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2025: First Quarter

Compliance Digest

Compliance Bulletins Released January to March

2025 Compliance Bulletins: First Quarter

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New Texas Prescription Drug Information Requirement

Issued date: 01/03/25

Beginning with the 2025 policy year, Senate Bill 622 requires Texas carriers to make prescription drug benefit information available upon request to members and providers in real time. The required information includes cost sharing, drug lists, utilization management requirements, and other coverage details. It applies to insured medical plans in Texas and not to self-funded medical or drug programs (other than those offered by professional employer organizations).

Summary:

A carrier must provide information regarding a covered prescription drug to an enrollee or the enrollee's prescribing provider on request. The information provided must include the carrier's drug formulary and, for the prescription drug and any formulary alternative:

1. the enrollee's eligibility;

2. cost-sharing information, including any deductible, copayment, or coinsurance, which must:

    a. be consistent with cost-sharing requirements under the enrollee's plan;

    b. be accurate at the time the cost-sharing information is provided; and

    c. include any variance in cost-sharing based on the patient's preferred dispensing retail or mail-order pharmacy or the prescribing provider; and

3. applicable utilization management requirements.

The carrier must:

1. respond in real time to a request made through a standard Application Programming Interface (API);

2. allow the use of an integrated technology or service as necessary to provide the required information;

3. ensure that the information provided is current no later than one business day after the date a change is made; and

4. provide the information if the request is made using the drug's unique billing code and National Drug Code.

A carrier may not restrict a prescribing provider from communicating to the enrollee information about the cash price of the drug, or any additional information on any lower cost or clinically appropriate alternative drug, whether or not the drug is covered under the enrollee's plan.

This requirement is effective beginning with a policy year beginning on or after January 1, 2025.

Employer Action

Employers with insured medical plans written out of Texas should be aware of the above change. No employer action is required.

New York Issues Guidance on Paid Prenatal Leave

Issued date: 01/06/25

As previously reported, effective January 1, 2025, New York employees will be entitled to 20 hours of paid prenatal leave in a 52-week period to be used for prenatal healthcare service appointments during their pregnancy or related to their pregnancy. New York has published guidance in the form of Frequently Asked Questions ("FAQs") to help employers prepare for the new paid leave requirement.

Highlights from the FAQs are summarized below.

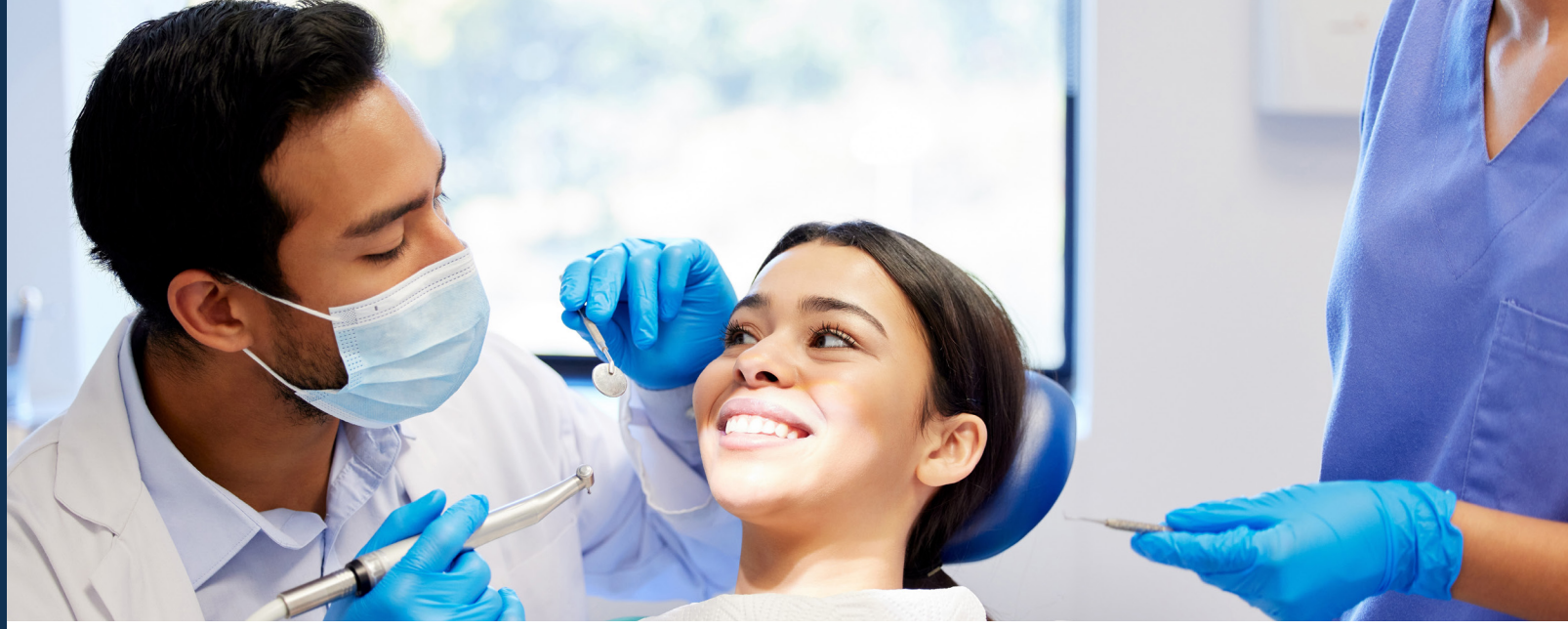
Summary:

Paid Prenatal Leave	Paid prenatal leave is a stand-alone benefit available to employees seeking prenatal healthcare services. An employer cannot require an employee to choose one leave type over another or require an employee to exhaust one type of leave before using paid prenatal leave.
Covered Employers	All private sector New York employers are subject to the paid prenatal leave requirements, regardless of size.
Covered Employees	All employees working for a private sector employer in any occupation are entitled to paid prenatal leave including full-time and part-time employees. This leave is only available to the employee and does not extend to the spouse, partner or other individual.
Amount of the Benefit	Employees are entitled to 20 hours of paid prenatal leave in a 52-week period measured from the first time the employee uses paid prenatal leave. The triggering date is the date that the leave is first recorded on an employee's timesheet.
When Benefits Are Available	Employees are entitled to 20 hours of paid prenatal leave as of their hire date as there is no requirement to work a minimum amount of time before benefits may be taken. This benefit is in addition to any other leave benefits that may be available such as under the New York sick leave provisions.

How Benefits are Taken and Paid	Paid prenatal leave is taken in hourly increments with employees paid their regular rate of pay, or the applicable minimum wage established by the Labor Law, whichever is greater.
Covered Health Care Services	Benefits include health care services received by an employee during their pregnancy or related to such pregnancy, including physical examinations, medical procedures, monitoring and testing, and discussions with a health care provider related to the pregnancy. In addition, leave may be taken for fertility treatment or care appointments, including in vitro fertilization as well as end-of-pregnancy care appointments. The leave does not apply to post-natal or postpartum care.
Employee Notification to the Employer	Employees should request time off in accordance with existing notification/request procedures within their workplaces and are encouraged to provide advance notice of such leave requests, when possible. Employers may not request medical records or ask employees to disclose confidential information about their health condition when requesting paid prenatal leave.
Employer Recordkeeping	Employers are not required to separately identify paid prenatal leave on employee paystubs but are encouraged to keep accurate records.
Retaliation	Employers may not retaliate against employees for requesting paid prenatal leave. Employees may report allegations of retaliation by emailing the Division of Labor Standards.

Employer Action

Employers should review and update leave policies to include the new paid prenatal leave benefit and ensure that eligible employees have access to the paid leave benefit as of January 1, 2025.



California Bans Certain Restrictions for Insured Dental Plans

Issued date: 01/08/25

California has enacted a state insurance law that prohibits fully insured dental plans in California from imposing:

- a *dental waiting period provision* for certain services in a large group dental plan that is fully insured, or
- a *pre-existing condition exclusion provision* in any dental plan that is fully insured.

The new state insurance law, which does not apply to self-funded dental plans, is effective for insurance policies and health maintenance organization ("HMO") dental contracts in California that are issued or renewed on or after January 1, 2025.

