2024 Mid –Year
Employee Benefits Compliance Update

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Today’s Speakers

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Agenda

- Changes to Medicare Part D
- ACA Section 1557 Health Care Nondiscrimination Final Rule
- Annual Benefit Notices and CHIP Update
- Gag Clause Attestations
- 2025 IRS Benefit Limits
- New Regulations on Handling PHI Relating to Reproductive Healthcare
- Mental Health Parity Regulations on Non-Quantitative Treatment Limitations
- ERISA Preemption and Legislation Impacting PBMs
- State Legislation on Dental Plan MLR
- State Paid Leave Update
- 2025 Compliance Calendar

Changes to Medicare Part D

Medicare Part D: Creditable Coverage

- Inflation Reduction Act (2022) made major changes to Medicare Part D (Rx) coverage
- True Out-Of-Pocket Costs (TROOP) are reduced to just $2000 in 2025 (versus $8000 in 2024)
- For plan years beginning on and after 1/1/2025, more difficult for employer plans to obtain creditable status because of increased value of Medicare D

Medicare Part D: Creditable Coverage

- Plans that offer Rx coverage must provide Medicare-eligibles an annual notice stating whether the Plan provides “Creditable Coverage”
  - Creditable coverage is not required, but the annual notice is
- How does employer determine creditable coverage status?
  - Carrier or third-party administrator (TPA) will provide information
  - plan sponsor (e.g., the employer) is responsible for making the determination
    - https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/CCSimplified091809.pdf
    - Unless plan meets Safe Harbor, should be done by an actuary
  - CMS indicated Safe Harbor may change or no longer be available in 2026

Medicare Part D: Creditable Coverage

Rx drug coverage is **creditable**:

actuarial value of the coverage ≥ **actuarial value of standard Part D Rx coverage**

The expected amount of paid claims for Rx under the coverage is at least as much as the expected amount of paid claims under the standard Part D benefit.

Medicare Part D: Creditable Coverage

- Real consequences for Part D eligibles
  - Part D eligibles permitted to delay enrollment if they are enrolled in other **creditable** prescription drug coverage
  - Individual who delays Medicare Part D enrollment and goes 63 days or more without creditable prescription drug coverage incurs late enrollment penalties when the individual eventually chooses to enroll in Medicare Part D
- Takeaways
  - Check creditable coverage status of health plans going into 2025 plan year
  - Engage an actuary, if necessary
  - **Clearly communicate any changes to plan members**

ACA Section 1557 Health Care Nondiscrimination Final Rule

ACA: Section 1557 – Health Care Nondiscrimination

Non-discrimination provision of the Affordable Care Act (ACA)

- Prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in specified health programs or activities, including those that receive Federal financial assistance

New Final Regulations –Effective for plan years beginning on and after January 1, 2025)

- Prohibits discrimination by health programs and activities based on race, color, national origin, sex, age or disability
- Extend protections against discrimination to include sexual orientation and gender identity

ACA: Section 1557 – Health Care Nondiscrimination

- Entities covered by 1557:
  - Health Plans that receive federal financial assistance from HHS
  - Health programs or activities administered by an entity that participates in the state and federal Marketplace
  - May include hospitals, health clinics, health insurance issuers, state Medicaid agencies, community health centers, physicians' practices, and home health care agencies
  - Does not apply to Employer's employment practices, including the provision of employee health benefits
- "Health program or Activity" means all operations principally engaged in providing or administering health services or health insurance coverage
- Does not technically extend to Employer health plans, but…
  - Fully-insured plans are likely to be compliant, because insurance carrier likely accepts federal funds and is subject to Rule
  - TPA for self-funded plans may also be compliant, because liability may extend to TPA
    - TPA potentially not liable if wasn't involved in plan design

