joins the growing list of states that have passed laws targeting PBM practices and prescription benefits. Whether and to what extent the law may be subject to ERISA preemption will not likely be known until the law becomes effective.

Key requirements of the Bill:

The Bill governs disclosure, reporting and contractual requirements for PBMs doing business in Idaho by:

- requiring PBMs to register with the state;
- requiring PBMs to pass through 100% of rebates to the plan;
- prohibiting spread pricing, the practice of charging a plan more than the pharmacy is paid for prescriptions services;
- requiring increased reporting to the Department of Insurance ("DOI");
- requiring increased reporting to plans related to costs for Rx services, fees charged, and rebates received related to the plans;
- requiring network adequacy standards that meet or exceed Medicare part D requirements; and
- continuity of care provisions related to mid-year formulary changes.

The Bill

Under the Bill, plans will be entitled to significant information related to how prescription services are provided by PBMs. This will include disclosure of:

- the cost, price, and reimbursement information of all prescription drugs;
- all fees, markups, and discounts charged or imposed on pharmacies with which the PBM has contracted; and
- the aggregate amount of all remuneration the PBM received from a drug manufacturer for a prescription drug including any rebate, discount, admin fee or any other payment or credit.

In addition to the increased disclosure requirements, PBM contracts will need to include the following:

- require pass through pricing where the PBM must charge the plan no more than the amount that they pay a pharmacy for prescription drugs;
- prohibit spread pricing where the PBM charges the plan more than a pharmacy is reimbursed for prescription drugs; and
- require 100% of manufacturer rebates to be provided to offset plan cost-sharing and reducing premiums with any remaining rebates to be used to reduce participant copayments in contracts that allow the PBM to negotiate rebates.

Network adequacy requirements are meant to expand pharmacy networks and increase options for covered members to obtain services at pharmacies of their choice. Additionally, network adequacy requirements often serve to counter a PBM from disfavoring unaffiliated or independent pharmacies that are often critical in providing services in rural areas. These requirements include:

- prohibiting a PBM from limiting a network to an affiliated pharmacy;
- prohibiting a PBM from limiting coverage to mail-order only;
- prohibiting the requirement that a covered member obtain services from an affiliated pharmacy; and
- prohibiting the participation in a network being conditioned on participation or non-participation in another network.

Additional requirements of the Bill include increased reporting to the DOI related to the difference in reimbursement rates, direct and indirect remuneration, fees or other price concessions, and clawbacks between an affiliated and unaffiliated pharmacy. Additionally, PBMs will be required to report an explanation of the reason why any drug was moved or reassigned to a formulary tier that has a higher cost, copayment, coinsurance, deductible for a covered individual or a lower reimbursement to a pharmacy.

Continuity of care provisions will require a PBM that implements mid-year formulary changes to allow a covered individual to continue to have access to the medication at the same cost for up to 60 days after the covered individual is notified of the change.

State PBM Laws and ERISA Preemption

ERISA preemption exempts self-funded ERISA-covered plans from the applicability of state law. As medical and prescription service costs continue to rise, there has been increased focus on PBMs at the state level. Various laws have been passed in different states that have placed requirements on PBM networks, contract provisions related to pricing and rebates, as well as setting rules and limits for how PBMs structure their pharmacy networks. Litigation has produced varied results related to ERISA preemption.

The U.S. Supreme Court held that an Arkansas statute that mostly regulated rate setting by PBMs was not preempted by ERISA. However, an Oklahoma law that included requirements directly affecting plan design and administration, as well as mail order pharmacy benefits, was found to be partially preempted by ERISA by the 10th Circuit Court of Appeals. The state has appealed the decision to the U.S. Supreme Court. It's uncertain whether the Court will accept the case and further weigh in on ERISA preemption.

Employer Action

Employers providing prescription drug benefits to Idaho residents should confirm their PBM's compliance with the new requirements.

- The provisions of the law related to contract requirements and network adequacy appear to be effective for any contract executed, amended, adjusted, or renewed on or after January 1, 2025.

