Employer **focus**

Benefits Compliance Newsletter for Employers | Q2 2024

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Second Quarter Benefits News Highlights

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Form 5500 Extensions (for calendar year plans)

The Form 5500 for an ERISA plan is due the last day of the seventh month after the end of the ERISA plan year, including short plan years. So, for a calendar year plan, the Form 5500 is generally due on July 31st. An extension of up to 2 1/2 months is available for employers that request an extension using Form 5558 (Application for Extension of Time to File Certain Employee Plan Returns). Form 5558 must be filed with the IRS, not with the DOL. If Form 5558 is filed on or before the normal due date of the Form 5500, the extension request will be automatically granted; no approval is necessary. For a calendar-year plan, the 2 1/2-month extension will result in a Form 5500 due date of October 15th.

2

Educational Assistance Programs – New IRS FAQs

The IRS released a set of FAQs that do not appear to make any changes, but simply clarify the tax-favored reimbursement available via educational assistance programs offered by employers to employees. Code §127 permits employers to reimburse employees for payments for tuition, fees and similar expenses, books, supplies and equipment. Through the end of 2025 (unless extended further by legislation), employers may also reimburse employees for principal or interest payments on qualified education loans. Such reimbursements may be excluded from employees' taxable income up to $5,250 per calendar year.

3

Gag Clause Attestation Updates for 2024

CMS released updated instructions and an updated user manual to assist responsible entities with submitting gag clause attestations by December 31, 2024 via CMS' website portal. As a reminder, the gag clause prohibition and corresponding annual attestation requirements apply to virtually all employer-sponsored health plans, but not excepted benefits (e.g., stand-alone dental or vision, health FSA, EAP), retiree-only plans, or account-based plans (e.g., HRAs). For 2024, minor changes were made to the webform to allow selection of an attestation year and attestation period and to further clarify the type of plan

that is reporting and the type of provider agreements included in the attestation. The webform now also includes a text box that allows for an explanation of the attestation if needed.

4

PCORI Fee Reminder

The PCORI fee for group health plans that ended sometime during 2023 must be reported and paid by July 31, 2024. Health insurance carriers pay the fee on behalf of fully-insured plans, but employers are responsible for reporting and paying the fee for any self-funded group health plans, including HRAs. The fees due in July 2024 are as follows:

- $3.00 per covered life for plan years ending in January – September 2023.
- $3.22 per covered life for plan years ending in October – December 2023.

Average covered lives used for reporting and paying the PCORI fee may be determined using one of three methods: (i) the actual count method; (ii) the snapshot method; or (iii) the Form 5500 method. The fee is reported and paid by employers sponsoring self-funded group health plans using quarterly excise tax Form 720, Line 133(c) and (d), and should be filed for the 2nd quarter ending June 30th, 2024.

5

§1557 Nondiscrimination Final Rules

The Department of Health & Human Services (HHS) finalized rules that expand the requirements previously set forth in agency interpretations of the ACA's §1557 nondiscrimination requirements, which prohibit covered entities from discriminating against individuals on account of race, color, national origin, sex, age, and disability in providing health programs and activities. Based on the final rules, the definition of a "covered entity" will now include health insurance carriers receiving any federal financial assistance from HHS as well as third party administrators operated by such carriers. That being the case, most employers other than those in a health-related role will not be covered entities directly subject to these rules. The rules clarify that employers and plan sponsors are not directly subject to §1557 requirements on behalf of their group health plan offerings unless the group health plan itself receives federal financial assistance from HHS (e.g., Medicare Part D subsidies). This is true for group health plans offered by covered entities or non-covered entities. However, because many employers obtain group health plan coverage from carriers or TPAs who would be covered entities that are required to offer plan designs and/or perform plan administration in accordance with §1557 nondiscrimination requirements, the group health plan offerings available to employers beginning in 2025 may see some changes. Specifically for group health plan offerings, things such as eligibility rules, cost-sharing, and coverage exclusions and limitations, should all be designed and administered in a way that does not discriminate on the basis of race, color, national origin, sex, age, disability, or any combination thereof. The rules do not provide specific examples of types of exclusions or limitations that might be discriminatory. There is limited guidance clarifying that the rules do not require coverage of abortions, but that broad exclusions or coverage limitations tied to gender transition or gender-affirming care would be discriminatory based on the broadened definition of sex. NOTE: There is an exception for compliance with any portion of §1557 requirements that covered entities find would violate their rights under Federal conscience or religious freedom laws.

