NEWFRONT

Office Hours Webinar:

Employee Benefits
Year in Review

January 16, 2025

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Today's Topics

2024 EB Year in Review

Plus What to Expect in 2025!

- The ACA continues to be a dominant force on the employee benefits landscape even as we move farther away from its birth in 2010.
- The CAA may not have been intended as a health bill, but it is proving to be the most significant health care reform effort since ACA (and bipartisan at that!). We're now at the full implementation phase.
- The election brings a new set of priorities to the White House. How will the change in President affect employee benefits?
- What else is new and interesting? Spousal incentive HRAs are becoming trendy as an interesting/creative way to offer a benefit that can cuts costs.

Year in Reivew Main Topics:

1. **The ACA Employer Mandate & ACA Reporting:** ACA reporting season looms with welcome changes this year (finally), that streamline the process by no longer requiring distribution to employees—plus new affordability percentage and A/B penalty amounts for 2025.
2. **The CAA:** The mega-bill's health plan-related provisions have now kicked into full gear as we reach the point of complete implementation in year five since passage at end of 2020.
3. **The White House Factor:** The Trump Administration will put their stamp on employee benefit policy as we move into the post-Biden era. What will change…what will stay the same?
4. **Other News:** 2025 limits, HSA relief for telehealth expires, student loan repayment assistance in final year, IRA changes to Medicare Part D affects employers, new HIPAA reproductive health rules with staggered effective dates, and the J&J class action grabs headlines and creates interesting questions.
5. **SIHRAs:** Each year brings a round of fresh benefit ideas to consider. This year, the biggest new kid on the block is the Spousal Incentive HRA approach for employees waiving the health plan. What are the compliance considerations?

01

The ACA Employer Mandate

& The Associated ACA Reporting Requirements

The ACA's Employer Mandate §4980H Penalties

Full Details: The ACA Affordability Determination in 2025

§4980H(a)—The "A Penalty" Aka: The "Sledgehammer Penalty"	§4980H(b)—The "B Penalty" Aka: The "Tack Hammer Penalty"

• **Failure to offer MEC to at least 95% of all full-time employees (and their children to age 26)**
• The A Penalty is triggered by at least one such full-time employee who is not offered MEC enrolling in subsidized exchange coverage
  • **2025 A Penalty liability is $2,900 annualized ($241.67/month) multiplied by all full-time employees**
  • **30 full-time employee reduction from multiplier**
	• Applies where the employer is not subject to the A penalty
	• **Failure to:**
	1. **Offer coverage that's affordable;**
	2. **Offer coverage that provides MV; or**
	3. **Offer MEC to a full-time employee (where employer offers at a sufficient percentage to avoid A Penalty liability)**
	• The B Penalty is triggered by any such full-time employee enrolling in subsidized exchange coverage
	• 2025 B Penalty liability is $4,350 annualized ($362.50/month) multiplied by each such full-time employee who enrolls in subsidized exchange coverage
	• Note that although the B Penalty amount is higher ($4,350 vs. $2,900), the multiplier is generally much lower (only those full-time employees not offered affordable/minimum value coverage who enroll in subsidized exchange coverage)

The ACA's Employer Mandate §4980H Penalties

Full Details: The ACA Affordability Determination in 2025

§4980H(a)—The "A Penalty" Aka: The "Sledgehammer Penalty"	§4980H(b)—The "B Penalty" Aka: The "Tack Hammer Penalty"
Simplified Version	**Simplified Version**

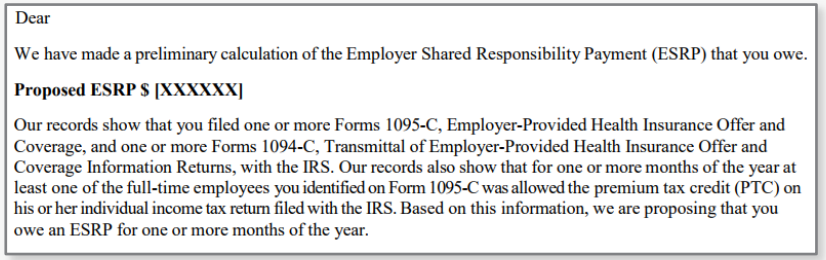
• To avoid the "A Penalty" **must offer MEC to at least 95% of full-time employees and their children to age 26**
• **2025 A Penalty liability is $2,900 annualized ($241.67/month)** multiplied by all full-time employees (reduced by first 30)
	• To avoid the "B Penalty", the offer of MEC must:
	  • **Be affordable; and**
	  • **Provide minimum value (MV)**
	• **2025 B Penalty liability is $4,350 annualized ($362.50/month)** multiplied by each such full-time employee who enrolls in subsidized exchange coverage

ACA Employer Mandate Penalties are Real

Full Details: Responding to IRS Letter 226J

IRS Letter 226J

- Applicable Large Employers (ALEs) have been receiving ACA employer mandate penalty assessments since late 2017
- ALEs continue to be informed of prior year penalty assessments
- Many penalties are the result of ACA reporting errors on the Forms 1094-C and 1095-C
- Explanation of reporting errors and corrected codes usually removes penalties
- Keep relevant data because Letters 226J are generally for two years prior
- Review full alert for details on how to respond to Letter 226J



Dear

We have made a preliminary calculation of the Employer Shared Responsibility Payment (ESRP) that you owe.

Proposed ESRP $ [XXXXXX]

Our records show that you filed one or more Forms 1095-C, Employer-Provided Health Insurance Offer and Coverage, and one or more Forms 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns, with the IRS. Our records also show that for one or more months of the year at least one of the full-time employees you identified on Form 1095-C was allowed the premium tax credit (PTC) on his or her individual income tax return filed with the IRS. Based on this information, we are proposing that you owe an ESRP for one or more months of the year.

2025 Affordability Safe Harbors: 9.02%

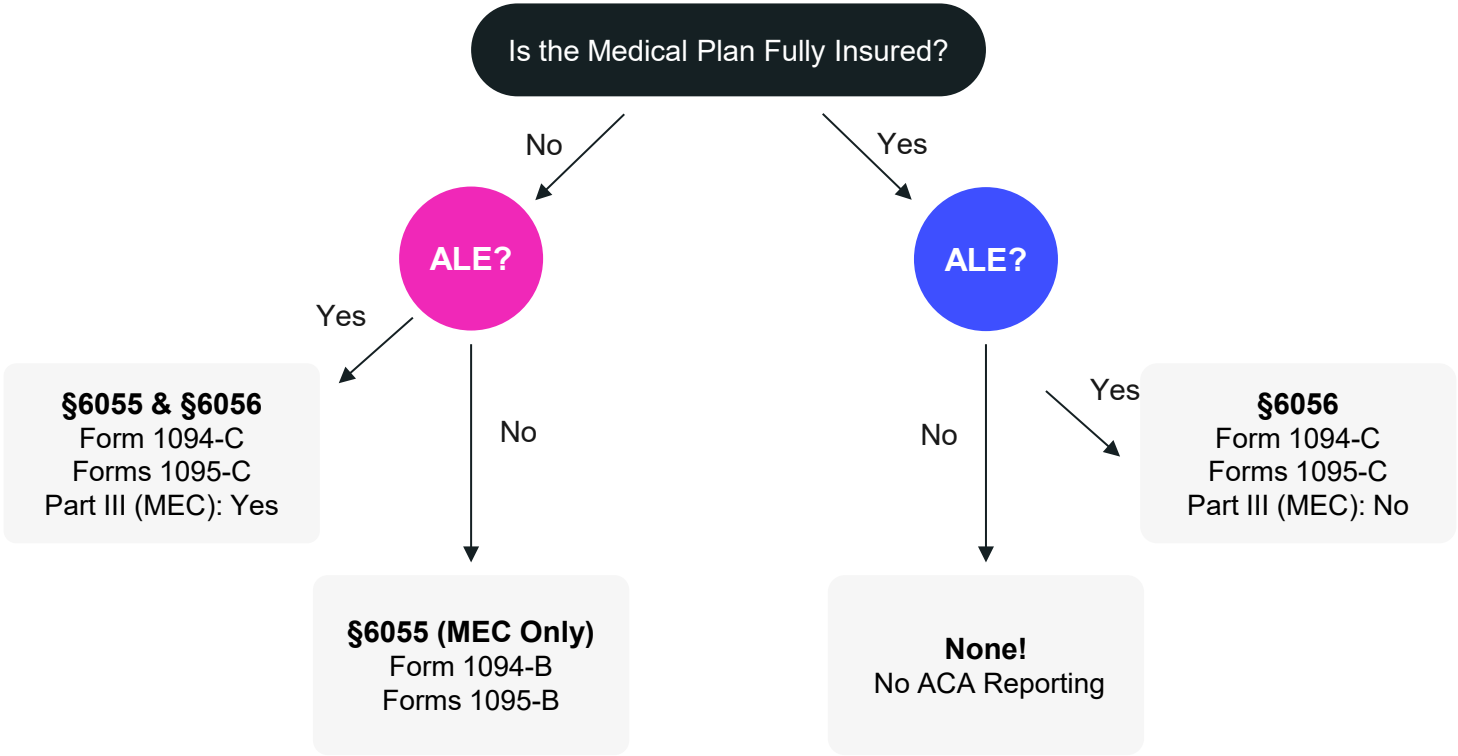
The employer mandate affordability safe harbors are indexed to a metric based on the rate of premium growth over the rate of CPI growth for the preceding year. For 2025, the applicable percentage increases **to 9.02%** (up from 8.39% in 2024).

Full Details Available Here: The ACA Affordability Determination in 2025

- **2025 Federal Poverty Line Safe Harbor:** 9.02% of the Federal Poverty Line
  - Prior-Year Federal Poverty Line (Contiguous 48 States): $15,060
  - 2025 Monthly Employee-Share of Premium for Lowest-Cost (Minimum Value) Plan Limit: **$113.20**
  - *Action Item: Always use this approach where the employer offers plan option at a cost that does not exceed $113.20/month*
- **2025 Rate of Pay Safe Harbor:** 9.02% of Rate of Pay
  - Hourly Employees: 9.02% of Employee's Hourly Rate of Pay x 130 Hours (regardless of actual hours of service)
  - Salaried Employees: 9.02% of Employee's Monthly Salary
  - *Action Item: Use this approach where the employer's cheapest (minimum value) plan option costs employees more than $113.20/month*
- **2025 Form W-2 Safe Harbor *(Not Recommended)*:** 9.02% of Box 1 Wages
  - *Disadvantage #1*: Retrospective Determination—Form W-2 safe harbor provides no predictability because Box 1 unknown until January of following year (i.e., employer will not know until January 2025 whether it met the Form W-2 safe harbor for 2024)
  - *Disadvantage #2:* Disregarded Compensation—Box 1 does not include many forms of compensation, including 401(k) deferrals and Section 125 salary reductions for health and welfare plan coverage
  - *Disadvantage #3:* Fixed Premium—The employee-share of the premium must remain consistent as an amount or percentage for the full plan year, which means employers cannot make mid-year adjustments to address lower-than-anticipated Box 1 amounts

ACA Reporting: Which Employers Must Report?

Full Details: ACA Reporting Deadlines and Compliance Requirements in 2025



ACA Reporting Penalties

Full Details: ACA Reporting Deadlines and Compliance Requirements in 2025

Same Penalties Apply as for Forms W-2 (Penalty Amounts for Forms Furnished/Filed in 2025)

General penalty is **$660** for each incorrect return (**$330** for return furnished to individual, **$330** for return filed with the IRS).

- Total fine not to exceed $3,987,000.
- Penalty reduced to **$60** if the corrected return is filed **within 30 days** after the required filing date—total fine max reduced to $664,500.
- Penalty reduced to **$130** if corrected by **August 1** of the year in which the filing due—total fine max reduced to $1,993,500.

Special Good Faith Efforts Applied in Previous Years–No Longer Available

For the Forms 1094-C and 1095-C filed in previous years, a “good faith efforts” standard applied.