Background:

Individuals who have postponed needed dental treatment are considered more likely to purchase dental insurance than healthier individuals with fewer treatment needs. To address this potential for adverse selection, some insurance carriers and HMOs impose waiting periods or pre-existing condition exclusions on the more costly dental services for newly enrolled individuals. Examples of these restrictions include the following:

- A waiting period of 3 to 12 months before the dental plan will pay for fillings, extractions, root canals, and other basic restorative care.
- A waiting period of 3 to 12 months before the dental plan will pay for crowns, dentures, implants, and other major restorative services.
- A pre-existing condition exclusion for teeth that are missing on the first day of coverage.
- A pre-existing condition exclusion for dentures, if the individual received dentures from a different dental plan within a specified time frame.

In some cases, a dental plan may waive the specific services waiting period or pre-existing condition exclusion if the enrolled individual provides proof of continuous dental insurance coverage with a different dental plan immediately prior to coverage with the current dental plan.

New California Dental Insurance Law

On and after January 1, 2025, an insurance carrier or HMO may not issue, amend, renew or offer a dental insurance policy or HMO contract that imposes the following types of restrictions that address adverse selection:

- **A *dental waiting period provision* is prohibited in a large group dental insurance policy or HMO contract.** The term "*dental waiting period provision*" means a provision in the policy or contract that limits coverage for certain services for a specified period following the individual's effective date of coverage. The prohibition applies only to a large group dental plan, which is defined by California as any group plan that is not a small group plan.

- **A *pre-existing condition provision* is prohibited in any dental insurance policy or HMO contract.** The term "*pre-existing condition provision*" means a provision in the policy or contract that excludes or limits coverage for services, charges, or expenses incurred following an individual's effective date of coverage, for a condition for which dental services, diagnosis, care, or treatment was recommended or received before the effective date of coverage. The prohibition applies to both large group and small group dental plans.

Application of New California Insurance Law to Dental Plans

The new California insurance law generally applies to:

- Group dental insurance policies issued or delivered (i.e., sitused) in California;

- Dental HMOs in California;

- Group dental insurance policies issued or delivered (i.e., sitused) outside of California, to the extent that the policy covers California residents, except when:

    - the employer's principal place of business is located outside of California, and

    - a majority of employees are located outside of California.

The new California insurance law does not apply to any dental plan that is self-funded.

Employer Action

As this is an insurance mandate, carriers and HMOs are responsible for compliance. It is likely that dental premiums in the fully insured market will increase.

Employers that want to address adverse selection by continuing to include a *dental waiting period provision* for certain services or a *pre-existing condition provision* in their dental plan may consider replacing their fully insured plan with a plan that is self-funded.

Legislation Reduces Burden of Employer Reporting

Issued date: 01/09/25

Congress passed two bills to reduce the burden of employer reporting related to the Affordable Care Act that President Biden signed into law on December 23, 2024. While small, these bills pack a big punch as they significantly reduce the employer (and carrier) responsibilities for Form 1095-C (and Form 1095-B) reporting.

Paperwork Burden Reduction Act

This Act provides an alternative furnishing method for Forms 1095-C and 1095-B, offering additional flexibility to employers and carriers responsible for sending these Forms to covered individuals.

Currently, most large employers are required to furnish a Form 1095-C to full-time employees. For employers that are self-funded (including level-funded), the employer is required to furnish a Form 1095-C (or Form 1095-B) to any primary insured. In most cases, these Forms are mailed to the home address of the employee or furnished electronically with appropriate notice and consent.

The new law provides that Form 1095-C or Form 1095-B may be furnished to individuals only upon request. In other words, employers are no longer required to furnish these Forms to covered individuals unless the individual requests it.

Employers (or carriers) that take advantage of this relief must:

- Ensure any request for an applicable Form is fulfilled by the later of January 31 or 30 days after the request is made; and
- Provide timely notice of the option. No guidance has been issued on the language for the notice or how it should be displayed or distributed. Employers should await this guidance before relying on this relief.

This law applies to statements with respect to any returns after 2023. This means, employers preparing reporting for calendar year 2024 can take advantage of this relief.

Even though employers relying on this alternative furnishing method are not required to furnish a Form 1095-C to individuals (unless requested), the Forms 1095-C (and 1095-B) must still be completed and timely filed with the IRS along

with a Form 1094-C (or Form 1094-B). All Forms 1095-C along with Form 1094-C for calendar year 2024 must be filed electronically with the IRS by March 31, 2025.

California, Massachusetts, New Jersey, Rhode Island and the District of Columbia have individual health insurance mandates with their own requirements for furnishing information regarding health coverage to residents of the state. All of these (except Massachusetts) allow reporting via the federal Forms 1095-C and 1095-B. It is not clear how the states with individual mandate requirements will respond to this federal action, as they do not have a similar "opt-in" provision. Employers who are subject to both state and federal reporting will need to await direction from the state for any further flexibility. Otherwise, they should be prepared to furnish statements to covered individuals as they have in prior years (e.g., by mail).

Massachusetts requires reporting on a separate Form 1099-HC and this requirement is unaffected by the change in federal reporting.

Employer Reporting Improvement Act

This bill:

- Allows a date of birth to be used instead of a tax identification number on the Form 1095-C or 1095-B when the tax identification number is not available. The tax identification number is usually the social security number.
- Codifies that an employer (or carrier) may furnish Form 1095-C (or Form 1095-B) electronically when the individual has consented to electronic delivery.
- Provides at least 90 days (versus 30 days) for an employer to respond to an IRS letter 226-J proposing an assessment under the employer shared responsibility mandate. This provision is effective for assessment proposed in taxable years beginning after 2023.
- Implements a 6-year statute of limitations for shared responsibility penalty assessments. Prior to this law, no statute of limitations applied.

Employer Action

While these two bills provide welcome relief, the timing is not the most favorable.

Employers should:

- With respect to furnishing Forms 1095-C for CY 2024, the due date is **March 3, 2025**. Given the relief afforded in the Paperwork Burden Reduction Act:
    - Consider whether to take advantage of the relief and only furnish the Forms to employees who request them. This will require that appropriate notice is provided to employees. Currently, there is no guidance on how to provide such notice. The IRS will likely issue this guidance, but timing is uncertain.
        - Absent guidance, employers with employees who are residents of a state with an individual mandate may still need to furnish a 1095-C (or 1095-B) to meet state requirements.
    - Given the short time frame before the March 3, 2025 deadline, some employers may consider furnishing the Forms 1095-C as they have in past years (e.g., by mail) and then move to the "opt-in" method for calendar year 2025 reporting (due in 2026).

- Always check the response date on any letter 226-J. While the time frame for a response will be longer – it will not apply until the IRS begins assessing penalties for calendar year 2024. If you receive a letter 226-J with an assessment applicable before 2024 (e.g., 2022), it will be subject to the 30-day response window.

Certain ERISA Deadlines Extended Due to Hurricanes in Southeast

Issued date: 01/14/25

The Departments of Labor and the Treasury issued guidance extending certain deadlines for health and welfare plans due to Hurricanes Helene and Milton. Similarly, the Department of Health and Human Services ("HHS") released a Bulletin to assist individuals and businesses impacted by these storms. Collectively, the Departments provided four pieces of guidance:

1. **EBSA Disaster Relief Notice 2024-01.** Extends the time for plans to provide ERISA-required notifications, such as SPDs, SMMs, and benefit determinations, provided there is a good faith effort to furnish these documents as soon as administratively practicable.
2. **Final Regulations.** Delays or suspends deadlines related to COBRA, HIPAA special enrollment, and claims/appeals, including the deadline for plan administrators to issue COBRA election notices.
3. **FAQs for Participants and Beneficiaries.** Helps participants affected by the hurricanes and tropical storm understand their ERISA rights, essentially reiterating previous guidance.
4. **Insurance Standards Bulletin Series.** Encourages non-federal governmental plans and health insurance issuers to extend participant deadlines and offers non-enforcement relief.

The extensions and suspensions in the Notice and Final Rule apply during the "Disaster Period," with deadlines tolled and resuming after this period ends.