6

IRS Request for Comment – ACA Employer Reporting (Form 1094-C & Form 1095-C)

The IRS is looking for feedback on the ACA employer reporting process, specifically the reporting on offers of coverage to full-time employees that is required of applicable large employers (50 or more FTEs). The IRS is asking for comments regarding: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the

burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information. It is possible that this feedback could lead to changes (hopefully simplification) of the annual reporting requirements and processes.

7

Advance EOB

One of the transparency requirements set forth in the Consolidated Appropriations Act of 2021 requires providers and group health plans to coordinate to provide a good faith estimate of the expected charges in advance of an individual receiving treatment or services. These provisions were originally scheduled to go into effect for plan years beginning on or after January 1, 2022, however, the agencies received feedback from the industry about the challenges of developing the technical infrastructure necessary for medical providers to transmit the necessary information to plans and carriers. The agencies released a Request for Information (as proposed regulations) in an effort to better determine and establish appropriate data transfer standards, amongst other things. Then just last week, the agencies released a summary providing a progress report of sorts. The summary indicates that because the advance explanation of benefits (EOB) will "require payers and providers to exchange health data in a way that has not been done before, technology will need to adapt to ensure that providers and payers can comply." The current recommendation is to develop a single data exchange standard that could be used for this purpose, which will take time. The summary suggests the agencies are continuing in these efforts, which are seen to play a critical role in price transparency and patient protections, but the actual requirements will not be going into effect for group health plans any time soon.

8

Association Health Plans – Final Rules

Back in 2018, agency rules provided a path for small employers and working owners to form association health plans (AHPs) that could offer a large group health plan to members who otherwise would have been required to offer small group market coverage. In addition, it would have allowed the AHP to be treated as a single plan for ERISA purposes rather than treating each participating employer as a separate ERISA plan sponsor. A court decision in 2019 invalidated portions of the final rule, removing the expanded AHP option. In an effort to clarify things, the agencies provided regulations that formally rescind the 2018 AHP rules and confirm that in most cases, when unrelated entities offer shared benefits via a multiple employer welfare arrangement (MEWA), the coverage available for a participating member will be based on that particular member's size, and each participating member will be seen as sponsoring their own separate group benefit plan(s). For the vast majority of employers, these rules will not have any impact, and employers participating in established, industry-based AHPs should be okay under the pre-2018 rules. The formal repeal of the 2018 AHP rules just reinforces that it is generally difficult for unrelated employers to band together to offer coverage to their employees.

9

IRS Priority Guidance Plan

The IRS responsibilities are widespread, and for employee benefits, the IRS often focuses more heavily on retirement plans. However, the most recent priorities guidance plan suggests a continued focus on §4980H assessments and collections. Therefore, applicable large employers (50 or more FTEs) should ensure that minimum value, affordable coverage is being offered to full-time employees and reported accurately using Form 1094-C and Form 1095-Cs.

10 —

2025 Notice of Benefit & Payment Parameters

The agencies released finalized 2025 Benefit and Payment Parameters regulations. The guidance generally focuses on the administration of the public Marketplaces, but also provides significant clarification on coverage requirements for prescription drugs. The regulations require that any prescription drugs covered in excess of the minimum number of drugs required to be covered under a state's benchmark plan are required to be covered as essential health benefits (EHBs) unless the coverage is provided solely to comply with a state coverage mandate. This means that prescription drugs covered under a group health plan cannot be categorized as non-EHB subject to annual or lifetime dollar limits or excluded from maximum out-of-pocket limits. While the guidance is focused primarily on coverage requirements for non-grandfathered individual and small group fully-insured plans, a corresponding FAQ suggests additional guidance is coming that will extend similar rules to large fully-insured group health plans and all self-funded group health plans.