- The IRS would not impose the penalties described above if the employer could show that it made “good faith effort” to comply with the information reporting requirements.
- Applied to incorrect or incomplete information (including SSNs).
- IRS has confirmed the end of good faith transition relief confirmed in new final regulations
- Reasonable cause penalty relief is still available in some circumstances
- More details: ACA Reporting Penalties

ACA Reporting Penalties: Filing Failures

Full Details: ACA Reporting Penalties

No Filing: IRS Letter 5699

- Employers that fail to file their ACA reporting forms will receive an IRS Letter 5699
- Letter asks the employer several questions related to why the forms have not been filed
- Questions are generally inquiring as to whether the employer was an ALE and what the status is of their filing
- Employer has 30 days to respond
- Failure to respond will result in IRS Letter 5698 and eventually referral to IRS examiner to pursue penalties for failure to file/furnish

Late/Incorrect Filing: IRS Notice 972CG

- Employers that do not timely file the ACA reporting forms will receive an IRS Notice 972CG informing them of the proposed penalties being imposed
- Employers have 45 days to respond to the Notice 972CG
- If employer agrees, they can simply respond with the payment
- Those disagreeing will state the reason the penalties (in full or in part) should not apply
- Employers that do not timely respond will receive a follow-up "Notice of Penalty Charge" bill that includes additional interest

Reasonable Cause Relief: IRS Publication 1586

- "Reasonable cause" relief is available to potentially reduce or eliminate ACA reporting penalties
- Employer must show:
  1. No willful neglect;
  2. That it acted in a responsible manner both before and after the failure occurred; and
  3. There were significant mitigating factors or events beyond its control
- Full description of the standard in Treas. Reg. §301.6724-1
- Summary of the standard in IRS Publication 1586

ACA Reporting Deadlines
Extension Stays, No More Good Faith Safe Harbor

Full Details: ACA Reporting Deadlines and Compliance Requirements in 2025

Extended Deadline Is Here to Stay

- The IRS finalized regulations to make the 30-day extension permanent*
- 30-day extension applies only to the deadline for providing the forms to individuals*
- Deadlines to file with the IRS remain standard
- In prior years the IRS also provided the good faith enforcement safe harbor to avoid penalties for incorrect or incomplete information (generally $330 per return)
- In prior years, IRS allowed employers filing fewer than 250 returns to file by paper
- **Remember:** No good-faith safe harbor available anymore—standard penalty scheme applies for incorrect information
- **Remember:** No option to file by paper anymore—going forward all employers must file electronically

New Furnishing Relief Available!

2025 ACA Reporting Deadlines for ALEs

Forms	Type of Distribution	Due Date
2024 Forms 1095-C	*Furnish to Individuals**	**March 3, 2025*** (Note: March 2 is a Sunday in 2025)
2024 Forms 1094-C (+Copies of Forms 1095-C)	*Electronically File with IRS*	**March 31, 2025**

Due Dates: 30-Day Extension to Furnish, No Longer Option to File by Paper

Full Details: ACA Reporting Deadlines and Compliance Requirements in 2025

Form 1095-C: To Employees	Forms 1094-C and 1095-C to the IRS: Electronic Only
New Furnishing Relief Available!	
• Must be furnished by **March 3, 2025***	• Must be filed electronically by **March 31, 2025**
• Standard deadline is January 31, but the new IRS final regulations make the 30-day extension from previous years permanently available going forward (great news!)	• Employers must file electronically if filing 10 or more returns (including ACA reporting, Form W-2, and 1099, etc.) starting in 2024—includes virtually all employers
• Unfortunate downside is they have also confirmed that the good faith enforcement safe harbor for incorrect/incomplete forms is no longer available	• Previous ability to file by paper where under 250 ACA form return threshold is now eliminated
• Note: The 30-day extension makes the deadline March 2 for a non-leap year, which falls on a Sunday in 2025	• More details: IRS Requires Electronic ACA Filing in 2024
	• Note: The filing deadline was extended in 2024 because March 31 fell on a weekend, but that's not the case in 2025

Furnishing the Form 1095-C to Employees: Electronic Delivery Barriers

Full Details: Furnishing Forms 1095-C to Employees Electronically

Option 1: Standard Paper Mailing (or Hand Delivery)	Option 2: Electronic Delivery
New Furnishing Relief Available!	
• The general rule is that the Form 1095-C must be furnished on paper by mail (or hand delivered)* • The form must be properly addressed and mailed on or before the due date • May truncate SSNs by replacing the first five digits with asterisks or Xs (but truncation not allowed on forms filed with IRS) • If mailed, must be sent to the employee's last known permanent address (or if no permanent address is known, to the employee's temporary address)	• Employers **must obtain affirmative consent** to furnish the Form 1095-C electronically • The consent **must relate specifically** to receiving the Form 1095-C electronically • Individuals may consent on paper or electronically—if consent is on paper, the individual must confirm consent electronically • Electronic distribution after proper consent is permitted by email or by informing the individual how to access the statement on a website • Note: This is different than the standard ERISA electronic disclosure rules—requires specific Form 1095-C authorization!

New ACA Reporting and ER Mandate Relief

Full Details: Congress Delivers ACA Stocking Stuffers

Form 1095-C Furnishing Relief:
Paperwork Burden Reduction Act Passed End of 2024

ALEs No Longer Have to Furnish Forms 1095-C

- Instead, ALEs simply have to make the forms available upon request, beginning with 2024 forms at start of 2025

Two requirements for employers to take advantage of this "alternative manner of furnishing statements":

1. *Notice of Availability:* Provide employees with clear, conspicuous, and accessible notice that they may request a copy of the Form 1095-C; and
2. *Provision Upon Request:* If the employee requests a copy, the employer must provide a copy by the later of a) January 31, or b) 30 days after the date of the request

- New law directs IRS to fill in the details such as how to provide the notice of availability
- Likely to follow the similar relief that has already been available for Forms 1095-B (and also codified here)

Employer Mandate Penalty Relief:
Employer Reporting Improvement Act Passed End of 2024

Additional Time to Respond to IRS Letter 226J

- New law provides employers with 90 days to respond to proposed ACA employer mandate penalty assessment in IRS Letter 226J
- Extends the period from the standard 30-day window that the IRS made available previously
- Employers can use additional time to respond to proposed assessment with information and documentation showing that the assessment should be reduced or eliminated (e.g., because of an ACA reporting error)

Statute of Limitations for Employer Mandate Penalties

- New law provides a six-year statute of limitations for any ACA employer mandate penalty assessment
- Previously the IRS took the position that there was no statute of limitations that applied in this context

02

The CAA

Reached Full Implementation in 2024

CAA Effective Dates Timeline

February 10, 2021

- **Mental Health Parity Comparative Analysis Documentation**

First Plan Year on or After January 1, 2022

- **Primary Care Provider Designation**
  - Expanded to non-grandfathered plans
- **Preventing Surprise Medical Bills: Emergency Services (No Surprises Act)**
- **Preventing Surprise Medical Bills: Non-Emergency Services (No Surprises Act)**
- **Ending Surprise Air Ambulance Bills (No Surprises Act)**
  - Reporting requirement delayed pending final regulations
- **Continuity of Care (No Surprises Act)**
  - Good faith, reasonable interpretation of the CAA provisions until regulations issued
- **Medical ID Card Cost-Sharing**
  - Good faith, reasonable interpretation of requirements until the Departments issue regulations

July 1, 2022

- **Machine-Readable In-Network Rates and Out-of-Network Allowed Amounts with Detailed Pricing Information**
  - Delayed from first plan year beginning on or after January 1, 2022

CAA Effective Dates Timeline

December 27, 2022

- **Annual Reporting on Pharmacy Benefits and Drug Costs**
  - Departments issued FAQ guidance on December 23, 2022 providing a grace period for first submission through January 31, 2023, and announcing a good faith efforts standard for enforcement of initial report (now annually required by 6/1)

First Plan Year on or After January 1, 2023

- **Price Comparison Tool for First 500 Shoppable Items/Services**
  - ACA regulations and CAA have nearly identical provisions, ACA provision delayed from 1/1/22
- The New CAA Surprise Billing Notice (Version 2)
  - For employers that maintain a public website for their group health plan

December 31, 2023

- **Gag Clause Prohibition Compliance Attestation**
  - Covers the period from date of CAA enactment (December 27, 2020) through the date of the attestation

First Plan Year on or After January 1, 2024

- **Price Comparison Tool for Remaining Shoppable Items/Services**
  - In addition to first 500 required by first plan year on or after 1/1/23

The New/Modified CAA Patient Protections: No Surprises Act

Full Details: The ACA and CAA Patient Protections

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Preventing Surprise Medical Bills: Emergency Services

Medical plans that cover emergency services must generally cover such services:

1. Without any prior authorization requirement;
2. Regardless of whether the provider is in-network;
3. Without imposing any requirement or limitation that is more restrictive for out-of-network emergency providers than in-network emergency providers;
4. Without any greater cost-sharing than would apply for in-network emergency services (no balance billing); and
5. By applying the cost-sharing payments for out-of-network emergency services toward any in-network deductible or out-of-pocket maximum in the same manner as if the services were provided in-network

- "Cost-sharing" for these purposes includes copayments, coinsurance, and (unlike the original ACA protection) deductibles

The New/Modified CAA Patient Protections: No Surprises Act

Full Details: The ACA and CAA Patient Protections

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Preventing Surprise Medical Bills: Non-Emergency Services

Medical plans that cover out-of-network non-emergency services must generally cover such services:

1. Without any cost-sharing requirement that is greater than would apply if provided in-network (no balance billing);
2. By calculating the cost-sharing as if the total amount charged by the provider is the "recognized amount" for such items and services;
3. With initial notice of payment or denial transmitted to the provider within 30 calendar days of the bill for such services;
4. With payment to the provider within 30 days of the determination date for amounts exceeding the cost-sharing owed by the participant; and
5. By counting the cost-sharing payments toward any in-network deductible and out-of-pocket maximum in the same manner as if the services were provided in-network

- The "recognized amount" is generally an averaging of cost determination, with the specific determination set based on state law if applicable, or otherwise set based on the Social Security All-Payer Model Agreement
- The CAA adds an independent dispute resolution process that permits the plan to engage in a 30-day negotiation process with the out-of-network provider
- Notice and Consent Exception: Protections against balance billing do not apply where health care provider provides notice and obtains participant's consent meeting a number of strict requirements for exception to apply

The New/Modified CAA Patient Protections: No Surprises Act

Full Details: The ACA and CAA Patient Protections

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Preventing Surprise Medical Bills: Employee Notice

New Model Notice to Post by First Plan Year Beginning on or After January 1, 2023:

- Available via CMS website, use “Version 2”
- Employers sponsoring a self-insured health plan must make the notice available on a public website of the plan
- No Surprises Act (NSA) rules require that health plans and insurance carrier post the notice on a public website of the plan
- Website must be “publicly available” to satisfy rules
- For employers with a public group health plan website, post version 2 of the Notice to that site
- For employers with a fully insured plan but without a public group health plan website, insurance carrier is required to post on their site
- For self-insured plans, Tri-Agency FAQ Guidance confirms that employers without a public website for the group health plan can rely on third-party administrator (TPA) where there is a written agreement for the TPA to post the files on its website on behalf of the plan

The New/Modified CAA Patient Protections: No Surprises Act

Full Details: The New CAA Surprise Billing Notice

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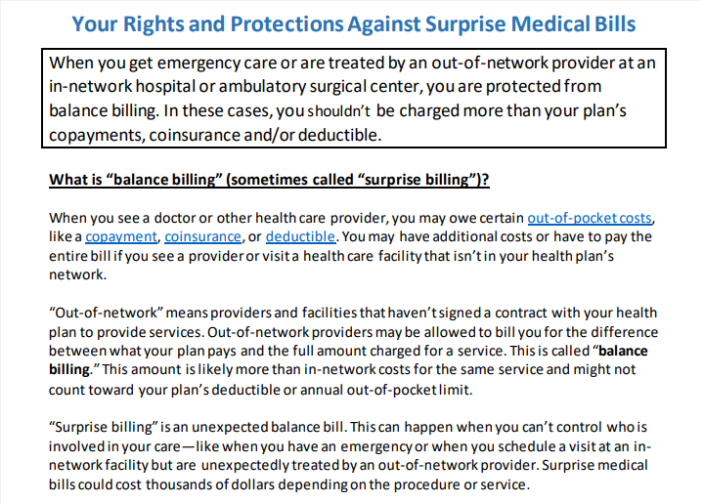
Preventing Surprise Medical Bills: Employee Notice

New Model Notice Issued to Post by First Plan Year on or After January 1, 2023:

- Available via CMS website, use "Version 2"
- Full details: The CAA Surprise Billing Notice



Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

The New/Modified CAA Patient Protections: No Surprises Act

Full Details: The ACA and CAA Patient Protections

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Preventing Surprise Medical Bills: Air Ambulance Services

Medical plans that cover air ambulance services must generally cover such services by an out-of-network air ambulance provider in the following manner:

1. By applying the same cost-sharing that would apply if the air ambulance provider were in-network; and
2. Counting the cost-sharing amounts towards the in-network deductible and in-network out-of-pocket maximum in the same manner as if the services were provided in-network.