Disaster Periods

- **Florida:**
  - Hurricane Helene: September 23, 2024 – May 1, 2025
  - Hurricane Milton: October 5, 2024 – May 1, 2025
- **Georgia** (Hurricane Helene): September 24, 2024 – May 1, 2025
- **North Carolina, South Carolina, Virginia** (Hurricane Helene and Tropical Storm Helene): September 25, 2024 – May 1, 2025

- **Tennessee** (Tropical Storm Helene): September 26, 2024 – May 1, 2025

The Notice

The Notice, which provides relief, applies to all Title I ERISA disclosures and notifications (except those in the Final Rule) and requires good faith efforts to provide these as soon as administratively practicable. Good faith delivery includes electronic communication methods such as email, text messages, and websites.

The notice provides examples of the type of benefit plan disclosure and notification timing extensions that would apply including:

- Summary Plan Descriptions and Summary of Material Modifications
- Forms 5500 and M-1
- Procedural requirements for plan loans and distributions
- Participant contributions and loan repayments
- Claims and appeal deadlines

The Notice also includes "General ERISA Fiduciary Compliance Guidance," urging plan fiduciaries to prevent benefit loss or undue delay.

Final Regulations

The Final Regulations suspend certain deadlines for health and welfare plan participants during the Disaster Period. These deadlines resume after the Disaster Period ends and apply to all ERISA and Internal Revenue Code plans. HHS encourages non-federal plans and health insurance issuers to extend participant deadlines and provide non-enforcement relief.

Plan Administrator Relief

The 14-day (or 44-day if the employer is the plan administrator) deadline for issuing COBRA election notices is suspended.

Participant Relief

- The following employee notification deadlines are suspended during the Disaster Period:
- HIPAA Special Enrollment Period
- COBRA Qualifying Event and Disability Extension Notices
- COBRA Election
- COBRA Premium Payments
- Benefit Claims and Appeals
- External Review and Perfecting a Request for External Review

Participants must have been in the disaster area or covered by an affected plan at the time of the hurricanes or tropical storm. A plan is directly affected if the employer's principal place of business, the office of the plan or administrator, or the primary recordkeeper's office was in the disaster area.

The companies that are eligible for these rules need to be in a county that is marked as eligible for *individual assistance* (and not only public assistance) through FEMA.

2025 Federal Poverty Guidelines Announced

Issued date: 01/21/25

The Department of Health & Human Services ("HHS") recently announced the 2025 federal poverty guidelines which, among other things, establish the federal poverty line ("FPL") affordability safe harbor for purposes of the Affordable Care Act ("ACA") employer mandate.

For plan years beginning February 1, 2025 or later, the 2025 FPL safe harbor is $117.63/month in the lower 48 states and DC, $146.95/month for Alaska, and $135.22/month for Hawaii.

As a reminder, a plan can use poverty guidelines in effect 6 months before the first day of the plan year for purposes of using the FPL affordability safe harbor.

Because the 2025 guidelines were announced after the start of the calendar year, plans with plan years beginning on January 1, 2025 use $113.20/month for the lower 48 states and DC ($141.38/month for Alaska and $130.11/month for Hawaii), which is 9.02% of the 2024 applicable federal poverty guidelines.

Background

Large employers may be subject to the employer mandate penalty under the ACA if they do not offer affordable, minimum value coverage to all full-time employees, and at least one full-time employee receives a subsidy in the Marketplace.

A large employer's offer of coverage will be considered "affordable" under the FPL safe harbor if the employee's required monthly contribution for the lowest cost self-only coverage that provides minimum value does not exceed 9.5% (as indexed) of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12. For 2025, this amount is 9.02%.

2025 FPL Affordability Safe Harbor

For FPL affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The 2025 FPL is $15,650 for a single individual in every state (and Washington D.C.) except Alaska or Hawaii. Thus, if the employee's required monthly contribution for the lowest cost self-only coverage that provides minimum value is $117.63 (9.02% of $15,650/12, rounded down) or less, the employer's offer of coverage meets the FPL affordability safe harbor for a plan year beginning February 1, 2025 or later in the lower 48 states and DC.

FPL Guidelines

The following are the 2025 HHS poverty guidelines:

2025 Poverty Guidelines for the 48 Contiguous States and DC	
Persons in family/household	Poverty guideline
1	$15,650
2	$21,150
3	$26,650
4	$32,150
5	$37,650
6	$43,150
7	$48,650
8	$54,150
For families/households with more than 8 persons, add $5,500 for each additional person.	

2025 Poverty Guidelines for Alaska	
Persons in family/household	Poverty guideline
1	$19,550
2	$26,430
3	$33,310
4	$40,190
5	$47,070
6	$53,950
7	$60,830
8	$67,710
For families/households with more than 8 persons, add $6,880 for each additional person.	

2025 Poverty Guidelines for Hawaii	
Persons in family/household	Poverty guideline
1	$17,990
2	$24,320
3	$30,650
4	$36,980
5	$43,310
6	$49,640
7	$55,970
8	$62,300
For families/households with more than 8 persons, add $6,880 for each additional person.	

Medicare Part D CMS Notification Reminder

Issued date: 01/22/25

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: https://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, 2025) must complete this reporting **no later than March 1, 2025.**

If there was a change in the creditable coverage status of a prescription drug plan offered by the employer (e.g., from creditable to non-creditable, or vice versa), notice should be provided to CMS within 30 days of the change. For example, if a change occurred in connection with the January 1, 2025 plan year, CMS should be notified by January 31, 2025.

Employer Action

- For **calendar year 2025 plans**, timely complete reporting with CMS. For **non-calendar year plans**, timely complete reporting with CMS following the start of your 2025 plan year.
- You will need to have the following information ready to include when you complete the CMS online reporting:
  - The creditable (or non-creditable) status of prescription drug coverage provided by all plan options available to employees.
  - The date that the annual creditable (or non-creditable) coverage notice was furnished to Part D eligible individuals. You may have included this notice with open enrollment materials or sent it following the start of the plan year.
  - An estimate of the number of Medicare Part D eligible individuals covered under the plan. This does not have to be an exact number.

Additional resources for completing the form are available at:

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

State Health Coverage Reporting Requirements for Calendar Year 2024

Issued date: 01/23/25

Five states (California, Massachusetts, New Jersey, Rhode Island, and Vermont) and the District of Columbia already have 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.

The Paperwork Burden Reduction Act permits the employer (or carrier) to furnish the federal forms 1095-C (or 1095-B) only upon request when:

- Timely, clear and accessible notice is provided to any individual who would otherwise receive a Form 1095-C (or 1095-B) that they can request a copy of the applicable Form; and
- Upon request, the applicable Form is furnished by the later of January 31 or 30 days after the date of such request.

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. As of the date of this article's publication, the applicable states and District of Columbia have not adopted the federal relief. Absent similar relief at the state level, employers (and carriers) should prepare to furnish Forms 1095-C (or 1095-B) to covered residents as they have in prior years (e.g., by mail).

The following chart summarizes important deadlines related to 2024 state individual mandate reporting.

State	Deadline to Furnish Statements to Employee Residents	Deadline to File Statements with State Agency
California	January 31, 2025. However, no penalty is imposed for failing to furnish by this deadline.	March 31, 2025. No penalties will be assessed if filed by May 31, 2025.
District of Columbia	March 3, 2025	April 30, 2025 (30 days after federal deadline)
Massachusetts	January 31, 2025	January 31, 2025

New Jersey	March 3, 2025	March 31, 2025
Rhode Island	March 3, 2025	March 31, 2025
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.

Maine Issues Final Paid Family and Medical Leave Regulations

Issued date: 01/29/25

The Maine Department of Labor ("Department") has released final regulations for the Maine Paid Family and Medical Leave ("PFML") program.

Background

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

Employer Coverage

All private and public employers who employ one or more employees in Maine are required to provide PFML. The program does not apply to employees of the federal government. Self-employed individuals and tribal governments can opt-in to the program.