11 —

Handling Level-Funded Plan Surplus Returns

We recommend treating these surpluses/refunds similar to how MLR rebates are handled for fully-insured group health plans. If there is plan document language specifically permitting the employer to keep any surplus/refund, which we're finding carriers are including more often in contracts, or if the plan document indicates that employee contributions will be used first to pay claims and claims exceed employee contributions for the plan year, then the employer may simply keep the surplus and use it as desired for any business expenses. On the other hand, if plan document language doesn't clearly permit the employer to keep the surplus, it would be best to treat at least a percentage of the surplus (equal to the percentage of employee contributions to total premiums) as plan assets. The plan assets must be used solely for the benefit of plan participants, which may require a distribution to plan participants as a premium holiday or taxable cash within 90 days of receipt.

12 —

All Payer Claims Database (APCD)

Employers may be receiving letters from their TPAs requesting that employers sponsoring self-funded plans opt-in or out of the All Payer Claims Database (APCD). This is not a federal requirement, but rather one that has been adopted by several states. Fully-insured and non-ERISA plans must report plan eligibility and claims information to the applicable state database which is then used to gain better intel about healthcare costs, trends, etc. Self-funded plans are not required to participate, but can choose to. The major benefit of choosing to participate is that the employer is contributing to the effort to lower overall health care costs. Some potential negatives are the hassle of providing the information, especially if the TPA will charge additional fees for the administration, and privacy concerns both for individual participants as well as broader use of the shared data.

FEATURE: Medicare Part D Creditable Coverage Notice & Reporting

NOTE: For 2025, Medicare Part D coverage will increase, making it harder for employer-sponsored prescription drug coverage to meet creditable status, especially high deductible health plans (HDHPs). Employers are not required to offer creditable coverage. However, employers must determine and communicate creditable status to eligible employees and their family members because if the prescription drug coverage is non-creditable, Medicare-eligible individuals probably shouldn't delay enrollment in Medicare Part D; doing so may result in late penalties for those who go more than 63 days without creditable prescription drug coverage.

Background

Employers sponsoring a group health plan that provides prescription drug coverage are required to determine whether the prescription drug coverage is creditable and then must communicate creditable or non-creditable coverage status annually to eligible employees and their family members and to the Centers for Medicare & Medicaid Services (CMS). The information assists individuals in making an informed decision about whether to enroll in Medicare Part D. Individuals who delay enrollment may face late enrollment penalties for failing to enroll in Part D when they are first eligible if it turns out that the employer's prescription drug plan is not creditable. The information reported to CMS helps them to determine when there might be other creditable coverage available to individuals who are eligible for Medicare.

Plans Required to Comply

Any group health plan that provides prescription drug coverage is required to determine the plan's creditable status, provide the required notice, and report to CMS. There is no exception for small employers.

Determining Whether an Employer's Prescription Drug Coverage Is Creditable

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D. In other words, coverage is creditable if the expected amount of paid claims for prescription drugs under the coverage is at least as much as the expected amount of paid claims under the standard Medicare Part D benefit. Often an insurance carrier or third-party administrator will provide information to a plan sponsor detailing whether a plan's drug coverage is creditable. But if a plan sponsor does not receive this information from the carrier or administrator, the plan sponsor (e.g., the employer) is responsible for making the determination, or for hiring an actuary to help with the determination. Medicare Part D prescription drug coverage will expand in 2025 as required under the Inflation Reduction Act (IRA), which could impact whether an employer's group health plan provides creditable prescription drug coverage.