- The plan has 30 days after receiving the bill for the out-of-network air ambulance services to respond to the provider with the initial notice of payment or denial
- There can be no balance billing charged to the participant in the process
- An independent dispute resolution will apply where the parties cannot agree to the appropriate out-of-network rate
- Plans will have a two-part, Tri-Agency reporting requirement to provide claims data related to air ambulance services (reporting requirement delayed indefinitely pending final regulations)

The New/Modified CAA Patient Protections: No Surprises Act

Full Details: The ACA and CAA Patient Protections

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Continuity of Care

Medical plans are generally subject to the continuity of care patient protections for "continuing care patients" with respect to a provider or facility where:

1. The in-network contractual relationship terminates;
2. Plan benefits terminate because of a change in the plan's terms of participation for the provider or facility; or
3. The termination of a group health plan's contract with a health insurance carrier causes loss of benefits for the provider or facility.

- Plan must offer "**continuing care patients**" the opportunity to elect to continue benefits with the provider or facility for up to 90 days of transitional care under the same terms and conditions that would have applied with respect to such items and services had the termination not occurred
- Plan must notify each individual who is a "**continuing care patient**" of the right to elect transitional care from the provider upon one of the events described above
- Plan must also provide the "**continuing care patient**" the opportunity to notify the plan of the need for transitional care
- Departments advise to follow a good faith, reasonable interpretation of the CAA until regulations issued

The New/Modified CAA Patient Protections: No Surprises Act

Full Details: The ACA and CAA Patient Protections

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Continuity of Care

Continuing care patients" are individuals who, with respect to a provider or facility, are:

1. Undergoing a course of treatment for a serious and complex condition;
2. Undergoing a course of institutional or inpatient care;
3. Scheduled to undergo nonelective surgery from the provider (including postoperative care);
4. Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. Determined to be terminally ill and receiving treatment for such illness.

CAA Prescription Drug Data Collection Reporting (RxDC)

Full Details: RxDC Reporting Considerations for Employers

New Annual Reporting on Pharmacy Benefits and Drug Costs	Reports Due Annually by June 1 for Prior Year

• **Reporting is designed "as a means to promote competition and bring down overall health care costs" by collecting:**
  • General information regarding the plan or coverage;
  • Enrollment and premium information, including average monthly premiums paid by employees versus employers;
  • Total health care spending, broken down by type of cost (hospital care; primary care; specialty care; prescription drugs; and other medical costs, including wellness services), including prescription drug spending by enrollees versus employers and issuers;
  • The 50 most frequently dispensed brand prescription drugs;
  • The 50 costliest prescription drugs by total annual spending;
  • The 50 prescription drugs with the greatest increase in plan or coverage expenditures from the previous year;
  • Prescription drug rebates, fees, and other remuneration paid by drug manufacturers to the plan or issuer in each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates; and
  • The impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs.
	• FAQ guidance issued 12/23/22 extended grace period for initial 2020/2021 reporting from 12/27/22 through 1/31/23
	  • Guidance also announced a good faith effort standard for enforcement for this initial reporting submission
	• Going forward the due date is June 1 annually to report on prior calendar year
	  • June 1, 2024 reported on 2023 calendar year
	  • June 1, 2025 reports on 2024 calendar year
	  • No good faith efforts standards or extensions apply
	• Employers rely on their insurance carrier or TPA/PBM to submit the Prescription Drug Data Collection (RxDC) Report
	  • For self-insured plans, the obligation lies with the employer, but the rules permit (and expect) employers to delegate to TPA/PBM

CAA Mental Health Parity Comparative Analysis

Full Details: The CAA Mental Health Parity Comparative Analysis Requirement

MHPAEA Overview

- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally provides that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits within its set classification
- Group health plans and insurance carriers may not impose non-quantitative treatment limitations (NQTL) with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the same classification

CAA Imposes New MHPAEA Documentation Requirement

- CAA expands upon the MHPAEA by requiring group health plans and insurance carriers that offer both medical/surgical benefits and MH/SUD benefits, and that impose NQTLs on MH/SUD benefits, to perform and document a comparative analysis of the design and application of the NQTLs.

Comparative Analysis Disclosure

- The CAA requires group health plans and insurance carriers that offer both medical/surgical benefits and MH/SUD benefits, and that impose NQTLs on MH/SUD benefits, to make their comparative analysis of the design and application of NQTLs available to the Departments (DOL/HHS/IRS) or applicable state authorities
- July 2023 Tri-Agency MHPAEA Report to Congress reported EBSA issued 25 letters requesting comparative analyses for 69 NQTLs from Nov. 2021 – July 2022
- Newly finalized regulations require plan sponsors to certify they have engaged in a prudent process to select/monitor the preparer of the comparative analysis
  - See next slide for more details…

The Comparative Analysis Employer Certification

Full Details: The Mental Health Parity Employer Certification Requirement

The Departments issued a lengthy set of new regulations in 2024 to address many of the specific aspects of the MHPAEA comparative analysis requirement added by the CAA. The rules are mostly effective for plan years beginning on or after January 1, 2025.

- *The new rules require that a named plan fiduicary (generally the employer) complete a certification contained within the the document.*

The Certification Requirement:	What the DOL Expects of Employers:	Enforcement Process:
Employer as fiduciary must certify: • They have engaged in a prudent process to select the service provider(s) to perform and document a comparative analysis in accordance with applicable law • The analysis is based on the imposition of any nonquantitative treatement limitations (NQTL) that apply to mental health and substance use disorder benefit (MH/SUD) under the plan • They have satisfied their duty to monitor the service provider(s) per the standard ERISA duty of prudence with respect to the performance and documentation of the comparative analysis	**DOL expects employers as fiduciary to:** • Review the comparative analysis prepared by or on behalf of the plan with respect to an NQTL applicable to mental health and substance use disorder benefits and medical/surgical benefits • Ask questions about the analysis and discuss it with service providers, as necessary, to understand the findings and conclusions documented in the analysis • Ensure that the service provider provides assurance that the comparative analysis complies with the requirements of MHPAEA	**1) Available Upon Request** • The plan must provide the comparative analysis to the relevant department (DOL/IRS/HHS) within 10 business days of the relevant department's request • The plan has 45 calendar days to correct issues if determined to be noncompliant **2) Notify Employees** • If the plan receives a final determination of noncompliance, it has 7 business days to notify all enrolled employees • Header: "Attention! The Department of [X] has determined that [plan name] is not in compliance with the MHPAEA!"

CAA Gag Clause Prohibition Compliance Attestation

Full Details: The CAA Gag Clause Prohibition Attestation Requirement

Prohibited Gag Clauses Under CAA

To increase transparency by removing gag clauses on price and quality information, CAA prohibits plans from entering into agreements with health care providers, network, TPA, or other service providers that have restrictions on relasing certain information:

1. Provider-specific cost or qualify of care information or data through a consumer engagement tool or any other means;
2. Electronic de-identified claims and encounter information or data for individuals upon request and consistent with HIPAA, GINA, and the ADA;
3. The ability to share information or data in 1) and 2) above (or to direct information be shared) with a HIPAA business associate, consistent with HIPAA, GINA, and the ADA.

CAA Imposes New Gag Clause Prohibition Compliance Attestation Requirement (GCPCA)

- The CAA includes an annual attestation requirement for plans to certify their compliance with the gag clause prohibition. This is referred to as the annual Gag Clause Prohibition Compliance Attestation, or “GCPCA”.

Satisfying the GCPCA

- For fully insured plans, the employer and carrier are both repsonsible, but FAQ gudiance confirms both will be treated as sastisfying if carrier submits
- For self-insured plans, the employer may satisfy the attestation requirement by entering into a written agreement with the for TPA to complete
- Attestation is due by December 31 annually (first was due in 2023), completed at the Gag Clause Prohibition Compliance Attestation website
- Full details: The CAA Gag Clause Prohibition Attestation Requirement

Price Transparency Revolution Underway with ACA and CAA

Full Details: The CAA Machine-Readable File Posting

Machine-Readable Files (MRF): Enforced as of July 1, 2022

Detailed Pricing Information Covering the Individual and Group Markets

- Available to consumers, researchers, employers, third-party developers, and the rest of the public
- Standardized format with monthly updates required
- Three separate machine-readable files with detailed pricing information:
  1. **In-Network:** Negotiated rates for all covered items and services between plan and in-network providers
  2. **Out-of-Network:** Historical payments to, and billed charges from, out-of-network providers
  3. **Prescription Drugs:** Previously delayed pending implementation of broader CAA Rx reporting rules—new guidance states there is no meaningful difference with CAA, so it is required going forward

Employer Issues: The Public Group Health Plan Website Conundrum

Employers Must Post Links to Machine-Readable Files in Some Situations

- Transparency in Coverage (TiC) rules require that "group health plan or health insurance issuer must make available on an internet website" the machine-readable files
- Website must be "publicly available" to satisfy rules
- For fully insured plans, this requirement is simply satisfied by the plan's insurance carrier
- For self-insured plans, issue is that many employers do not have a public website for the group health plan
- CMS Technical Guidance and Tri-Agency FAQ Guidance both confirmed that employers without a public website for the group health plan can rely on TPA where there is a written agreement for the TPA to post the files on its website on behalf of the plan

Price Transparency Revolution Underway with ACA and CAA

Full Details: The TiC Participant-Level Disclosures

Internet-Based Tool:
Personalized & Real-Time Out-of-Pocket Cost Information

The New State of the Art for Shopping and Comparing Prices Before Receiving Care

- Employees will be able to access actual out-of-pocket cost information prior to receiving service or purchasing item
- Four main components of the internet-based tool:
  1. **Cost-Sharing Information:** The deductible, coinsurance, and copay for any covered item or service
  2. **Accumulated Amounts:** The participant's YTD amounts incurred toward the deductible and out-of-pocket maximum
  3. **In-Network Rate:** The plan's negotiated rate (reflected as dollar amount) for an in-network provider for the covered item or service
  4. **Out-of-Network Allowed Amount:** How much the plan will pay for an out-of-network item or service (dollar or percentage)

Staggered Availability:
Final Phase of Tool Available in 2024

First Plan Year Beginning On or After January 1, 2023

- For the first plan year these rules are in effect, the plan was required to disclose an initial list of 500 shoppable services
- CMS summary: 500 Items and Services List for Price Comparison Tool

First Plan Year Beginning On or After January 1, 2024

- The remaining prices for covered items and services must be disclosed via the internet-based tool

Employers Will Rely On Insurance Carrier or TPA

- Rules provide that employer can enter into a written agreement for carrier/TPA to maintain this internet-based tool
- Potential $100/day penalties apply for non-compliance

03

The New Administration

What to Expect for Employee Benefits

Trump Administration: Likely EB Priorities

Full Details: Potential Employee Benefits Changes in Second Trump Term

The second Trump term will likely avoid the ACA repeal/replace efforts that plagued the initial year of the first term. At this point, it still is not clear exactly what they will pursue, but expect efforts to address some of the items left on the table from the last time around.