Eligibility to Receive Benefits

To receive PFML benefits, a covered individual must work for an employer subject to PFML and:

- Have earned wages paid in the state 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.
- Be employed when timely submitting an application for benefits;
- Have not been declared ineligible due to fraud; and
- Satisfy one of the qualifying reasons to take PFML:

- to bond with the covered individual's child during the first 12 months after the child's birth or the first 12 months after the placement of the child for adoption or foster care with the covered individual;
- to care for a family member with a serious health condition;
- to attend to a qualifying exigency (same as per federal FMLA);
- to care for a family member of the covered individual who is a covered service member;
- to take safe leave; or
- any other reason allowed under the state's existing unpaid family leave laws.

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 will be reduced by amounts taken under FMLA or state FMLA in the 12-month period preceding the start of leave, unless the leaves are taken concurrently.

Wage Definition

Wages paid in the state include all forms of compensation for personal services, such as regular salary, tips, commissions, bonuses, and severance pay. It does not cover payments made to independent contractors. For payroll and premium purposes, wages are calculated similarly to how Maine Unemployment wages are determined but applied to a larger base of employees that are not traditionally subject to the Maine Unemployment contributions tax. Wages exclude amounts above the annual base limit set by the U.S. Social Security Administration.

Amount of Benefit

The weekly benefit 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.

Use and Types of Leave

Covered individuals may take up to 12 weeks of approved 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.

- **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.

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 PFML program caps the amount of an employee's earnings subject to contributions at the same amount of earnings subject to Social Security taxes.

Employers must determine the number of covered employees for each federal employer identification number ("FEIN") separately. An employer that employs 15 or more covered employees on their payroll in 20 or more calendar workweeks during the 12-month period preceding September 30 of each year will be an employer of 15 or more employees for the following calendar year. This count includes the total number of employees on establishment payrolls employed full or part-time who receive pay for any part of the pay period. Employers will determine their size for each upcoming calendar year as of October 1, 2024 (i.e., effective January 1, 2025) and October 1 of each year thereafter.

The penalty for an employer failing to pay contributions and/or submit wage reports is 1 percent of the employer's total quarterly payroll. Employers will receive a notification if they have failed to pay contributions or submit a wage report and will have time to correct the issue before the penalty is assessed.

Approved Private Plans

Employers may apply for a private plan exemption after **April 1, 2025**. Applications for substantially equivalent private plans (fully insured or self-funded with a surety bond paid to the state) must be submitted online on a form provided by the Department along with an application fee set initially at $250 for review of the application, and an additional $250 administrative reimbursement fee if the application is approved for the substitution. The application fees may be increased by the Department on **January 1, 2026**, or thereafter. An approved private plan is valid for three years.

Employers will generally owe premiums to the state plan until their exemptions are approved. All employers must pay premiums to the state for the first quarter of 2025. The employer is responsible for PFML premiums until the effective date of exemption and premiums owed prior to the effective date of exemption must be remitted to the state and are non-refundable.

Unionized Workforces

Public employers and employees that are subject to a collective bargaining agreement that was in effect on October 25, 2023, are not required to participate in the PFML program until the collective bargaining agreement expires.

Job Protection

Any employee that has been employed with their employer for at least 120 consecutive calendar days is entitled, upon return from leave, to be restored by the employer to the position held by the employee when the leave commenced, or to be restored to an equivalent position with equivalent employment benefits, pay and other terms and conditions of employment.

Tax Issues

The Department has provided the following tax advice in the PFML FAQs on the Department's PFML website. Premiums are calculated on total subject wages, before federal income tax, state income tax, and Social Security and Medicare taxes are deducted. Whether PFML premiums are taxable is reliant on the guidance and processes of the federal Internal Revenue Service. Employers should work closely with their tax professionals on this question. Employee premium contributions should be listed under Box 14 of the W-2 form with the label "MEPFML."

Employer Notifications to Employees

Maine Law requires the Department to issue the workplace notice in English, Spanish, French, Somali and Portuguese and any other language that is the primary language of at least 2,000 residents of the state. Employers must post the workplace notice in English and each language other than English that is the primary language of 3 or more employees of that workplace.

Employers must also provide a written notice to new employees within 30 days of hire that contains the employee's contribution amount and the employees' rights and obligations under the law.

An employer that fails to comply with the poster and employee notice requirements will be liable for a civil penalty of $50 per employee for the first offense and $150 per employee for each subsequent violation.

Employer Action

Employers should review all the available information from the Department, including the final regulations, and continue to work with employment counsel, leave vendors, payroll processors and any other related business advisors to ensure compliance with the PFML program by the requisite dates.

- All employers must be prepared to **withhold** contributions beginning **January 1, 2025**.
- The new Maine PFML Portal ("portal") will be **launching January 6, 2025**.
- All employers will be required to **register** with the Department via the portal to determine their liability for PFML contributions and to designate a third-party payroll or employee leasing company if they wish.
- Employers must **submit premiums and wage reports** quarterly through the portal. The first submission starts **April 1, 2025**, due by **April 30, 2025**.

Fixed Indemnity Notice Invalidated by District Court

Issued date: 01/30/25

On December 4, 2024, the United States District Court for the Eastern District of Texas (the "District Court") vacated the new notice requirement for fixed indemnity insurance coverage issued as a final rule by the Departments of Labor, the Treasury, and Health and Human Services (collectively, "the Departments") on April 3, 2024. The notice requirements were set to take effect for plan years beginning on or after January 1, 2025; however, the District Court held that the Departments exceeded their rulemaking authority with the final rule. Accordingly, employers are not required to include the notice with open enrollment materials as previously required by the final rule.

Background

Under the final rule, for group fixed indemnity coverage to qualify as an excepted benefit, the plan or carrier must prominently display a notice, in at least 14-point font, on the first page of any marketing, application, and enrollment materials provided to participants at or before enrollment and reenrollment. The notice explains that the fixed indemnity policy is not health insurance and outlines the limitations of fixed indemnity insurance in addition to providing resources for more information about how to obtain comprehensive health insurance.

Model notices were provided by the Departments and many plan sponsors had already complied with the rule by including the notice with open enrollment materials for their plan years beginning on or after January 1, 2025.

Lawsuit Challenging Notice Requirement

An insurance company brought a lawsuit in the Eastern District of Texas, Manhattan Life Insurance and Annuity Co, et al v. U.S. Department of Health and Human Services et al., challenging the final rule, specifically asking the court to block the notice requirement as it exceeded the Department's statutory authority.

In a very short decision, the District Court held in favor of the plaintiffs and ruled that the Departments could not enforce the notice requirement, finding that the compelled notice requirement exceeded the statutory authority of the Departments and "was not a logical outgrowth" from the proposed regulations.

Employer Action

The fixed indemnity notice for group coverage no longer applies. Employers and carriers are not required to furnish this notice with enrollment materials for fixed indemnity insurance policies.

DOL Penalties Increase for 2025

Issued date: 02/04/25

The Department of Labor ("DOL") has published the annual adjustments for 2025 that increase certain penalties applicable to employee benefit plans.

Annual Penalty Adjustments for 2025

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

Description	2024 Penalty (OLD)	2025 Penalty (NEW)
Failure to file Form 5500	Up to $2,670 per day	Up to $2,739 per day
Failure of a MEWA to file reports (i.e., M-1)	Up to $1,942 per day	Up to $1,992 per day
Failure to provide CHIP Notice	Up to $141 per day per employee	Up to $145 per day per employee
Failure to disclose CHIP/Medicaid coordination to the State	$141 per day per violation (per participant/beneficiary)	$145 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,406 per failure	Up to $1,443 per failure
Failure to furnish plan documents (including SPDs/SMMs) to DOL won request	$190 per day $1,906 cap per request	$195 per day $1,956 cap per request
Genetic information failures	$141 per day (per participant/beneficiary)	$145 per day (per participant/beneficiary)
De minimis failures to meet genetic information requirements	$3,550 minimum	$3,642 minimum
Failure to meet genetic information requirements – not *de minimis* failures	$21,310 minimum	$21,864 minimum
Cap on unintentional failures to meet genetic information requirements	$710,310 maximum	$728,764 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.

IRS Issues Guidance on State Paid Family and Medical Leave Tax Treatment

Issued date: 02/04/25

The IRS recently issued Revenue Ruling 2025-04 (the "Revenue Ruling") explaining the tax treatment of contributions and benefits related to state paid family and medical leave laws ("PFML"). The welcomed guidance provides clarity related to the federal income tax treatment of contributions, including employee deductions, and benefits for state sponsored PFML plans, as well as providing transitional relief for reporting obligations. Tax treatment for state income tax purposes is not within the scope of this guidance.