Simplified Method for Determining Creditable Status – Changes in 2026

Guidance issued in 2009 provided a "simplified method" for determining whether the prescription drug coverage in a plan is creditable. The method was available so long as the plan sponsor was not applying for the subsidy available to sponsors of a qualified retiree prescription drug plan. Plans meeting the simplified method were considered creditable. Due to the stringent requirements, many plans did not satisfy the simplified method (e.g., HDHPs) and were then forced to instead turn to carrier/administrator or actuarial determinations. Details for the simplified method description can be found here – https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/CCSimplified091809.pdf

CMS guidance indicates that the simplified method will continue to be available for 2025, but that it may be changed or no longer available beginning in 2026. See final Part D redesign program instructions here - https://www.cms.gov/files/document/final-cy-2025-part-d-redesign-program-instructions.pdf.

Required Disclosure of Creditable Coverage to Eligible Plan Participants

Detailed guidance from CMS on these disclosures can be found here - https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/Updated_Guidance_09_18_09.pdf

Content of the Disclosure

Disclosures of creditable (or non-creditable) coverage must address the following:

- That the employer has determined that the prescription drug coverage is creditable (or non-creditable);
- The meaning of creditable coverage;
- That an individual generally may only enroll in a Part D plan from October 15 through December 7 of each year; and
- Why creditable coverage is important and that the individual could be subject to payment of higher Part D premiums if there is a break in creditable coverage of 63 days or longer before enrolling in a Part D plan.

CMS makes model notices available in both English and Spanish for purposes of the disclosure requirement. The model notices can be found on CMS' page here – https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html

Timing of the Disclosure

The notice is required to be provided to Medicare Part D eligible individuals at the following times:

1. Prior to commencement of the annual enrollment period for Medicare Part D (Oct. 15);
2. Prior to an individual's initial enrollment period (IEP) for Medicare Part D;
3. Prior to the effective date of coverage for any Medicare Part D eligible individual who enrolls in the plan sponsor's prescription drug coverage;
4. Whenever the employer no longer offers prescription drug coverage or changes it so that it is no longer creditable or becomes creditable; and
5. Upon request by a Medicare Part D eligible individual.

TIP for Distribution Timing

The first three occasions use the term "prior to," which according to CMS means within the last 12 months, so the employer can meet the first three timing requirements by providing the notice at the following times:

- Each year during the employer's open enrollment period, or in late September/early October to coincide with the Medicare Part D open enrollment period; and
- When individuals are first eligible for the prescription drug coverage (e.g., new hires).

Who Is Entitled to Receive the Disclosure

The notice must be provided to Medicare Part D eligible individuals who are eligible to enroll in the plan sponsor's prescription drug plan. This includes employees, COBRA participants, and retirees, as well as their spouses and dependents. Individuals are

eligible for Medicare Part D if they are enrolled in either Medicare Part A or Medicare Part B and live in the service area of a Medicare Part D plan. In other words, if somebody is both Medicare Part D eligible AND eligible to enroll in the plan sponsor's prescription drug plan, a notice is required.

Since it may be difficult for a plan sponsor to identify which individuals are eligible for Medicare Part D (e.g., spouses or disabled dependents), many plan sponsors choose to provide the disclosure notice to everyone who is eligible to enroll in their prescription drug plan.

Method of Delivery for the Disclosure

When providing the notices, CMS prefers using paper documents because Medicare Part D eligible individuals are more likely to receive and understand them, and because it is easier to ensure that paper documents have been received by both employees and eligible spouses and dependents. However, although paper notices sent by mail are preferred, the notices may be sent electronically in accordance with the Department of Labor's (DOL's) electronic delivery safe harbor for required ERISA disclosures. The safe harbor allows for electronic distribution to those who have access to the employer's electronic system as an integral part of their daily duties at their regular workplace, and to those who provide consent to an electronic distribution.

CMS has indicated that a plan sponsor providing a disclosure notice may generally provide a single notice to both the eligible individual and all his or her eligible dependents. However, a separate disclosure notice must be provided if the plan sponsor knows that any eligible spouse or dependent resides at a different address from the participant.