- *Everything remains status quo unless and until any of the potential policy goals discussed are actually enacted/promulgated/implemented.*

Trump Campaign Materials:

While the most recent campaign did not address EB in detail, the first promoted:

- Permit the sale of health insurance across state lines
- Permit indivdiuals to fully deduct health premium expenses
- Expand the use and benefit of HSAs
- Permit working parents to deduct daycare expenses for children and elderly parents
- Create a dependent care savings account (DCSA) modelled after HSAs to pay for daycare expenses

ACA Repeal/Replace Efforts:

While the effort ultimately failed, there were several items that may still be priorities:

- Eliminate the ACA employer mandate provisions (zero out penalties)
- Double the HSA contribution limits and allow tax-free distributions for premiums
- ACA reporting eliminated or moved to a box on Form W-2 reporting months of coverage
- Elimination of the ACA cap on health FSA salary reduction contributions
- Focus on state block grant approach with more flexibility to states than ACA

Potential New Priorities:

1) Codify ICHRAs

- ICHRAs became available in 2020 through a regulation promulgated by the first Trump administration
- Republicans have tried to codify and enhance ICHRAs through the CHOICE Arrangement Act that President Biden publicly opposed
- Also will look for clarity on affordability rules that Biden administration withdrew

2) Revisit Association Health Plans

- Regulations from first Trump administration were overturned in court and rescinded by Biden administration

Trump Administration: Likely EB Priorities

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- *Everything remains status quo unless and until any of the potential policy goals discussed are actually enacted/promulgated/implemented.*

What Does This All Mean for Employers?

Employers should have an eye on the horizon for possible future action items tied to any potential changes taking effect:

- Possible ability to move group health plan full-time eligible status up to 40 hours/week and or base eligibility on regularly scheduled hours (both common in the pre-ACA employer mandate era)
- Possible ability to discontinue offering a group health plan and instead move to an ICHRA (available since 2020, but likely to have more favorable legal landscape going forward)
- Possible ability to offer a large opt-out credit or group health plan alternative funding that is deposited into employee HSA accounts upon proof of HDHP enrollment on individual market (would be viable without an employer mandate and with the expansion of HSAs to higher limits and use for premiums)
- Possible ability to discontinue service with ACA reporting vendor (made possible by elimination of reporting rules or simplified W-2 alternative previously proposed)
- Possible ability to shop for insurance policies across state lines (potentially avoiding more costly insurance mandates in employer's primary place of business)
- Possible ability to enter into association health plans with unrelated employers to create a larger experience pool and achieve lower costs (including the ability of small employers to avoid the community rated small group market and instead achieve experience-rated underwriting)
- Possible ability to offer employees dependent care savings accounts (DCSAs) to save and invest for child and elder care expenses (with the same triple-tax advantaged structure as HSAs)

04

Other News

The Health FSA Contribution & Carryover Limits

Full Details: 2025 Health FSA Limit Increased to $3,300

Salary Contribution Limit:
$3,300 for Plan Years Beginning On or After 1/1/2025

ACA Original $2,500 Limit Indexed for Inflation

- Adjusts in $50 increments based on a complex cost-of-living calculation tied to the chained and standard consumer price index increases for the preceding year
- The cost-of-living increases in 2024 were sufficient to boost the 2025 limit by two $50 increments ($100 total)
- Means that for plan years beginning on or after January 1, 2025, the health FSA salary reduction contribution limit is $3,300

Historical FSA Limits:

2025: $3,300	2022: $2,850
2024: $3,200	2021: $2,750
2023: $3,050	2020: $2,750

Carryover Limit:
$660 for PY Starting in 2025 to PY Starting in 2026

IRS Now Indexes the Carryover Limit

- Executive Order 13877 in June 2019 directed the IRS to increase the $500 carryover limit
- The IRS announced in Notice 2020-33 that it was increasing the carryover limit to an amount equal to 20% of the maximum health FSA salary reduction contribution
- The carryover limit for plan years starting in 2024 to plan years starting in 2025 was at $640 (20% of $3,200)
- The carryover limit for plan years starting in 2025 to plan years starting in 2026 is now set at $660 (20% of $3,300)
- Reminder: CAA FSA relief provisions permitted full carryovers for both the health FSA and the dependent care FSA for plan years ending in 2020 and 2021 into the subsequent plan years ending in 2021 and 2022, respectively. That provision has now sunset.

HSA and HDHP 2025 Limits

The annual statutory maximum HSA contribution limits are for all contributions combined (employer and employee). These amounts are subject to cost-of-living adjustments each year based on chained CPI (modified by TCJA).

Full Details: 2025 HSA Contribution Limits

	2024	**2025**
Annual Contribution Limit	Individual Coverage: $4,150 Family Coverage: $8,300 Age 55+ Catch-Up: $1,000	**Individual Coverage: $4,300** **Family Coverage: $8,550** **Age 55+ Catch-Up: $1,000**
Minimum Annual Deductible	Individual Coverage: $1,600 Family Coverage: $3,200	**Individual Coverage: $1,650** **Family Coverage: $3,300**
Annual Out-of-Pocket Maximum	Individual Coverage: $8,050 Family Coverage: $16,100	**Individual Coverage: $8,300** **Family Coverage: $16,600**

2025 Employee Benefit Limits

Full Details: 2025 Health and Welfare Employee Benefit Amounts

Employee benefit limit	2024	2025
HSA Individual	**$4,150**	**$4,300**
HSA Family	**$8,300**	**$8,550**
HSA Catch-Up (55+)	**$1,000**	**$1,000**
HDHP Maximum Out-of-Pocket	**$8,050 / $16,100**	**$8,300 / $16,600**
HDHP Minimum Deductible	**$1,600 / $3,200**	**$1,650 / $3,300**
Health FSA Salary Reduction Contribution	**$3,200**	**$3,300**
Health FSA Carryover to Following Year	**$640**	**$660**
Dependent Care FSA	**$5,000 ($2,500 married filing separately)**	**$5,000 ($2,500 married filing separately)**
Highly Compensated Employee	**$150,000**	**$155,000**
Mass Transit/Vanpooling	**$315/month**	**$325/month**
Qualified Parking	**$315/month**	**$325/month**
401(k) Elective Deferral	**$23,000**	**$23,500**
401(k) Catch-Up (50+)	**$7,500**	**$7,500**
FICA Wage Base (SS Only)	**$168,600**	**$176,100**
ACA Employer Mandate Penalties	**A Penalty: $2,970, B Penalty: $4,460**	**A Penalty: $2,900, B Penalty: $4,350**
ACA Employer Mandate Affordability	**8.39%**	**9.02%**
ACA Federal Poverty Level Safe Harbor	**$101.93/month**	**$113.20/month**
Adoption Assistance	**$16,810**	**$17,280**

End of CARES Act HSA Relief

First-Dollar HDHP Telehealth Expired at End of 2024 for Calendar Plan Years

Full Details: HSA Telehealth Relief Extension Ends in 2025

Prior Relief: HSA Eligibility Preserved

HDHPs could provide first dollar coverage for telehealth or other remote care services

- Meant that individuals covered under a HDHP that waived the deductible for telehealth services or other remote care could maintain HSA eligibility
- Included non-preventive telehealth/remote care

CARES Act/CAA 2022 Relief: Originally applied for plan years beginning on or before December 31, 2021

- CAA 2022 extension applied from April – December 2022

CAA 2023: Extension of relief made it available through 2024

- Extension applied to plan years beginning after December 31, 2022 and before January 1, 2025
- Included 2023 and 2024 for calendar plan year HDHPs
- **For plan years beginning on or after January 1, 2025, no relief is available (absent a new act of Congress to again extend relief)**

Practical Considerations for Prior Relief – Plan Design Issues

First-dollar telehealth relief was an optional plan provision

- HDHPs were not required to offer free telehealth care
- The relief simply permitted it without causing loss of HSA eligibility

Fully Insured Plan

- Was up to the insurance carrier to make the determination of whether to add first-dollar telehealth/remote care

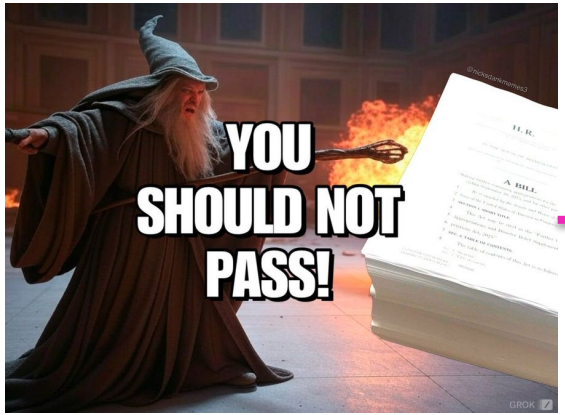
Self-Insured Plan

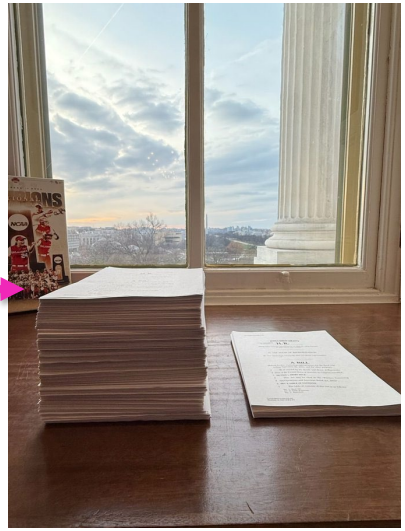
- Employers could work with TPA and stop-loss provider to make this plan design decision

What Could Have Been…

- The original version of the end-of-year funding bill included a two-year extension of the telehealth relief (through 2026)
- That version was subsequently streamlined from 1,500+ pages to 100+ pages, and the HSA relief extension provision was removed
- **We may still see legislation extend the relief this year, stay tuned!**

What Happened to HSA Telehealth Relief?





HDHPs and Telemedicine: Standard HSA Eligibility Rules *(Applicable 2025 After Expiration of CARES/CAA Relief)*

Full Details: HSA Telehealth Relief Extension Ends in 2025

Telemedicine That is Part of the HDHP: Not Disqualifying Coverage

- In this case, the employee's costs related to the telemedicine services are subject to the same HDHP cost-sharing rules as non-telemedicine services
- In other words, the HDHP deductible applies to telemedicine in the same manner as in-person services
- Preventive care or EAP/Wellness/Disease Management services are not required to be subject to the deductible (same as in-person services)

Telemedicine That is Not Part of the HDHP: May Be Disqualifying Coverage

- Separate telemedicine plans that are not subject to the HDHP deductible—another exception must applyto avoid blocking HSA eligibility
- Main exemptions that could apply are:
    1. **Preventive Services:** Telemedicine limited to preventive services only
    2. **EAP/Wellness/Disease Management:** Telemedicine that does not provide "significant benefits in the nature of medical care or treatment"
    3. **FMV Charge:** Require that employees pay the fair market value for sessions (at least before satisfying minimum deductible)

"Significant Benefits" Standard Difficult to Apply to Telemedicine

- Best examples come from HIPAA/ACA excepted benefit regulations preamble:
- **For example**, "an EAP that provides only limited, short-term outpatient counseling for substance use disorder services (without covering inpatient, residential, partial residential or intensive outpatient care) without requiring prior authorization or review for medical necessity does not provide significant benefits in the nature of medical care. At the same time, a program that provides disease management services (such as laboratory testing, counseling, and prescription drugs) for individuals with chronic conditions, such as diabetes, does provide significant benefits in the nature of medical care."

Expanded HDHP Contraception Preventive Services

Full Details: HDHP Preventive Care Expanded to More Contraceptives

IRS Notice 2024-75 makes additional types of contraception available as a preventive service that can be covered by the HDHP prior to satisfaction of the deductible without affecting HSA eligibility. It also clarifies the scope of preventive services for breast cancer screening, glucose monitoring, and insullin. Check your HDHP plan terms to confirm whether they are covered pre-deductible.