- The disclosure requirements may be effective January 1, 2025, without any delay. Self-funded plan sponsors should confirm with their TPAs or PBMs whether and when those service providers intend to provide the required disclosures.

While ERISA preemption for some of the provisions of the law may be possible, self-funded plan sponsors should review PBM contracts to determine what changes may be needed to comply with the new requirements. The law allows for penalties against the PBM for any violation, enforceable by the DOI.

Washington State PBM Law

Washington state recently passed E2SSB 5213 which further regulates Pharmacy Benefit Managers ("PBMs") and Health Care Benefit Managers ("HCBMs" include PBMs) doing business in the state.

Unlike PBM laws passed in other states, the Washington law is clear that PBMs are not required to comply with E2SSB 5213 for self-funded ERISA group health plans unless that self-funded health plan opts into the protection of the law. This "opt-in" provision was likely added to the legislation to avoid ERISA preemption challenges that have occurred with respect to PBM laws in other states around the country.

Fully insured health plans and health plans offered to public employees are subject to these PBM requirements.

Under E2SSB 5213, a PBM may not:

- reimburse a network pharmacy an amount less than the contract price between the PBM and the third-party payor the PBM has contracted with to provide a pharmacy benefits plan or program;
- exclude a pharmacy from the network on the basis that the pharmacy is new, has only been open for a limited time, or has transferred locations, unless there is a pending investigation for fraud, waste, and abuse;
- reimburse a pharmacy or pharmacist an amount less than the amount the PBM would reimburse an affiliate for the same service
- require a covered person to pay more for a drug than the lesser of the applicable cost sharing for the drug or the amount the person would pay if buying the drug in cash; or
- require or coerce a covered person to use a pharmacy owned or affiliated with the PBM.

The law requires that PBMs must:

- apply the same fees, utilization review, and days allowance regardless of which participating pharmacy a covered person uses;
- permit the covered person to receive delivery or mail order of a medication through any network pharmacy that is not primarily engaged in dispensing prescription drugs to patients through the mail or common carrier; and
- for new prescriptions issued after January 1, 2026, receive affirmative authorization from a covered person before filling prescriptions through a mail order pharmacy.

In addition:

- Registration process for PBMs and HCBMs. All HCBMs, including PBMs, must register with the state's Office of Insurance Commissioner ("OIC") and meet other requirements.

- Mail order. If a covered person uses a mail-order pharmacy, the PBM must allow for dispensing at a local network pharmacy if the mail-order is delayed by more than one day after the expected delivery day provided by the mail-order pharmacy, or if the order arrives in an unusable condition. The PBM must also ensure that covered persons using a mail-order pharmacy have easy and timely access to prescription counseling by a pharmacist.

- Pharmacy appeals process. PBMs must establish a process by which a network pharmacy, or its representative, may appeal its reimbursement for a drug. A network pharmacy may appeal a reimbursement cost for a drug if the reimbursement for the drug is less than the net amount that the network pharmacy paid to the supplier of the drug.

- No fee for network participation. A PBM may not charge a pharmacy a fee related to credentialing, participation, certification, or enrollment in a network, and it may not condition or link restrictions on fees related to credentialing, participation, certification, or enrollment in a PBM's pharmacy network with a pharmacy's inclusion in the PBM's pharmacy network for other lines of business.

- Retaliation prohibited. A PBM may not retaliate against a pharmacy or pharmacist for disclosing information in court, an administrative hearing, legislative hearing, or to a law enforcement agency if the pharmacy or pharmacist has a good faith belief the information is evidence of a violation of a state or federal law, rule, or regulation.

These requirements apply to PBMs and HCBMs and become effective on January 1, 2026.

Employer Action

As much of the law appears to take effect January 1, 2026, PBMs will likely be making changes to their processes. The OIC is currently undergoing a ruling making process to further clarify these requirements.

Employers with an ERISA covered self-funded group health will need to determine whether to "opt-in" to the state protections. It will be important to discuss with the plan's third-party administrator and/or PBM to determine whether they will be able to comply with the requirements before making an opt-in election. The OIC is likely to establish a process for making an "opt-in" election in future guidance or rulemaking.

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