Background

In recent years, many states have enacted and continue to enact paid family and/or medical leave laws that require employees to contribute to state funds to be eligible for partial wage replacement benefits in the event of leave for certain family or medical reasons. This includes California, Colorado, Connecticut, Delaware (2025), Washington D.C., Illinois, Maine (2025), Maryland (2025), Massachusetts, Minnesota (2026), Nevada, New Hampshire (voluntary), New Jersey, New York, Oregon, Rhode Island, Vermont (voluntary), and Washington.

Some states allow employers to sponsor private benefit programs to provide the benefits required by these laws. As state PFML laws have been enacted, there have been questions about the federal income tax treatment of the contributions and benefits. The IRS has not been clear as to whether employers were required to treat the employee contributions that were deducted as pre-tax or post-tax deductions on employee pay statements and W-2s.

Revenue Ruling

The guidance details the tax treatment and reporting requirements for:

- Employee contributions;
- Employer contributions;
- Medical leave benefits; and
- Family leave benefits.

The following guidance applies to contributions paid to state PFML programs and benefits paid from state PFML programs only.

Employers will need to consult with service providers, counsel, or tax professionals to determine how this guidance informs their treatment of contributions and benefits related to employer sponsored PFML programs (sometimes called “voluntary plans”).

Employee Contributions

According to the guidance, similar to mandatory state disability benefit program contributions that are considered income taxes, employee deductions for contributions for state PFML programs are tax deductible for federal income tax purposes. Accordingly, the PFML contribution paid by an employee via payroll deduction is deductible by the employee on their individual income tax return subject to the rules in the Code. However, amounts withheld from an employee’s paycheck to pay a state income tax are includible in the employee’s federal gross income. Therefore, the employee’s PFML contribution is included in the gross wages of the employee as reported on Form W-2. Employers will need to ensure that employee contributions for the state program are properly detailed on wage statements and included in gross wages.

Any amount of required PFML contribution paid on an employee’s behalf by the employer should be imputed as income to the employee.

Employer Contributions

Required employer contributions to state PFML programs for the employer’s share of PFML premiums are considered excise taxes paid or accrued in carrying on its trade or business that are deductible at the federal level and no part of the required employer contribution is reported as income for the employee.

However, any payments of employee contributions paid by an employer for an employee’s required contribution to a state PFML program would be considered income to the employee and should be imputed as income to the employee and reported as such. The employee may be able to deduct this amount as a state income tax on their federal individual income tax return subject to the SALT (state and local tax) limitation. Also, any amount of PFML contribution paid by the employer on behalf of the employee is deductible as an ordinary and necessary business expense by the employer for employee compensation. Employers will need to ensure that employer contributions paid on behalf of employees for an employee’s required contribution to the program are properly imputed as income and reported on Form W-2.

Medical Leave Benefits

Benefits payable to an employee under a state PFML program for reasons of medical leave for the employee’s own serious health condition are treated as if received from accident or health insurance and are not reported as income to the employee. However, the amount of medical leave benefits attributable to an employer’s contribution for medical leave would be considered income to the employee. Therefore, the amount of medical leave benefits attributable to the employer’s contribution would be reported as income to the employee on Form W-2. For example, if an employer pays 40% of the required contribution to the program, then 40% of the medical leave benefits received by an employee would be reportable as income to the employee.

Medical leave benefits attributable to amounts paid on behalf of an employee by the employer for the employee’s required contribution to the program would not be included in the medical leave benefits reported as income to the employee as the contribution amounts should already be included in the reported income to the employee. In other words, medical leave benefits attributable to employer pick-up payments for an employee’s required contribution to the program are not included in the amount of medical leave benefits reported as income to the employee since the contributions have already been imputed as income to the employee when they were contributed.

Amounts received by employees for medical leave benefits that are reportable as income are subject to all required employment taxes and reporting.

Family Leave Benefits

Benefits payable to an employee under a state PFML program for reasons of family leave are considered income to the employee because they are unrelated to the employee's own health condition and cannot be treated as being received through accident or health insurance. However, family leave benefits are not taxed as wages and should be reported to the IRS and the employee using Form 1099.

Transition Relief

Calendar Year 2025 will be a transition period for enforcement of the requirements in the Revenue Ruling.
For Medical Leave benefits paid to an individual in 2025 attributable to employer contributions:

- neither a state nor an employer is required to follow the income tax withholding and reporting requirements applicable to third-party sick pay;
- neither a state nor an employer will be liable for penalties for failure to file or furnish a correct payee statement;
- neither a state nor an employer is required to withhold and pay associated taxes and will not be liable for any associated penalties.

For employee pick-up payments paid on behalf of an employee in 2025 for the employee's required contribution to a state program:

- employers are not required to treat any pick-up payments as wages for federal income tax purposes.

Employer Action

Employers will want to ensure that their payroll systems correctly identify taxable income for employees related to employer and employee required contributions to state PFML programs. Additionally, employers may want to discuss the deductibility of employer contributions as a business expense or excise tax with their own accounting or tax professional.

Employers that sponsor their own PFML plans (e.g., a voluntary plan) will need to discuss this guidance with any service providers or carriers and likely their own counsel to determine how to treat and report employee and employer contributions and benefits paid under their employer sponsored plans.

Lastly, nothing in the guidance explains how a state program will provide information to employers regarding the amount of benefits paid to an employee that may be subject to payroll taxes. Employers will need to look to state programs for this information. While the guidance does provide limited transitional relief related to certain medical leave benefits and employer pick-up payments, employers will still need to determine how their state programs will address the guidance prior to 2026.

Update on the Johnson & Johnson ERISA Fiduciary Lawsuit

Issued date: 02/10/25

On January 24, 2025, the U.S. District Court of New Jersey dismissed claims made in a class action lawsuit against Johnson & Johnson ("J&J") regarding management of their prescription drug benefits.

In *Lewandowski v. Johnson & Johnson*, the plaintiffs alleged that J&J breached its fiduciary responsibilities under ERISA by mismanaging the prescription drug benefit program, costing employees millions of dollars in the form of higher payments for prescription drugs, higher premiums, deductibles, coinsurance and copays and lower wages and limited wage growth. In addition, the plaintiffs alleged J&J failed to furnish requested plan documents as required by ERISA.

In response, J&J filed a motion to dismiss the lawsuit. The court ruled in J&J's favor regarding the plaintiff's two fiduciary breach claims, finding the plaintiff lacked Article III standing to bring the lawsuit. To establish standing under Article III, the plaintiff must generally show that they have sustained a concrete injury, the injury was caused by the defendant, and the injury could be fixed by the court.

- **Higher health insurance premiums.** The plaintiff claimed that J&J's breach of fiduciary duty by mismanaging the prescription drug plan caused the plaintiff to pay higher premiums for the group health plan coverage. The court held that the plaintiff's alleged injury, paying more in premiums, was not sufficient to establish standing because the allegation about higher premiums is speculative and "stands on nothing more than supposition."
- **Increased out-of-pocket costs.** The plaintiff also alleged that she paid higher out-of-pocket costs because of the higher prices for prescription drugs in the plan. While the court held that the Plaintiff's allegations that she suffered an injury are traceable to the employer's alleged fiduciary violation, the injury alone is not sufficient to establish standing. The plaintiff also needed to show that the injury would likely be redressed by judicial relief. This requires a "substantial likelihood" that the injury can be remedied by a court's decision. The court ruled that the injury was not redressable by court action. Specifically, it appears that plaintiff satisfied her out-of-pocket maximum so a court's decision in her favor would not reimburse her the costs for her prescription drug costs.
    - "In straightforward terms, a favorable decision would not be able to compensate Plaintiff for the money she already paid. Even if Defendants were to reimburse Plaintiff for her out-of-pocket costs on a given drug—that is, the higher amount of money she spent as a result of Defendants' breaches—that money would be owed to her insurance carrier to reimburse it for its expenditures on other drugs that same year. In short, there is nothing the Court can do to redress Plaintiff's alleged injury."