Additional Types of Contraception

The guidance adds two types of contraception as preventive services that do not affect HSA eligibility if covered pre-deductible:

1. Over-the-Counter (OTC) Oral Contraceptives
   - Incudes progestin-only birth control (the "minipill") and emergency contraception levonorgestrel (the "morning after pill" or "Plan B One-Step") regardless of prescription
2. Male Condoms
   - Expanded to include male condoms (previously only female condoms included) regardless of prescription

Clarification of Existing Preventive Services

The guidance clarifies three types of preventive services that do not affect HSA eligibility if covered pre-deductible:

1. Breast Cancer Screening
   - Not limited to just mammograms, also includes MRIs, ultrasounds, and similar breast cancer screening services
2. Continuous Glucose Monitors
   - Not limited to just glucometers, also includes continuous glucose monitors for individuals diagnosed with diabetes
3. Selected Insulin Products
   - No prescription required, and includes devices used to administer or deliver the selected insulin products

PCORI Fee for Self-Insured Plans

Full Details: ACA PCORI Fee Due in July via IRS Form 720

Congress Extended the PCORI Fee for Another Decade (to 2029)

- 2019 was to be the final year the Patient Centered Outcomes Research Institute (PCORI) fees were required
- Major industry groups (AHIP, BCBSA, ERIC, NRF, US Chamber) pushed for 10-year extension to 2029
- That legislation was ultimately incorporated into the same massive “Further Consolidated Appropriations Act, 2020”
- Employers with self-insured medical plans (including level funded plans) need to file and pay for the PCORI fee!
- **Only employers with a self-insured major medical plan (including level funded plans) and/or HRA (special HRA rules apply) must file for and pay the PCORI fee (the insurance carrier files/pays for fully insured plans)**

PCORI Fees	July 31, 2024 Form 720 PCORI Filing	July 31, 2025 Form 720 PCORI Filing
Plan Year Ends January 1–September 30	Applicable Rate: • $3.00 per covered individual	Applicable Rate: • $3.22 per covered individual
Plan Year Ends October 1–December 31 (Including Calendar Plan Years)	Applicable Rate: • $3.22 per covered individual	Applicable Rate: • $3.47 per covered individual

Qualified Educational Assistance Program (§127)

CARES Act Added Student Loan Repayment, CAA Extended Through 2025

The CARES Act expanded upon the existing §127 qualified educational assistance provisions to include student loan reimbursement in 2020. The CAA extended the optional employer tax-free offering through the end of 2025.

Full Details: Employer Tax-Free Student Loan Repayment Available Through 2025

IRC §127 Permits Tax-Free Educational Assistance

- Allows employers to cover the cost of educational expenses for an employee tax-free
- Did not include student loan repayments prior to CARES Act
- Capped at $5,250 per calendar year

Tax-Free Student Loan Repayment Permitted Through 2025

- The CARES Act permitted employers to offer an educational assistance program to reimburse student loans tax-free in 2020
- The CAA extended the availability of this tax-free student-loan repayment assistance option through the end of 2025
- Employer payment can be made to the employee or directly to the lender
- For principal or interest on a “qualifying education loan” incurred by the employee
- Capped at the same standard $5,250 limit under §127, and includes any other forms of assistance (tuition, books, fees, etc.)

What Does the Future Hold for Tax-Advantaged Employer Student Loan Repayment Assistance?

- Could this be the launching point for a permanent expansion of §127? Hard to imagine it sunsetting in 2026 after six years
- For the feature to become even more useful, Congress could allow employee pre-tax contributions (e.g., through the cafeteria plan) to count toward the limit.
- Also should look to index the $5,250 limit for inflation given increases in costs (that fixed amount dates back to 1979!)

Qualified Educational Assistance Program (§127)

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Full Details: Employer Tax-Free Student Loan Repayment Available Through 2025

H.R. 9164: The Employer Participation in Repayment Act (Proposed in Congress)

118TH CONGRESS
2D SESSION

H. R. 9164

To amend the Internal Revenue Code of 1986 to make the exclusion for certain employer payments of student loans under educational assistance programs permanent.

IN THE HOUSE OF REPRESENTATIVES

JULY 25, 2024

Ms. MALLIOTAKIS (for herself and Mr. PETERS) introduced the following bill; which was referred to the Committee on Ways and Means

A BILL

To amend the Internal Revenue Code of 1986 to make the exclusion for certain employer payments of student loans under educational assistance programs permanent.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Employer Participation in Repayment Act".

SEC. 2. EXCLUSION FOR CERTAIN EMPLOYER PAYMENTS OF STUDENT LOANS UNDER EDUCATIONAL ASSISTANCE PROGRAMS MADE PERMANENT.

(a) IN GENERAL.—Section 127(c)(1)(B) of the Internal Revenue Code of 1986 is amended by striking "in the case of payments made before January 1, 2026,".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made after the date of the enactment of this Act.

○

The J&J Prescription Drug Case Makes Waves

Full Details: The J&J Case Practical Considerations (ERISA Fiduciary Duties)

Full Details: The J&J Case Practical Considerations (ERISA Trust Rules)

ERISA Fundamentals Revisited

The Allegation: Excessive Prescription Drug Costs

- The class plaintiff in *Lewandowski v. Johnson & Johnson, et. al.* principally allege that the company breached its fiduciary duty by mismanaging the health plan's Rx benefits
  - Argument is that cost employees millions in the forms of higher Rx payments, higher premiums, higher cost-sharing, and lower wages or limited wage growth
- Class plaintiff alleges that J&J breached its fiduciary duty of prudence by failing to engage in a prudent and reasoned decision-making process to lower the cost of drugs

Key Points to Keep in Mind

- The J&J case is merely at the initial complaint stage and it is unclear whether these novel breach of fiduciary duty theories will be successful—so try to avoid knee-jerk overreactions
- The J&J plan is very large and *funded by a trust*, which allows the plaintiff to establish a clear connection between the employer's fiduciary duties and the trust funds held as plan assets
- Given that this area of law remains unsettled pending the J&J (and similar Wells Fargo) litigation, employers should be cautious considering any radical changes to plan governance
  - *Best practice:* **Return to the basics** of proven ERISA compliance methods/strategies while monitoring developments for any outcomes that may drive new best practices going forward

Will a Plan Committee Really Solve These Issues?

- J&J's plan had a fiduciary benefits committee but was still the target of this case
- The individuals serving on the committee were a clear target as defendants, with the CHRO and VPs of HR personally named
- Board delegation of fiduciary duties to a committee with oversight of H&W plan benefits traditionally has been a practice adopted only by very large employers because of the time and cost

HIPAA Reproductive Health Privacy: Timeline

Full Details: The New HIPAA Reproductive Health Rules

April 26, 2024

- **Final Rules Published in the Federal Register**
  - Full preamble and regulations publication (90+ pages): https://www.federalregister.gov/documents/2024/04/26/2024-08503/hipaa-privacy-rule-to-support-reproductive-health-care-privacy
  - Short summary “Fact Sheet”: https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/final-rule-fact-sheet/index.html

June 25, 2024

- **Effective Date of New Regulations**
  - Started the clock of 180-day minimum required “compliance period” for HIPAA rule modifications

December 23, 2024

- **General Compliance Date for New Requirements (180 Days After 6/25/24 Effective Date)**
  - Includes new attestation requirement (but not the new NPP required changes)

February 16, 2026

- **Compliance Date for Changes to Notice of Privacy Practices**
  - Provides additional time for covered entities to update and distribute revised NPP with new reproductive health rules

HIPAA Reproductive Health Privacy: Overview

The new rule is designed to “protect access to and privacy of reproductive health care after the Supreme Court’s decision in Dobbs v. Jackson,” consistent with President Biden’s Executive Order 14076.

Full Details: The New HIPAA Reproductive Health Rules

Prohibition

Covered Entity and BA Cannot Use or Disclose PHI for either:

- Conducting criminal, civil, or other forms of legal proceedings based on act of seeking, obtaining, providing, or facilitating reproductive health care where such care is lawful under the circumstances in which it is provided; or
- Identifying any person for the purpose of conducting such investigation/proceeding

Application

Reasonably Determined That:

- The reproductive health care is lawful in state/circumstances (e.g., travelling to state where abortion is legal);
- The reproductive health care is protected regardless of the state in which it is provided (e.g., contraception); or
- The care was not provided by the entity that receives the PHI request, and the presumption in righthand column applies

Presumption

Presumed Lawful Unless:

- Covered entity or business associate has actual knowledge that the care was not lawful under circumstances provided; or
- Covered entity or business associate receives factual information from person making request that demonstrates the care was not lawful under circumstances provided

HIPAA Reproductive Health Privacy: Action Items

Employers with self-insured health plans face two new requirements under the new HIPAA rules.

Full Details: The New HIPAA Reproductive Health Rules

Attestation Requirement
Compliance Date: December 23, 2024

Purpose

- Ensure compliance when a covered entity or business associate receives a request for PHI potentially related to reproductive health care, and inform of potential penalties

Application

- Request for PHI potentially related to reproductive health care for health oversight activities, judicial or administrative proceedings, law enforcement purposes, or disclosure to coroners and medical examiners

Attestation

- Must obtain a signed attestation by party requesting PHI that the use or disclosure is not for a prohibited purpose

Notice of Privacy Practices Updates
Compliance Date: February 16, 2026

Reproductive Health Updates

- A description (with at least one example) of the new rules prohibiting criminal, civil, or other forms of legal proceedings based on act of seeking, obtaining, providing, or facilitating reproductive health care where such care is lawful under the circumstances in which it is provided
- A description (with at least one example) of the types and uses of disclosures for which an attestation is now required under the new rules

Substance Use Disorder Updates

- Description of new limitations referred to as “Part 2” rules added by the CARES Act to protect the confidentiality of substance use disorder treatment records

HIPAA Reproductive Health Privacy: The HHS Model Attestation

Full Details: The New HIPAA Reproductive Health Rules

Covered entities and business associates should use the template available here:
https://www.hhs.gov/hipaa/for-professionals/special-topics/reproductive-health/index.html

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

The entire form must be completed for the attestation to be valid.

Name of person(s) or specific identification of the class of persons to receive the requested PHI.
e.g., name of investigator and/or agency making the request
Name or other specific identification of the person or class of persons from whom you are requesting the use or disclosure.
e.g., name of covered entity or business associate that maintains the PHI and/or name of their workforce member who handles requests for PHI
Description of specific PHI requested, including name(s) of individual(s), if practicable, or a description of the class of individuals, whose protected health information you are requesting.
e.g., visit summary for [name of individual] on [date]; list of individuals who obtained [name of prescription medication] between [date range]

I attest that the use or disclosure of PHI that I am requesting is not for a purpose prohibited by the HIPAA Privacy Rule at 45 CFR 164.502(a)(5)(iii) because of one of the following (check one box):

☐ The purpose of the use or disclosure of protected health information is **not** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care or to identify any person for such purposes.

☐ The purpose of the use or disclosure of protected health information **is** to investigate or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for such purposes, but the reproductive health care at issue was **not lawful** under the circumstances in which it was provided.

I understand that I may be subject to criminal penalties pursuant to 42 U.S.C. 1320d-6 if I knowingly and in violation of HIPAA obtain individually identifiable health information relating to an individual or disclose individually identifiable health information to another person.

Signature of the person requesting the PHI

_____ Date _____

If you have signed as a representative of the person requesting PHI, *provide a description of your authority to act for that person.*

_____

This attestation document may be provided in electronic format, and electronically signed by the person requesting protected health information when the electronic signature is valid under applicable Federal and state law.

New DOL Guidance on Cybersecurity

Full Details: Compliance Assistance Release No. 2024-01

The DOL put out cybersecurity guidance in 2021 that was widely regarded as directed toward retirement plans. In 2024, the DOL clarified that employers have the same fiduciary responsibility to include cybersecurity matters as part of the process to prudently select and monitor vendors for non-retirement plan benefits.