Required Reporting to CMS

In addition to the disclosure requirements to eligible individuals, plan sponsors of prescription drug plans are also required to report to CMS annually, within 60 days after the beginning of the plan year. For example, for a 2023 calendar year plan, the employer should report by early March 2023 on whether the coverage offered for 2023 is creditable or non-creditable. Note that this reporting requirement is also separate and distinct from the Medicare Secondary Payer reporting requirements under Section 111 that are due to CMS on a quarterly basis and typically handled by the insurance carrier or administrator. Reporting to CMS on the creditable status of the prescription drug coverage is generally the responsibility of the employer. This reporting is done electronically. The instructions and online form for reporting creditable status to CMS can be found here - https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure

FEATURE: HIPAA Privacy Rule to Support Reproductive Health Care

Deemed necessary by the Department of Health and Human Services (HHS) following the U.S. Supreme Court's decision in Dobbs v. Jackson Women's Health Organization and its aftermath of state-level abortion laws, HHS has issued a HIPAA Privacy Rule to Support Reproductive Health Care Privacy (the "2024 Privacy Rule"). The 2024 Privacy Rule amends the HIPAA privacy rule to afford greater protection to protected health information (PHI) that is related to reproductive health care, with the goal of maintaining the necessary trust between patient and healthcare provider. The 2024 Privacy Rule also supports President Biden's Executive Order on protecting access to reproductive health care, and specifically directing HHS to consider additional actions, including under HIPAA, to enhance protection for information related to reproductive health care.

2024 Privacy Rule Summary

The primary purpose of the 2024 Privacy Rule is to further restrict the use or disclosure of PHI related to reproductive health care. Previously, HIPAA-regulated entities (i.e., covered entities and business associates) were generally permitted to disclose PHI for certain public policy-related reasons, including law enforcement. The 2024 Privacy Rule further restricts this permission by prohibiting such entities from disclosing PHI related to lawful reproductive health care in certain situations. To support this effort, the 2024 Privacy Rule adds and clarifies a couple definitions, imposes a new attestation requirement to be used upon receipt of a request for PHI potentially related to reproductive health care, and requires covered entities to make changes to their Notice of Privacy Practices.

New Definitions

Person

Previously, the term "person" was defined by the HIPAA rules as "a natural person, trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private." This definition has been clarified under the 2024 Privacy Rule to mean "a natural person (meaning a human being who is born alive), trust or estate, partnership, corporation, professional association or corporation, or other entity, public or private."

Reproductive Health Care

A new term, "reproductive health care," has been added as a subset of the term "health care," to mean health care "that affects the health of the individual in all matters relating to the reproductive system and to its functions and processes." This definition would include, but is not limited to:

- contraception, including emergency contraception;
- preconception screening and counseling;
- management of pregnancy and pregnancy-related conditions, including pregnancy screening, prenatal care, miscarriage management, treatment for preeclampsia, hypertension during pregnancy, gestational diabetes, molar or ectopic pregnancy, and pregnancy termination;
- fertility and infertility diagnosis and treatment, including assisted reproductive technology (e.g., in vitro fertilization (IVF));
- diagnosis and treatment of conditions that affect the reproductive system (e.g., perimenopause, menopause, endometriosis, adenomyosis); and
- other types of care, services, and supplies used for the diagnosis and treatment of conditions related to the reproductive system (e.g., mammography, pregnancy-related nutrition services, postpartum care products).

Public Health

A new definition of "public health" in the context of surveillance, investigation, or intervention will refer to "population-level activities to prevent disease and promote the health of populations," to be clearly distinguished from a criminal investigation.

New Category of Prohibited Use or Disclosure of PHI

Prohibited Purposes

Under certain conditions described below, HIPAA-regulated entities will be prohibited from using or disclosing PHI for the following purposes:

- To conduct a criminal, civil, or administrative investigation into a person, or to impose civil, criminal, or administrative liability on any person, for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or
- To identify any person for any purpose described above.