It is important to note that the court did not dismiss the Plaintiffs claim that requested plan documents were not timely furnished. This claim is allowed to proceed under the court's decision.

With respect to the above claims, the court is providing the plaintiff with leave to amend the complaint to cure the failures identified by the court as to the issue of standing (they have 30 days to do so). In addition, the plaintiff may seek to file an appeal.

Employer Action

While this decision is a victory for J&J and plan sponsors, the story is not over. Though the court's opinion highlights the challenges for plaintiffs to establish standing to bring these lawsuits against plan sponsors, it does not close the door to other lawsuits alleging fiduciary breach as it comes to plan costs and management of benefits.

Employers should continue to monitor developments in the health and welfare litigation space and continue to review and understand the fiduciary responsibilities with respect to their health and welfare plans, particularly as it comes to monitoring and selecting service providers.

In addition, the decision serves as a reminder for employers to timely respond to requests for ERISA plan documents. Under ERISA, fiduciaries must furnish plan documents within 30 days of a written request of a participant or beneficiary. Penalties of up to $110/day may apply to these failures.

New No Surprises Act and Gag Clause Guidance Issued

Issued date: 02/10/25

On January 14, 2025, the Departments of Labor, Health and Human Services, and the Treasury ("the Departments") issued FAQ Part 69 to clarify:

- Open negotiation and notice and disclosure requirements for plans or issuers, and providers related to the Independent Dispute Resolution ("IDR") process,
- The coordination of the surprise billing rules between plans or issuers, providers, and facilities about the out-of-pocket rate for items or services subject to the No Surprises Act ("NSA") in cases where state law does not provide a method for determining the out-of-pocket rate,
- Plan sponsor responsibilities related to gag clauses included in subordinate agreements, and
- The Gag Clause Prohibition compliance attestation ("GCPCA") requirements when gag clauses remain in provider agreements.

NSA Background

Since its initial passage under the Consolidated Appropriations Act, 2021 (the "CAA"), the NSA provides protections against surprise medical bills for participants, beneficiaries, and enrollees of a group health plan offered by a health insurance issuer with respect to certain out-of-network costs. This is primarily achieved by limiting individual cost-sharing for NSA covered claims to an amount based on the qualified payment amount ("QPA"). However, the method for calculating the QPA has been the subject of litigation. As a result, plans and issuers face significant challenges in calculating QPAs that comply with the NSA.

NSA IDR Process

As part of the NSA, the Departments established a federal Independent Dispute Resolution ("IDR") process for resolving disputes between plans or issuers and providers, facilities, or providers of air ambulance services related to

reimbursement amounts subject to the NSA. The payment determination that results from the IDR process relies heavily on the QPA.

Notably, FAQ 69 addresses the impact of recent litigation on the final rules, including a United States Court of Appeals for the Fifth Circuit opinion, which partially reversed an opinion of the lower district court regarding provisions related to the methodology for calculating QPAs, and affirmed the district court's decision to vacate certain deadline provisions.

Additionally, FAQ 69 addresses several other implementation questions under the NSA including:

- QPA payment calculation for purposes of determining patient cost-sharing,
- Requirements for initial payments or notices of denial of payment and related disclosures when the disclosures are not provided at the same time or in the same format,
- Requirements for the initiation of open negotiation periods and the federal IDR process,
- Requirements for patient cost sharing for OON emergency services and applicable non-emergency items and services,
- Clarification that cost sharing for individuals may not be increased after the IDR process results in a payment determination, and
- Extending enforcement discretion related to QPA calculation for claims before August 1, 2025.

Gag Clause Prohibition Attestation Compliance

As previously reported, group health plans and health insurance issuers ("carriers") are prohibited from entering into an agreement with a health care provider, network or association of networks, third-party administrator ("TPA"), or other service provider offering access to a network that would directly or indirectly restrict the plan or issuer from:

1. Making provider specific cost or quality of care information available to eligible participants, beneficiaries, and enrollees of the plan,
2. Electronically accessing de-identified claims and encounter information upon request, and
3. Sharing such information as described above with a business associate.

These prohibitions are collectively referred to as the "Gag Clause Prohibition," which went into effect on December 27, 2020. Along with this prohibition, plans and issuers must annually submit an attestation of compliance, the GCPCA, with these requirements to the Departments.

The Departments have previously issued guidance on these requirements, including clarification on the meaning of "gag clause" and the attestation process. FAQ 69 continues the trend of answering questions about the prohibition and requirements. This latest FAQ provides the following clarifications:

- Downstream agreements that contain gag clauses violate the Gag Clause Prohibition.
    - For this purpose, a downstream agreement is where the TPA or other service provider that offers access to a network of providers may have separate agreements with entities other than the plan (or carrier) to provide or

administer the plan's (or carrier's) network. Restrictions in those downstream agreements will also constitute a prohibited gag clause if the plan (or carrier) is restricted from providing, electronically accessing or sharing information described in (1).

- Agreements between healthcare providers, networks, TPAs, or other service providers and plans may not restrict de-identified claims data from being shared between the plan and a business associate,

- A limitation on the scope, scale, or frequency of electronic access to de-identified claims and encounter information is a restriction on de-identified claims and encounter information or data that is prohibited by the Gag Clause Prohibition, to the extent the provision places unreasonable limits on the ability of plans and issuers to access such information upon request. The FAQ includes the following examples of some restrictions on an audit or claims review that would be considered an impermissible gag clause:

    - Limiting access to a statistically significant or the "minimum necessary" number of de-identified claims;

    - Limiting the scope of access to the data to specific, narrow purposes (such as limiting access to the context of an audit);

    - Unreasonably limiting the frequency of claims reviews (e.g., no more than once per year);

    - Limiting the number and types of de-identified claims that a plan or issuer may access;

    - Restricting the data elements of a de-identified claim that a plan or issuer may access; and

    - Providing access to de-identified claims data only on the TPA's or service provider's physical premises.

- Plans and issuers that are aware of the presence of a gag clause in their agreements must still submit the annual GCPCA. They may use the GCPCA webform system in the text box labelled "Additional Information" on Step 3 for this purpose. Such additional information includes (but is not limited to):

    - any prohibited gag clauses that a service provider has refused to remove;

    - the name of the TPA or service provider with which the plan or issuer has the agreement containing the prohibited gag clause;

    - conduct by the service provider that shows the service provider interprets the agreement to contain a prohibited gag clause;

    - information on the plan's or issuer's requests that the prohibited gag clause be removed from such agreement; and

    - any other steps the plan or issuer has taken to come into compliance with the provision.

It is important to note that The Departments have indicated that a plan or issuer that submits an attestation of compliance that includes such additional information will be considered to satisfy the requirement to submit a GCPCA, and the Departments will consider good-faith efforts to self-report a prohibited gag clause in any enforcement action.

Employer Action

The requirements of the NSA are handled by carriers and TPAs but typically at an additional cost per claim subject to NSA requirements. Employers sponsoring group health plans may receive communications from carriers or TPAs related to this guidance. Plan sponsors may also want to confirm that their carriers or TPAs are complying with all NSA requirements related to calculation and disclosure of QPAs as it relates to the QPA calculation method.

Plan sponsors should also expect to comply with the GCPCA requirements.

- For fully insured plans, most carriers are subject to the gag clause prohibition and will submit the attestation on behalf of the carrier's own responsibility and that of the plan. Employers sponsoring fully insured plans should confirm the carrier will submit the GCPCA and that their contracts are free from prohibited gag clauses.

- For self-funded plans (including level funded), most TPAs and other vendors will not submit the GCPCA on behalf of the plan. This is an employer's responsibility. It will be important to confirm with vendors that there are no gag clauses (including in downstream agreements). As noted in the FAQ, even if there are gag clauses in the agreements, plans must still submit the attestation.

- A limitation on the scope, scale or frequency of electronic access on de-identified claims is a prohibited gag clause as is restricting plans from accessing de-identified claims data. Carriers or TPAs that impose limits or restrictions on accessing de-identified claims data or sharing such data with business associates of the plan have impermissible gag clauses.

We will continue to monitor developments in this area.