- *The guidance provides a useful set of materials that employers can use to satisfy the fiduciary standards for cybersecurity.*

Tips for Hiring a Service Provider:

- A number of tips for employers of all sizes and for all types of ERISA plans for what to ask and evalutate with respect to any service provider's cybersecurity practices.

Also includes suggested contractual terms:

- Information Security Reporting
- Clear Provisions on the Use and Sharing of Information and Confidentiality
- Notification of Cybersecurity Breaches
- Compliance with Records Retention and Destruction, Privacy and Information Security Laws
- Insurance

Cybersecurity Best Practices:

- 12 best practice approaches for plan service providers to ensure proper mitigation of cybersecurity risks.

Includes the following key themes:

- Identify the risks to assets, information and systems
- Protect each of the necessary assets, data and systems
- Detect and respond to cybersecurity events
- Recover from the event
- Disclose the event as appropriate
- Restore normal operations and services

Online Security Tips:

Tips for employees to reduce the risk of fraud and loss online:

- Register, set up and routinely monitor your online account
- Use strong and unique passwords/passphrases
- Use Multi-Factor Authentication
- Keep personal contact information current
- Close or delete unused accounts
- Be wary of free wi-fi
- Beware of phishing attacks
- Use antivirus software and keep apps and software current

California IVF and SDI/PFL Updates

Full Details: New CA IVF Insurance Mandate | CA SDI/PFL Benefits Increase in 2025

California Mandates IVF Coverage:
Effective in 2026 for Calendar Policy Years

Current Law (Pre-2026)

- No mandate for health insurance policies to cover infertility treatment, including IVF
- Carriers must offer employers the option to add infertility treatment as a rider, but IVF excluded from the requirement

New SB 729 Requirements

Large Group Policies (100+ Employees)

- **Must cover** the diagnosis and treatment of infertility and fertility services, including at least three cycles of IVF

Small Group Policies (1-100 Employees)

- Must **offer** employers **the option to cover** the diagnosis and treatment of infertility and fertility services, including at least three cycles of IVF

Not Applicable to Self-Insured Plans (Incl. Level Funded)

- ERISA preempts state insurance mandates for self-insured plans

California SDI/PFL Changes:
Payroll Cap Eliminated and Benefits Increased

Wage Ceiling Was Removed as of 2024

- SB 951 removed the SDI/PFL contribution wage ceiling as of 2024 (cap was $153,164 in 2023)
- Means that all wages paid are now subject to the SDI/PFL 1.2% (2025) payroll tax
- Has a significant impact on high wage earners—an employee earning $500,000 in 2025 will pay $6,000 SDI/PFL payroll tax (vs. $1,378 in 2023 with cap in effect)
- CA EDD changed its position in 9/14/23 “Guidelines for Voluntary Plan Employers Retaining the Wage Ceiling” document by stating that employers with a VDI alternative may in some cases by able to keep the wage ceiling

SB 1090 Increases Benefit Levels Again in 2025

- 2024 Benefit Levels: 60% or 70% (depending on income)
- 2025 Benefit Levels: 70% or 90% (depending on income)

Medicare Part D: What's New?

The Inflation Reduction Act made significant changes to Medicare Part D coverage, including an out-of-pocket maximum capping enrollee costs at $2,000 (indexed after 2025).

Full Details: IRA Changes Affect Notice of Creditable Coverage Considerations

- The creditable status determination can be a pain point
- **Ideally the plan's insurance carrier or TPA will perform the assessment and inform the employer of creditable status!**
- Where the carrier/TPA refuses to perform the analysis, the employer will need to determine creditable status independently
- The potential loss of the simplified determination approach could lead to employers needing to engage with an actuary to perform the creditable status assessment

HDHP Creditable Status

More Difficult Starting 2025

- HDHPs have always had a more difficult time meeting creditable status than standard health plans
- CMS guidance states that *"it may be more difficult for high deductible health plans to qualify as creditable coverage"* starting in 2025 when IRA enhancements take effect

What if HDHP is Non-Creditable?

- Employee should take note of the non-creditable coverage notice to either a) enroll in a different creditable plan option made available, or b) enroll in Part D to avoid late enrollment penalties

Simplified Determination

May Not Be Available After 2025

Two Different Approaches

1. Simplified Determination
2. Actuarial Determination

Simplified Determination at Risk

- CMS initially threatened to remove the simplified option as of 2025
- After receiving many comments, they agreed to continue to make it available at least through 2025
- CMS will *"re-evaluate"* whether it will remain available or be revised for 2026 and beyond
- If it is eliminated, actuarial determinations would be required

Fully Insured Nondiscrimination Rules Delayed Until…?

Full Alert: What's Left to be Implemented Under the ACA?

ACA Added Fully Insured Nondiscrimination Rules

- The ACA provides that insured group health plans will be subject to rules "similar to" the nondiscrimination requirements that have long applied to self-insured plans under Internal Revenue Code §105(h)
- These rules technically were scheduled to apply at the same time as the first wave of market reforms (first plan year on or after September 23, 2010)
- **However, the IRS issued Notice 2011-1 at the end of 2010 confirming that employers are not required to comply until the Departments issue regulations or other administrative guidance to implement the rules**

Will the Trump Administration Finally Implement/Enforce?

- The Notice states that any such guidance will not apply until plan years beginning a specified period after issuance
  - For example, they may not apply until the first plan year beginning on or after six months following the regulatory issue date
- One of the few employer-side ACA items that may have actually been affected by Trump's ACA executive order
- Will Treasury/IRS now take up these rules under a Trump administration? They seem to have largely slipped off the radar
- If they do implement the rules, we should still have plenty of time before they take effect to revise any problematic plan structures

Required SBC Lanugage Translations

SBCs Must be Provided In a **“Culturally and Linguistically Appropriate Manner”**

Full Details: Providing SBCs to Employees

The SBC Language Requirements

- Employers must satisfy the following standards for the SBC:
  - Oral language services (e.g., phone customer service hotline) that includes answering questions in the non-English language
  - Upon request, the plan must provide the SBC translated in the non-English language
  - Must include a prominently displayed statement in SBC in the non-English language of how to access these language services
- SBC template includes access taglines in non-English languages on page four of the SBC (“Language Access Services”)

When the SBC Language Services Requirement Applies

- **SBC language services required (including translations upon request) where provided to an employee/dependent in county where at least 10% of the the population residing in the county is literate only in the same non-English language**
  - Departments use survey and census information to periodically update which counties qualify
  - Most recent Culturally and Linguistically Appropriate Services County Data (CLAS County Data) is from 2023

New 2023 CLAS County Data Applies Going Forward

- **Applies to SBCs for Plan Years beginning on or after January 1, 2025**

Where to Access 2023 CLAS County Data: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/clas-county-data-2023.pdf

Where to Access SBC Translations: https://www.cms.gov/marketplace/resources/forms-reports-other

Required SBC Lanugage Translations

SBCs Must be Provided In a **"Culturally and Linguistically Appropriate Manner"**

Full Details: Providing SBCs to Employees

Which Languages Qualify? (*New for 2025)

- **Spanish**
  - 216 Counties in AZ, AK, CA, CO, FL, GA, ID, IA, KS, MN, NE, NM, NY, NC, OK, OR, PR, TX, VA, WA
- **Tagalog (includes Filipino)**
  - 10 Counties in AK, Northern Mariana Islands
- **Samoan***
  - 3 Counties in American Samoa
- **Chamorro***
  - 3 Counties in Northern Mariana Islands
- **Pennsylvania Dutch (Includes Yiddish/West Germanic)***
  - 2 Counties in IN, OH
- **Chinese (includes Mandarin and Cantonese)**
  - 1 County in CA
- **Navajo**
  - 1 County in AZ
  - *Note:* Navajo oral translation also available (mp3 format)
- **Carolinian***
  - 1 County in Northern Mariana Islands

New 2023 CLAS County Data Applies Going Forward

- **Applies to SBCs for Plan Years beginning on or after January 1, 2025**

Where to Access 2023 CLAS County Data: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/clas-county-data-2023.pdf

Where to Access SBC Translations: https://www.cms.gov/marketplace/resources/forms-reports-other

Will SBC Enforcement Finally Ramp Up?

Full Details: Providing SBCs to Employees

The Neverending Story: Good Faith Enforcement Safe Harbor

SBC Penalty Provisions

- An employer that willfully fails to provide SBCs in accordance with the SBC rules is subject to a penalty of up to $1,406 (indexed) per failure
  - Failure with respect to each employee or dependent constitutes a separate offense
  - If the employee has a family of four, the penalty could be up to $5,624!
- Failures may also trigger the standard $100/day ACA excise tax liability under IRC §4980D
- Failures may also be considered a breach of fiduciary duty under ERISA

Temporary Good Faith Standard Appears to Still Apply

- Since SBCs took effect in 2012, Tri-Agencies (DOL/IRS/HHS) have stated that they "will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the [SBC rules]"
- Tri-Agencies reiterated in 2014 that this good faith enforcement safe harbor from potential penalties applies "until further guidance is provided"
- Although it raised eyebrows that the good faith standard went unaddressed in the most recent 2015 SBC regulations, no further guidance has wound down this long-lasting safe harbor

Will the IRS Finally Enforce the SBC Rules?

- During the Obama Administration when the good faith standard began, SBCs were new and therefore it made sense to have a transitional period
- Given the long runway now (over a decade) for employers to adjust, it seems appropriate to see an end to the penalty relief soon
- As we enter a new era of SBC templates/translations, it may be time to wind down the relief and begin enforcement

05

Spousal Incentive HRAs

Popular New Opt-Out Incentive for Employees

What is a Spousal Incentive HRA?

Full Details: Ten Spousal Incentive HRA Compliance Considerations

A New Type of HRA Designed to Integrate with Spouse's Plan

What is a Spousal Incentive HRA?

- *Spousal Incentive HRA (SIHRA):* Reimburses employees for cost-sharing amounts incurred through the group health plan sponsored by the employer of the employee's spouse
- Employees get access to the SIHRA by waiving their employer's group health plan and instead enrolling as a dependent on the spouse's group health plan
- An alternative to the traditional incentive approach to offer employees an opt-out credit to waive—the SIHRA offers the carrot of providing actual coverage for the deductible, copay, and coinsurance amounts incurred under the spouse's plan

General Overview

- SIHRAs provide a creative and new approach to integrating the employer's HRA offering with a spouse's health plan
- Offers an interesting plan design alternative for employers to consider
- SIHRAs have similar compliance considerations to other specialty HRAs

Examples of Other Types of HRAs

- *Cost-Sharing HRA:* Reimburses a portion of the deductible, coinsurance, and copayment cost-sharing amounts under the employer's medical plan
- *Specialty HRA:* Reimburses expenses not sufficiently covered by the group health plan, such as infertility, gender affirmation, mental health, abortion-related travel, and autism
- *Individual Coverage HRA (ICHRA):* Reimburses individual medical insurance premiums as an alternative to the traditional employer-sponsored group medical plan

What are the Compliance Considerations for SIHRAs?