The use or disclosure of PHI for one of the above purposes will be prohibited if the HIPAA-regulated entity that receives the request for PHI can reasonably determine that one or more of the following three conditions exists:

1. The reproductive health care is lawful under the law of the state in which the care is provided and under the circumstances in which it is provided;
2. The reproductive health care is protected, required, or authorized under federal law, including the U.S. Constitution, under the circumstances provided, regardless of the state in which care is provided; or
3. The reproductive health care was provided by a person other than the HIPAA-regulated entity that receives the request for PHI and the presumption (described below) applies.

The presumption under the 2024 Privacy Rule is that reproductive health care provided by a person other than the HIPAA-regulated entity receiving the request for PHI was lawful unless the HIPAA-regulated entity has actual knowledge that the reproductive health care was not lawful under the circumstances in which it was provided; or the HIPAA-regulated entity receives factual information from the person making the request for the use or disclosure of PHI that demonstrates a substantial factual basis that the reproductive health care was not lawful under the circumstances in which it was provided.

Note that because of the types of requests to which these new rules apply, the covered entity may find itself having to defy what on its face would appear to be a valid subpoena, court order, or administrative request from law enforcement, a court or regulatory agency in order to satisfy its obligations under the HIPAA privacy rule.

The Attestation

When a HIPAA-regulated entity receives a request for PHI potentially related to reproductive health care, the entity must first obtain a signed attestation from the person requesting the information that the use or disclosure is not for a prohibited purpose. The requirement for an attestation will apply when the request for PHI is for any of the following reasons: health oversight activities; judicial and administrative proceedings; law enforcement purposes; and disclosures to coroners and medical examiners.

A valid attestation must include a clear statement that the use or disclosure of PHI is not for a prohibited purpose as well as a statement that a person may be subject to criminal penalties for knowingly obtaining or disclosing PHI in violation of HIPAA. The attestation must be written in plain language and cannot be combined with any other document (though other additional supporting documentation may be provided). A model of the attestation form is forthcoming from HHS.

It is a violation of HIPAA rules to rely on a defective attestation in the use or disclosure of PHI – a defective attestation includes one that contains an element or statement that is not required by the 2024 Privacy Rule (i.e., that goes above and beyond what is required). The attestation is also defective if the HIPAA-regulated entity has actual knowledge that material information in the attestation is false, or when a reasonable entity in the same position would not believe that the attestation is

true. In considering whether an attestation is true, an entity must consider the "totality of the circumstances surrounding the attestation," including who the requestor is and the permission upon which the requestor relies.

Effective Date

Compliance with the above amendments to the HIPAA Privacy Rule is required by December 22, 2024. While employers are unlikely to be the primary target of PHI requests subject to these new rules, employers should nevertheless plan to adjust their HIPAA policies and procedures and required HIPAA training for their workforce members that have access to PHI to satisfy these new rules.

Changes to Notice of Privacy Practices

The 2024 Privacy Rule also requires covered entities to make changes to their Notice of Privacy Practices that address both the new prohibited purposes of use or disclosure of PHI related to reproductive health care and the confidentiality of substance use disorder patient records that were originally addressed in a separate final rule that was released on February 16, 2024 (the Part 2 Final Rule).

Compliance with the changes to the Notice of Privacy Practices is expected by February 16, 2026. An updated model Notice of Privacy Practices is expected to be released by that time.

Summary

In complying with the 2024 Privacy Rule, employers will need to revise their HIPAA policies and procedures to account for the new category of prohibited use or disclosure of PHI as well as update their HIPAA training provided to any employees with access to PHI by December 22, 2024. That said, we are expecting further guidance from HHS, including a model attestation form to comply with the 2024 Privacy Rule.

Finally, employers will also need to update their Notice of Privacy Practices by February 16, 2026, though we do expect an updated model Notice of Privacy Practices to be issued by that time.