New Guidance Provides Additional Details on Form 1095-C Reporting Relief

Issued date: 02/28/25

On February 21, 2025, the Internal Revenue Service ("IRS") released Notice 2025-15 (the "Guidance") providing guidance on an alternative method for furnishing Form 1095-C (and Form 1095-B) to individuals under the Affordable Care Act ("ACA"). The Guidance includes information on how to provide notice that the employer will use this new method for furnishing the applicable form to employees and covered individuals.

Background

Prior to the Paperwork Burden Reduction Act (the "Act"), large employers were required to provide all full-time employees with a Form 1095-C and most employers with a self-funded (or level-funded) plan were required to provide a Form 1095-C or Form 1095-B (the "Forms") to any primary insured. These Forms could be provided to individuals via mail or electronically with appropriate notice and consent.

In December of 2024, the Act was signed into law; it permits employers to provide these Forms only upon request if certain requirements are met, including providing advanced notice to covered individuals.

It is important to note that that the Act **does not** alter an employer's obligation to provide reporting to the IRS. All 2024 Forms must be timely furnished to the IRS by March 31, 2025.

Notice 2025-15

The Guidance describes how an employer may notify full-time employees (and other covered individuals) that it will take advantage of the relief and only furnish the Forms upon request.

- **Content.** The notice to full-time employees and covered individuals should:
    - be written in clear language with font size large enough (or provide other visual cues) to call to the reader's attention that the notice contains important tax information; and
    - contain a statement that individuals have a right to receive a copy of the Forms upon request as well as contact information (e-mail, mailing address, and phone number) and instructions on how to request a copy of the Forms.

- **Timing.** Per the Guidance, notice must be posted by the due date for providing the Forms, including the automatic 30-day extension. This means, for 2024 statements, this notice must be posted by **March 3, 2025**. The notice must also be accessible through October 15 of the following year. In addition, if a Form is requested by a participant, it must be provided by the later of 30 days following the request or January 31 of the following year.
- **Posting the Notice.** The notice may be posted in a location on the employer's website that is reasonably accessible to all individuals. For example, a reporting entity's website provides a clear and conspicuous notice if it includes a statement on the main page – or a link on the main page, reading "Tax Information," to a secondary page that includes a statement in capital letters "IMPORTANT HEALTH COVERAGE TAX DOCUMENTS."

Unfortunately, the Guidance did not include a sample notice. Rather it referred to a notice description found in previously issued regulations.

Employer Action

Employers subject to reporting obligations under the ACA should review their current delivery policies and procedures to determine whether to take advantage of the relief provided by the Act and detailed in the Guidance. Since the IRS had not issued a sample notice, cautious employers may want to furnish the Forms 1095-C (or 1095-B) as they have in past years until the IRS issues further guidance.

Employers who wish to take advantage of this relief should work with any reporting vendors they use for reporting in order to comply with any pre-existing contractual arrangements.

Employers that utilize this new furnishment method must post the notice by **March 3, 2025**.

Employers that are not taking advantage of this alternative method should prepare to furnish Forms 1095-C (or 1095-B) for calendar year 2024 by **March 3, 2025**.

It should be noted that employers that are required to furnish Forms 1095-C (or 1095-B) pursuant to a state individual coverage mandate may still need to furnish these Forms as they have in prior years to covered employees who reside in states with an individual mandate (e.g., California, Washington D.C., New Jersey, and Rhode Island).

Further all 2024 Forms 1095-C must be filed with the IRS electronically along with a Form 1094-C by **March 31, 2025**.

New Executive Order Addresses Price Transparency Rules

Issued date: 03/17/25

On February 25, 2025, President Trump signed an Executive Order (EO 14221), directing federal agencies to update the existing health care price transparency guidance and enforcement efforts.

Background

In 2019, Executive Order 13877 (EO 13877) directed the Departments of Labor, Health and Human Service and the Treasury (collectively, "the Departments") to create regulations for hospitals and health plans to establish price and quality transparency resources.

In response, the Departments issued final transparency rules requiring:

- a price comparison tool with price estimates of all common health care items and services; and
- machine-readable files ("MRF") posted (and timely updated) by hospitals and health plans detailing in-network and out-of-network pricing for medical services and prescription drugs.

It should be noted that for group health plans, the requirement to create and post the MRF for in-network rates and out-of-network allowed amounts went into effect for plan years beginning on and after January 1, 2022 (with enforcement deferred until July 1, 2022 pending guidance). In 2023, the Departments issued guidance announcing their intent to develop and issue technical requirements and an implementation timeline for the prescription drug MRF. To date, this guidance has not been released.

New Price Transparency and Enforcement Guidance

EO 14221 builds on the existing transparency rules and directs the Departments to issue guidance within 90 days (by May 26, 2025). The EO directs the Departments to:

- replace cost estimates with actual prices for health care services and items;
- standardize how hospitals and health plans report pricing data to members; and
- strengthen enforcement policies to ensure compliance with the price transparency requirements.

Employer Action

Currently, there are no immediate action items for employers.

As a reminder, with respect to the transparency requirements currently in effect:

Fully insured plans: Health insurance carriers remain responsible for compliance with transparency requirements. Employers should obtain written confirmation that the carrier posts this information on behalf of the plan.

Self-funded plans: Employers are responsible for ensuring compliance but may contract with third-party administrators (TPAs) and pharmacy benefit managers (PBMs) to fulfill these obligations.

Generally, an employer sponsoring a self-funded plan can satisfy the MRF disclosure requirements by entering into a written agreement under which a TPA posts the MRFs on its public website on behalf of the plan. However, if the TPA fails to do so, the plan is liable. Employers without such a written agreement should post a link to the TPA's MRFs.

When the Departments provide their guidance, employers should reach out to their carriers, TPAs, and PBMs to understand how they plan to comply with the new transparency requirements and whether updates to service agreements may be necessary.

We will continue to monitor these developments and provide updates as new information becomes available.

Tobacco Surcharges Face Growing Scrutiny in Recent Lawsuits

Issued date: 03/19/25

There has been a recent uptick in class action litigation filed against large group health plan sponsors alleging that the additional insurance premiums levied against tobacco users ("tobacco surcharges") through their wellness programs violate HIPAA nondiscrimination rules.

The litigation reminds employers to carefully review their plan designs for compliance with these rules. Below you will find a summary of the arguments being put forth by the plaintiffs as well as some high-level considerations for employers when implementing tobacco related incentives.

Background

The HIPAA nondiscrimination rules prohibit group health plans from discriminating against plan participants on the basis of a health status-related factor, including tobacco use. There is an exception that allows for the use of incentives or surcharges ("rewards") through a wellness program.

A program that imposes premium surcharges on individuals who use tobacco is considered a health-contingent wellness program and must comply with the following five requirements:

1. There must be an opportunity to qualify for the incentive (or avoid the surcharge) at least once a year.
2. The amount of the reward cannot exceed 50% of the cost of the coverage under the plans.
3. The program must be designed to promote health and prevent disease.
4. The reward must be available to all similarly situated individuals and provide for a reasonable alternative.
5. Plan materials describing the wellness program must include a disclosure of the availability of a reasonable alternative.

The Litigations

While lawsuits challenging tobacco surcharges are not new, the number of suits being filed (and filed as potential class actions) is new. The lawsuits primarily target very large, self-insured health plans such as those sponsored by 7-Eleven;

Walmart; XPO, Inc.; Target; Nike; Campbell Soup Company; and Tractor Supply Company. So far, no court has ruled on the merits and only one has been voluntarily dismissed—the plaintiff in Walmart filed a voluntary dismissal back on December 13, 2024. The Department of Labor has also focused on the surcharges, filing an action against Macy's in September 2024.

The plaintiffs allege that plan sponsors are violating their fiduciary duties and violating HIPAA because the wellness program at issue discriminates against them on the health status-related factor of tobacco use. Allegations common within each lawsuit include the plan sponsors' failure to:

- provide a reasonable alternative standard to being tobacco-free;
- disclose the reasonable alternative standard to the surcharge in plan materials discussing the wellness program; and/or
- provide the full reward once a reasonable alternative is satisfied.