1. ACA Integration Required
2. HSA Eligibility
3. Section 105(h) Nondiscrimination
4. PCORI Fees
5. ACA Reporting
6. COBRA Cost of Coverage
7. No Medicare Reimbursement
8. No Premium Reimbursement
9. Domestic Partner Health Plans
10. The Standard GHP Requirements

SIHRA Compliance: ACA Integration General Rule

Full Details: Ten Spousal Incentive HRA Compliance Considerations

The Friday the 13th Guidance (September 13, 2013)

IRS Notice 2013-54; DOL Technical Release 2013-03

- The beginning of a long series of (particularly IRS) guidance confirming the ACA prohibition of individual coverage payment/reimbursement by employers
- **Guidance provided that employers cannot directly purchase individual policies or reimburse employees for the cost of individual policies through an "Employer Payment Plan" or a "Non-Integrated HRA"**

The IRS ACA Potluck Guidance (2015)

IRS Notice 2015-17; IRS Notice 2015-87

- Additional guidance reiterating the IRS prohibition of Employer Payment Plans and Non-Integrated HRAs
- Confirmed that even taxable reimbursements are prohibited, and that integration rules apply to employees, spouses and dependents

Penalties

IRC §4980D

- Employers offering an Employer Payment Plan or Non-Integrated HRA for employer reimbursement of individual policies violates the ACA market reform rules
- **Penalty is $100/day/employee excise taxes—resulting in potential penalties of $36,500 per employee per year**

SIHRA Compliance: ACA Integration
How to Meet the Required "Integrated HRA" Standard

Full Details: Ten Spousal Incentive HRA Compliance Considerations

The HRA Integration Rules
SIHRAs That Reimburse Only Cost-Sharing and Can Use Either Approach

MV Integration Requirements

1. Employer offers major medical that provides minimum value (MV) to the employee
2. Employee covered by HRA is also enrolled in a group major medical plan that provides MV—whether through that employer or a spouse/DP/parent
3. HRA is available only to employees enrolled in a group major medical plan that provides MV—whether through that employer or a spouse/DP/parent
4. Employee is permitted to permanently opt-out of HRA at least annually and upon termination

Non-MV Integration Requirements

1. Employer offers major medical to the employee
2. Employee covered by the HRA is also enrolled in group major medical—whether through that employer or a spouse/DP/parent
3. HRA is available only to employees enrolled in a group major medical plan—whether through that employer or a spouse/DP/parent
4. HRA reimburses only cost-sharing amounts under the major medical and/or non-essential health benefits
5. Employee is permitted to permanently opt-out of HRA at least annually and upon termination

SIHRA Compliance: ACA Integration:
How to Meet the Required “Integrated HRA” Standard

Full Details: Ten Spousal Incentive HRA Compliance Considerations

Summary of the ACA HRA Integration Rules

Non-Integrated HRA Prohibition

- Employers offering an HRA have to meet the “integration” requirements stemming from the Friday the 13th Guidance
- Those rules generally require that the employee be enrolled in an employer-sponsored major medical group health plan that provides minimum value to be eligible for reimbursement
- Most important piece is that HRAs cannot not be integrated with individual market coverage
- *Note: Indivdiual Coverage HRAs (ICHRAs) meeting several conditions are an exception to this rule*

SIHRA Integration Considerations

- With SIHRAs, employees are not enrolled in their employer’s major medical plan
- Instead they are enrolled as a dependent under their spouse’s employer’s major medical plan
- Fortunately, the rules are clear that the employee may enroll in any employer-sponsored group major medical plan
  - Doesn’t matter whether the plan is sponsored by the same employer offering the HRA
  - Generally never going to be in question since the SIHRA is for cost-shairng under spouse’s plan

SIHRA Complinace: HSA Eligibility

Full Details: Ten Spousal Incentive HRA Compliance Considerations

HRAs Will Generally Block HSA Eligibility

- HRAs that are not specially designed as HSA-compatible are disqualifying coverage for any individual covered by a High Deductible Health Plan (HDHP)—including SIHRAs

Post-Deductible HRAs Are Not Disqualifying Coverage

- To avoid the HRA blocking employee's HSA eligibility, the HRA needs to be structured as post-deductible (some SIHRAs offer this)
- This requires that the HRA not permit any reimbursements (i.e., not pay any benefits) until the employee has reached the statutory minimum deductible (2025: $1,650 individual/$3,300 family) in expenses covered by the HDHP

Example	Result
• Mookie's employer offers a SIHRA—he is covered under his spouse's medical plan in a HDHP • The SIHRA reimburses cost-sharing for the employee and spouse under the spouse's medical plan	• The general rule is that both Mookie and his spouse are not HSA-eligible (i.e., they cannot make or receive HSA contributions) • The SIHRA can prevent this by making the SIHRA post-deductible for anyone covered by an HDHP through their spouse's plan • This requires that Mookie incur at least $3,300 in expenses covered by the HDHP before the SIHRA can pay

SIHRA Compliance: §105(h) Nondiscrimination Rules

HRAs are self-insured group health plans, and therefore they are subject to the §105(h) nondiscrimination rules. There are three main components to the rules:

Full Details: Ten Spousal Incentive HRA Compliance Considerations

Eligibility Test	• Can exclude or provide different eligibility terms for categories of employees only if the classification is "reasonable and nondiscriminatory" • Definition of "reasonable and nondiscriminatory" specifically refers to distinctions based on the nature of compensation, such as hourly vs. salaried, and geographic location • Generally fine for employers to provide different SIHRA eligibility terms to employees based on hourly vs. salaried or employee groups in different regions
Benefits Test	• Requires that all benefits provided to eligible Highly Compensated Individuals (HCIs) under the plan also be available to all eligible non-HCIs • Creating different classes of benefits for eligible employees can be a problem because it may result in non-HCIs in the lower tier class not receiving the richer benefits available to HCIs in the higher class • §105(h) rules do allow employers to disaggregate into separate plans for testing purposes by specifying in the SIHRA plan document that the different arrangements are treated as separate plans
Operational Discrimination	• Umbrella provision preventing self-insured group health plans from discriminating against non-HCIs in operation—a facts and circumstances test based on each plan's specific arrangement • Unlikely to become an issue in SIHRA plan design because plan is not considered discriminatory merely because HCIs participating in the plan utilize benefits to a greater extent than non-HCIs • Main practice to avoid is employer selectively establishing, amending, or terminating the SIHRA in a manner designed to benefit HCIs (e.g., to specifically cover only certain HCIs expenses)

SIHRA Compliance: §105(h) Nondiscrimination Rules

HRAs are self-insured group health plans, and therefore they are subject to the §105(h) nondiscrimination rules. There are three main components to the rules:

Full Details: Ten Spousal Incentive HRA Compliance Considerations

HCI Definition	• The §105(h) rules define highly compensated individuals (HCIs) differently than the §125 highly compensated participant (HCP) and §129 highly compensated employee (HCE) definitions
	• For purposes of §105(h), an HCI is:
	  • One of the top five highest-paid officers;
	  • A shareholder who owns more than 10% of the value of the employer's stock; or
	  • Among the highest-paid top 25% of all employees in the current plan year

Separate Plans Provision	• Template HRA plan document provision to disaggregate the plan for §105(h) purposes: • *Pursuant to the "Multiple plans" provisions set forth in Treas. Reg. §1.105-11(c)(4), each coverage level, each group of Employees covered by the Plan, and each class of benefits provided under the Plan constitute a separate "plan" for purposes of the Internal Revenue Code §105(h) nondiscrimination requirements and any other applicable law.*

Failing the §105(h) Rules	• If the IRS were to audit a SIHRA and find its arrangement to be discriminatory under §105(h):
	  • All HCIs would be taxed on all or a portion of the benefits they received under the plan, referred to as the "excess reimbursement"
	  • This could be a significant tax liability depending on the amount and cost of services received by the HCIs

SIHRA Compliance: PCORI Fees

Full Details: Ten Spousal Incentive HRA Compliance Considerations

The PCORI Fee Applies to SIHRAs

- HRAs (including SIHRAs) are self-insured health plans subject to the PCORI fee
- Only Employee HRA Exception Applies to SIHRAs: SIHRAs can take advantage of the special counting rules that apply to HRAs
  - Allows employers to determine the PCORI fee based solely on the employee (not counting spouse/dependents as covered lives)
- Self-Insured Plan HRA Exception Does Not Apply to SIHRAs: No PCORI fee required for the HRA if it is paired with a self-insured major medical plan sponsored by that employer with the same plan year as the HRA (avoids a double PCORI fee for both the self-insured medical plan and the HRA)
  - This exception does not apply to SIHRAs
  - Exception does not apply because the employee is enrolled in a major medical plan through a different employer (spouse's employer)
  - Means that the employer sponsoring the SIHRA has to pay the PCORI fee for all SIHRA participants regardless of their health plan

PCORI Fees	July 31, 2024 Form 720 PCORI Filing	July 31, 2025 Form 720 PCORI Filing
Plan Year Ends January 1–September 30	Applicable Rate: • $3.00 per covered individual	Applicable Rate: • $3.22 per covered individual
Plan Year Ends October 1–December 31 (Including Calendar Plan Years)	Applicable Rate: • $3.22 per covered individual	Applicable Rate: • $3.47 per covered individual

SIHRA Compliance: Form 1095-C

Full Details: Ten Spousal Incentive HRA Compliance Considerations

- This form is completed for **every** full-time employee
- Self-insured plans (including SIHRAs) also need to report all individuals covered (self-insured non-ALEs use Form 1095-B)
- Two main topics being reported:
  1. **§6055: Individuals covered by MEC**
     - Self-insured plans must complete, including SIHRAs
     - Special HRA rule to avoid this **does not** apply to SIHRAs because the employee is not enrolled in medical coverage through the same employer (instead enrolled through spouse's employer)
     - Requires Social Security Number (or reasonable efforts to obtain) for all covered individuals
  2. **§6056: Employer mandate compliance for §4980H penalties**
     - All ALEs must report on this – both self-insured and fully insured
     - Requires detail as to plan's offer of coverage to all full-time employees

SIHRA Compliance: Form 1095-C

Full Details: Ten Spousal Incentive HRA Compliance Considerations

Part III Coverage Information – SIHRAs Must Complete

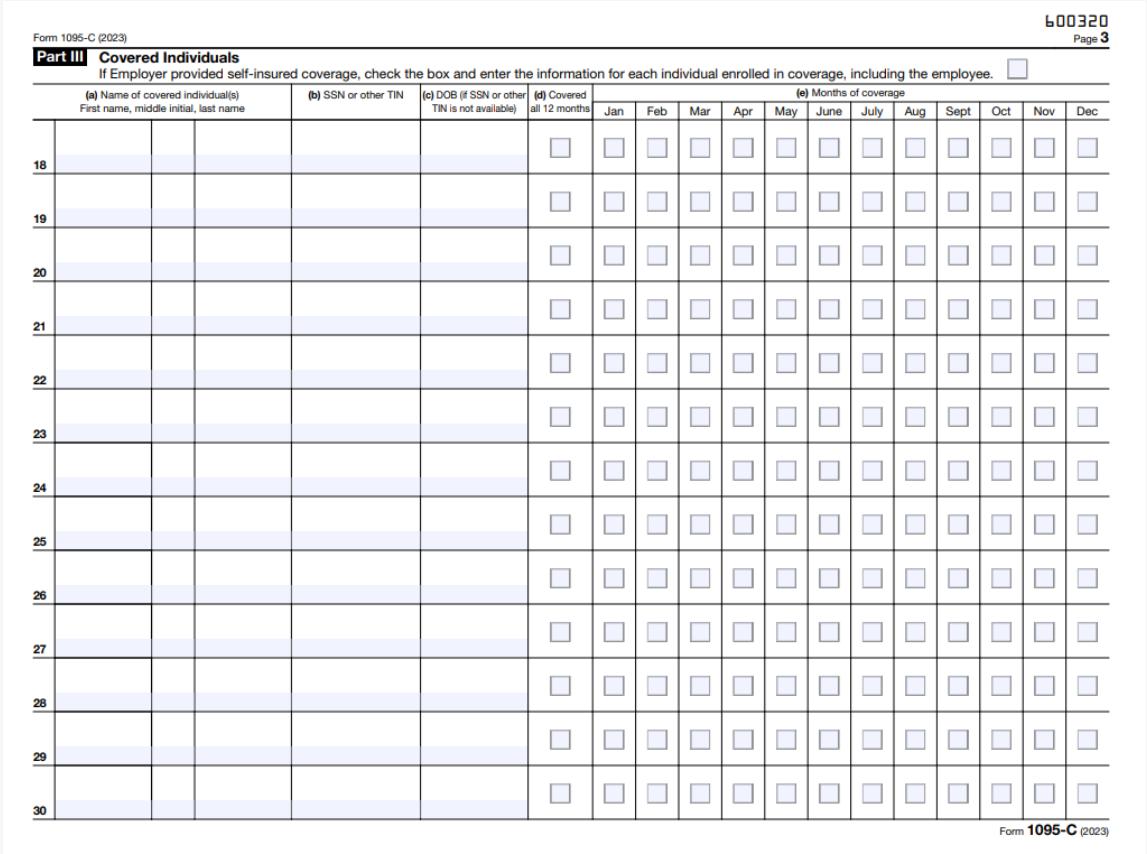
Self-insured plans (including SIHRAs) must include MEC coverage information in Part III of the Form 1095-C:

- Names of all covered individuals
- SSNs of all covered individuals
  - Must make "reasonable efforts" to obtain the SSN for all covered individuals
  - Requires **three attempts** to solicit the SSN:
    1. **Account Opened Solicitation:** Initial solicitation upon the employee's election to enroll the dependent
    2. **First Annual Solicitation:** If not received, second solicitation within 75 days of the employee's election to enroll the dependent
    3. **Second Annual Solicitation:** If not received, third solicitation by December 31 of the year following the year the employee elected to enroll the dependent
- Enter date of birth for any covered individuals who don't provide the SSN
- Months of coverage (not just offered coverage, but actually enrolled) for all covered individuals in the plan

Form 1095-C

- Part III completed for individuals enrolled in a SIHRA

Full Details: Ten Spousal Incentive HRA Compliance Considerations



Form 1095-C (2023) 600320 Page 3

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
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30				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Form **1095-C** (2023)

SIHRA Compliance: COBRA

Five Main Concerns for Employers in Addressing this Tricky Issue

Full Details: Ten Spousal Incentive HRA Compliance Considerations

1	Determining the HRA Premium
2	Determining the HRA Balance During COBRA
3	Determining Which Employees Have COBRA Rights Under the HRA
4	Determining the HRA COBRA Maximum Coverage Period
5	Determining Who Would Elect COBRA for a HRA

SIHRA Compliance: COBRA

Reminder: All HRAs are Subject to COBRA (Not Optional)

Full Details: Ten Spousal Incentive HRA Compliance Considerations

1

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4

5

Determining the SIHRA Premium

- Upon experiencing a qualifying event, SIHRA participants must receive a COBRA election notice that includes the option to elect COBRA under the SIHRA—but at what rate?
- This is the most difficult aspect of applying the COBRA rules to an HRA
- The limited IRS guidance in this area states that the standard rules apply that permit the employer to charge up to 102% of a reasonable estimate of the cost for providing the HRA to the participant
  - Employers generally are comfortable setting a reasonable estimate at 60% to 80% of the amount made annually available under the HRA
  - Based on the general rule of thumb that participants tend to take reimbursement of roughly 60%-80% of the full HRA balance made available each year
  - For example, employers might set the COBRA premium for a SIHRA with a $10,000 annual limit at 75% of that amount plus the 2% administrative fee ($637.50/month)
  - Note that the COBRA rate is not tied to the employee's balance remaining in the HRA at the time of the qualifying event—all COBRA qualified beneficiaries will have the same premium rate set at the beginning of the plan year

SIHRA Compliance: COBRA

Reminder: All HRAs are Subject to COBRA (Not Optional)

Full Details: Ten Spousal Incentive HRA Compliance Considerations

1
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5

Determining the SIHRA Balance During COBRA

- COBRA qualified beneficiaries will continue to have access to the full amount made available under the SIHRA, reduced by all claims reimbursed while active and through COBRA
- Most SIHRAs are designed with an annual limit, which must continue to be available through COBRA
  - The COBRA qualified beneficiary is entitled to the full new annual limit each year for the duration of the COBRA maximum coverage period in the same manner as an active employee

SIHRA Compliance: COBRA

Reminder: All HRAs are Subject to COBRA (Not Optional)

Full Details: Ten Spousal Incentive HRA Compliance Considerations

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Determining Which Employees Have COBRA Rights Under the SIHRA

- Only those employees participating in the SIHRA have COBRA rights to continue coverage
- Employers take different approaches to determine who is a participant in the HRA upon experiencing a COBRA triggering event (e.g., termination of employment)
  - *Default Approach:* All employees eligible for the SIHRA (and who have not affirmatively opted out of HRA coverage) are participants who have COBRA rights upon a triggering event
  - *Alternative Approach:* Employer requires employees to "enroll" in the SIHRA to determine whether they are participants
    - Enrollment is a nebulous concept for an HRA because (by definition) it has no employee contributions—but it can serve a purpose for COBRA and other administrative ends
  - *Aggressive Approach:* Treat only those employees who received reimbursement from the SIHRA as a participant for determining whether COBRA rights apply
    - Not a technically correct approach under COBRA rules because employees are covered by a group health plan regardless of whether they submit claims—but it does happen in practice

SIHRA Compliance: COBRA

Reminder: All HRAs are Subject to COBRA (Not Optional)

Full Details: Ten Spousal Incentive HRA Compliance Considerations

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Determining the SIHRA COBRA Maximum Coverage Period

- Employees who experience a qualifying event are entitled to the full maximum coverage period through COBRA
- The most common qualifying events (loss of coverage caused by termination of employment or reduction of hours) provide for an 18-month maximum coverage period
  - Note that the special health FSA rule that shortens the COBRA maximum coverage period to only the remainder of the current plan year does **not** apply to HRAs
  - Note that state mini-COBRA laws also do **not** apply to HRAs because the HRA is a self-insured group health plan

SIHRA Compliance: COBRA

Reminder: All HRAs are Subject to COBRA (Not Optional)

Full Details: Ten Spousal Incentive HRA Compliance Considerations

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Determining Who Would Elect COBRA for a SIHRA

- Very rare for employees to elect COBRA for an HRA
- In vast majority of situations, the employee will have no interest in paying the required COBRA premium on an after-tax basis to maintain the SIHRA continuation coverage
- In rare situations where the employee experiences a qualifying event and expects to immediately incur expenses covered by the SIHRA, COBRA may make sense
  - For example, an employee who terminates employment and expects to incur significant cost-sharing expenses under the spouse's plan in the upcoming months
  - In that situation, it could make sense for the employee to continue coverage under a SIHRA through COBRA to pay only a few months of COBRA premiums for potentially a larger sum in cost-sharing expense reimbursement
  - These situations are not likely to occur very often

SIHRA Compliance: No Medicare Reimbursement

The MSP rules are also designed to ensure that employers don't provide financial or other incentives to waive the GHP in favor of Medicare enrollment. This prohibits a SIHRA from reimbursing expenses for those on Medicare.

Full Details: Ten Spousal Incentive HRA Compliance Considerations

1	**No Medicare or Medicare Supplement Reimbursement**
	• Employer cannot pay for Medicare or Medicare supplement premiums (incluidng through a SIHRA)
	• Medicare and Medicare Supplement reimbursement also raises complex issues under the ACA's individual policy reimbursement prohibition
	  • Medicare reimbursement generally permitted for employers not subject to MSP rules, under certain conditions set forth in IRS Notice 2015-17, or under an Individual Coverage HRA (ICHRA)
	  • Medicare supplement reimbursement permitted under ACA (but not MSP)

2	**No Coverage Designed to Supplement Medicare** • Employers cannot provide coverage to active employees (including a SIHRA) that is designed to supplement Medicare coverage • Not an issue for retiree-only plans (because MSP rules do not apply)
3	**No Special Opt-Out Credits for Age 65+ Employees** • Any encouragement to waive the GHP in favor of Medicare, including a payment in the form of an opt-out credit, is a clear MSP violation • However, DOL has confirmed that an opt-out credit available equally to all employees (regardless of Medicare eligibility) does not violate MSP rule

SIHRA Compliance: The Other Stuff

Full Details: Ten Spousal Incentive HRA Compliance Considerations

No Premium Reimbursement:

- Employee's spouse will invariably pay the employee-share of the premium for the spouse and employee's coverage on a pre-tax basis through the spouse's employer's Section 125 cafeteria plan
- IRS guidance is clear that HRAs cannot reimburse premium amounts that are paid by the employee's spouse on a pre-tax basis
- Part of the general prohibition against double-dipping for account-based plans
- Employers can still reimburse for the amount of the spouse's premium, but it must be done on taxable basis outside the SIHRA

Domestic Partner Health Plans:

- SIHRAs can reimburse the employee's cost-sharing amount through a domestic partner's health plan in the same manner as with a spouse's health plan
- However, HRAs cannot reimburse a non-tax dependent domestic partner's health expenses because they do not qualify as an eligible §213(d) medical expense under §105(b)
- This means that a SIHRA cannot be designed to reimburse the domestic partner's cost-sharing amounts tax-free
- Employers could always reimburse a non-tax dependent domestic partner's cost-sharing amounts on a taxable basis

The Other GHP Requirements:

- SIHRAs (as with any type of HRA) are group health plans subject to the standard legal requirements of any group health plan
- Includes standard ERISA requirements that it be administered pursuant to the written terms of the plan document, there by an SPD summarizing the benefit for employees, the form 5500 requirements, and the standard fiduciary duties apply
- Also subject to the standard HIPAA obligations imposed upon health plans as a covered entity under the privacy and security rules

WRAP-UP

Takeaways

Year in Review – Top Five Summary

Remember: This is just a short thumbnail sketch of the boundless issues we face in employee benefits compliance for health and welfare plans. For all the latest alerts, guides, and FAQs throughout the year: https://www.newfront.com/blog/category/compliance

1 ACA Employer Mandate & Reporting

- The §4980H employer mandate penalties continue be enforced—make sure to offer affordable coverage to all full-time employees to avoid potential liability
- The affordability threshold increases in 2025 to 9.02%, automatic pass by offering coverage at or below $113.20/month

Key New Point for 2025

- Distribution of Forms 1095-C to all full-time employees is no longer required! These can now instead be available upon request. Electronic filing of all forms with the IRS is still required.

2 CAA Has Reached Full Implementation

- The slow build each year since enactment reached a crescendo in 2024 as the last items took full effect
- Employers with fully insured plans can largely rely on their insurance carrier to address most of the CAA requirements
- Employers with self-insured plans (including level funded) need to coordinate with the TPA to determine what aspects they will assume on the plan's behalf

Key New Point for 2025

- The new MHPAEA fiduciary certification rule requires that employers certify their prudent oversight as part of the comparative analysis document

3 Potential Trump Administration Priorities

- Expand the use/benefit of HSAs by increasing contribution limits and allowing use for premiums
- Eliminate ACA employer mandate penalties
- Eliminate or significantly simplify ACA reporting
- Codify ICHRAs and add improvements
- Create dependent care savings accounts (DCSA)
- Revisit association health plan (AHP) rules

Key New Point for 2025

- The ACA repeal/replace effort appears dead
- Still likely to pursue many of these priorities

4 The Other News

- HDHPs lose their telehealth relief, must impose deductible to preserve HSA eligibility
- The tax-free employer student loan repayment assistant offering expires at the end of 2025, will it be extended?
- New HIPAA reproductive health rules require an attestation document and updates to the Notice of Privacy Practices
- 2025 Medicare Part D changes imposed by the IRA are causing ripple effects for employers in the creditable status determination

Key New Point for 2025

- The J&J case made waves with a novel breach of fiduciary duty claim based on excessive Rx costs—will the plaintiffs prevail?

5 SIHRAs Present New Compliance Considerations

- What is a SIHRA? It's a way to incentivize employees to enroll in their spouse's plan by reimbursing cost-sharing amounts incurred under the spouse's health plan
- SIHRAs are just the latest in a variety of different types of HRAs that have gained in popularity in recent years
- As an HRA, SIHRAs are a group health plan subject to the full spectrum of compliance requirements
- Ten primary compliance considerations include ACA, COBRA, HSA eligibility, PCORI, and more

Key New Point for 2025

- There's always new benefit ideas to consider offering to your employees—SIHRAs are an interesting and creative idea to explore

Content Disclaimer

EB Year in Review

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Thank you

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