While it is still early in the litigation process, it appears that most group health plans are fighting back in these cases. However, at least one plan offered by Bass Pro Groups LLC became the first to file a notice of class action settlement related to their tobacco surcharge lawsuit in the United States District Court for the Western District of Missouri.

It is still too soon to tell the expected outcome from the remaining lawsuits, as none of the other defendants have indicated an interest in settling to date.

Tobacco Surcharges

These lawsuits do not mean that all tobacco surcharges violate the HIPAA nondiscrimination rules. As described earlier, there are five requirements for health contingent plans that must be met.

As reflected in the allegations contained in the lawsuits, employers may not understand or implement the requirements correctly. The following summarizes some common issues employers fail to address in their tobacco-surcharge programs.

- *Reasonable Alternative.* Employers must offer a reasonable alternative to earn the reward without satisfying the health-related standard. In other words, for those who are not "tobacco free" there must be another way they can earn the reward (or avoid the surcharge). This may be through participation in a tobacco cessation program or through a program recommended by their doctor. Often, employers fail to offer another way to earn the reward (or avoid the surcharge).
- *Full reward must be available.* When an individual earns the reward by completing the reasonable alternative standard (e.g., attend a smoking cessation class) the full reward must be made available. The reward cannot be pro-rated for only those months after the individual met the standard. It also cannot be conditioned on the individual being a "non-smoker."
- *Disclosure.* Finally, it's important that plan materials describing the wellness program include language that notifies individuals of the availability of a reasonable alternative standard. Model language is provided by the Department of Labor:
    - Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at [insert contact information] and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Employer Action

Employers offering wellness programs with tobacco surcharges should monitor developments as these lawsuits progress. They should also review their program to ensure it meets the requirements under the HIPAA nondiscrimination rules.

Michigan Amends the Earned Sick Time Act and Minimum Wage

Issued date: 03/27/25

The Michigan Legislature recently passed amendments to the Earned Sick Time Act ("ESTA") and the Improved Workforce Opportunity Wage Act ("Wage Act") in response to the Michigan Supreme Court's decision in the *Mothering Justice v. Attorney General*. This means a higher minimum wage and increased sick leave for employees that became immediately effective on February 21, 2025.

Earned Sick Time Act

Michigan employers with at least 1 employee are now required to offer sick leave annually to employees. The only exception is the United States government. Who is considered an employee is broadly defined with only 4 enumerated exceptions. The four exceptions are: (1) an individual employed by the United States government; (2) an unpaid intern or trainee; (3) an individual employed in accordance with the youth employment standards act; and (4) an individual whose arrangement meets requirements enumerated in the act.

Employees accrue 1 hour of leave for every 30 hours worked. Regarding the number of hours of leave able to be accrued, there is a distinction between small employers with 10 or fewer employees and large employers with more than 10 employees. The total number of employees is based upon total employees on payroll and not limited to employees located in Michigan. However, only Michigan employees are entitled to sick leave.

Employer Requirements

Large employers must provide 72 hours of paid sick leave each calendar year. Small employers must offer 40 hours of paid sick leave and are exempt from complying with ESTA until October 1, 2025. Additionally, if a small business did not employ an employee on or before February 1, 2022, then the small employer does not have to begin to provide sick leave or otherwise comply with ESTA until 3 years after the date the first employee was hired.

Regardless of employer size, the employer does have the option of offering more leave. Employees must carry over all accrued but unused sick time; however, an employer is not required to allow the employee to use more than 72 hours (large employers) or 40 hours (small employers) 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. An employer can impose a waiting period of 120 days for any new employee hired on or after February 21, 2025, before they are eligible to use accrued time. Employers must maintain records that show the hours worked and sick time taken for each employee for a minimum of 3 years.

If an employer frontloads leave at the beginning of the year, the employer is exempt from: (1) allowing employees to carryover hours to the following year, (2) calculating and tracking an employee's accrual of sick leave, and (3) paying the employee the value of the employee's unused accrued paid earned sick time at the end of the year in which the earned sick time was accrued. Frontloading though does not absolve the employer of maintaining records for 3 years.

Employees are allowed to take sick leave in one-hour increments or "the smallest time increment that the employer uses to account for absences of use of other time."

Part-Time Employees

Regardless of employer size, employers have options regarding compliance for part-time employees. Employers can follow the standard accrual method or use an alternative method to provide the part-time employee at the beginning of the year with sick leave hours available for immediate use if:

- The employer provides this employee with written notice of how many hours the employee is expected to work over the next year when hired;
- The amount of the sick leave provided is, at a minimum, proportional to the earned time the employee would have earned if the employee worked all the hours expected that was detailed in the written notice; and
- If the employee works more hours than detailed in the written notice, the employer must provide the employee the additional sick leave in accordance with the accrual requirements.

Notice Obligations, Documentation & Miscellaneous

Notice obligations vary depending whether the use of sick leave is foreseeable or not. If the need for taking leave is foreseeable, then an employer can require advance notice not to exceed 7 days prior before the date of the leave. If the leave is not foreseeable, the employer can require notice:

- As soon as practicable; or
- In accordance with the employer's policy regarding use of sick time or leave if:
    - On the date of hire, effective date of ESTA or effective date of employer's policy (whichever is latest) the employer provides the employee with a written copy of its policy detailing the procedure for how the employee must provide notice; and
    - The employer's notice requirement allows the employee to provide notice after the employee is aware of the need for the sick time.

An employer may require documentation if sick leave is taken for more than 3 consecutive days, but if they do, the employer will be responsible for any out-of-pocket costs associated with obtaining the documentation. The employee must provide this documentation within 15 days of the employer's request and the employer then has the obligation to keep confidential health information and any information related to domestic violence and sexual assault.

The ESTA also includes anti-retaliation provisions when an employee uses sick leave. Failure to comply with ESTA could result in the Director of Licensing and Regulatory Affairs ("LARA"):

- Imposing civil remedies such as payment of earned sick time, back pay, damages incurred, and reinstatement in the case of job loss
- $1,000 administrative fine with the potential for an additional civil fine up to 8 times the employee's normal hourly wage
- A civil action filed on behalf of the employee

Minimum Wage Law

Beginning February 21, 2025, the legislation created a phased-in approach to minimum wage requirements and adjustments to the tip credit. The tip credit will not be phased out and will diminish by 2% annually until 2031 when the tipped worker's wage would equal 50% of the state's full minimum wage.

Date	Minimum Wage	Tip Credit Rate
February 21, 2025	$12.48	38% of minimum wage
January 1, 2026	$13.73	40% of minimum wage
January 1, 2027	$15.00 plus inflation adjustment	42% of minimum wage
January 1, 2028	Inflation adjusted	44% of minimum wage
January 1, 2029	Inflation adjusted	46% of minimum wage
January 1, 2030	Inflation adjusted	48% of minimum wage
January 1, 2031	Inflation adjusted	50% of minimum wage

Employer Action

Employers should:

- Review sick leave policies to ensure that accrual periods are calculated correctly.
- Ensure that sick leave policies allow employees a minimum of 40 hours (small employers) or 72 hours (large employers) of sick leave annually.
- Prepare written notice of the sick leave policy and distribute the notice in English and, Spanish (MI Licensing and Regulatory Affairs has sample notices posted on their website).
- Amend document retention policies to maintain sick leave records for at least 3 years
- Adjust hourly rates when the State's Treasurer releases the new minimum wage adjusted for inflation.
- Review affordability of plans 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 Affordable Care Act.
- Consult with employment counsel if intending to rely upon any exceptions in the ESTA to ensure meeting definitions and other obligations.

Massachusetts Releases 2026 MCC Amounts

Issued date: 03/28/25

The Commonwealth Health Insurance Connector Authority (“Health Connector”) recently published Administrative Bulletin 01-25 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 2026 and provides those respective dollar amounts. All limits increased from 2025.

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 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 01-25 sets the 2026 maximum MCC deductibles as $3,200/$6,400. If the plan has a separate prescription drug deductible, the amounts cannot exceed $400/$800 and the total maximum deductible applies.

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 2026, the OOPMs under MCC will be $10,150/20,300.

Effective Dates

Administrative Bulletin 01-25 takes effect immediately; the changes applicable to employer-sponsored plans will be incorporated with plan years beginning on or after January 1, 2026.

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