ACA: Section 1557 – Health Care Nondiscrimination

- If covered, the Final Rule requires:
  - Must provide and post notice informing individuals of their civil rights under Section 1557 & must provide language assistance services to those with limited English proficiency
  - Cannot restrict a participant's ability to receive medically necessary health care based on the protected classes
  - Cannot impose blanket restrictions or nominal restrictions prohibiting plan level coverage of benefits relating to the treatment of gender dysphoria (cannot state gender dysphoria is a mental health disorder)
  - Coverage must be provided in neutral and non-discriminatory manner
  - Denial of care Must ensure that algorithms, devices or tools (including AI) is not discriminatory
  - If have 15 or more employees, then must appoint a Section 1557 coordinator, implement written policies & procedures, and train relevant employes on the policies and procedures

ACA: Section 1557 – Health Care Nondiscrimination

- Rule does not require:
  - Standard course of treatment/care – no affirmative obligation to offer any healthcare, including gender-affirming care, that is not clinically appropriate (or if religious freedoms/conscience protections apply)
  - Can raise legitimate and nondiscriminatory reasons for denial of care(cannot be based on unlawful animus or bias or constitute a pretext for discrimination)

- Employers should Review plan to determine if changes are needed in the benefit design

Annual Notices and CHIP Update

Annual Notices – New Model CHIP Notice for 2025

Children's Health Insurance Program ("CHIP")

- US Dept of Labor requires employers to annually provide information on potential opportunities for premium assistance under Medicaid or CHIP
- US DOL provides model annual notice that informs each employee (regardless of enrollment status) of potential opportunities for premium assistance in the state in which the employee resides
- Updated periodically to reflect changes in the states that offer premium assistance subsidies
- Employers sponsoring a group health plan should provide the CHIP notice with other health plan eligibility materials, including at new hire enrollment, annual open enrollment, and with the summary plan description (SPD)
- https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra

Annual Notices – Medicare Part D Disclosure

- Plans that provide prescription drug coverage must disclose to Medicare-eligible individuals whether the prescription drug coverage provided by the group health plan is "creditable"
- Because of Medicare Part D changes as of 1/1/2025, Plans should determine whether prescription drug coverage maintains its status as "creditable" or has changed to "not creditable"
- CMS provides model notice that can be customized
- Notice must be provided on or before October 15th each year

***Note:** HRA plans must provide notice of creditability (either as stand-alone or combined)

Gag Clause Attestations

Gag Clause Prohibition Compliance Attestations

- The CAA prohibits Plans and insurers from entering into agreements with health care providers, networks, TPAs and other service providers that contain contract provisions that directly or indirectly limit or restrict sharing information allowed and consistent under HIPAA, GINA and ADA including:
  - Specific cost and quality information with plan participants
  - Claim data sharing with plans and their service providers
  - Applies to all contracts entered on or after December 27, 2020
- Annual requirement to attest compliance to CMS
  - Attestations must be submitted on or before December 31st of each year
- Employers must submit attestation on behalf of Plan
  - If fully-insured, most carriers have agreed to submit attestation of compliance on Plan's behalf
  - If self-funded, then employer must submit.
- Attestation Reporting doesn't apply to: ICHRAs, HRAs, FSAs, HSAs, and HIPAA-excepted benefits

2025 IRS Benefits Limits

HSA & HDHP

Contribution and Out-of-Pocket Limits for Health Savings Accounts and High- Deductible Health Plans			
Component	**2025**	**2024**	**Change**
HSA Contribution Limit (Employer + Employee)	**Self Only: $4,300 Family: $8,550**	**Self Only: $4,150 Family: $8,300**	**Self Only: +$150 Family: +$250**
HSA Catch-Up Contributions (Age 55+)	**$1,000**	**$1,000**	**No Change**
HDHP Minimum Deductibles	**Self Only: $1,650 Family: $3,300**	**Self Only: $1,600 Family: $3,200**	**Self-Only: +$50 Family: +$100**
HDHP Maximum Out-of-Pocket Amounts (deductibles, co-payments, and other amounts, but not premiums)	**Self Only: $8,300 Family: $16,600**	**Self Only: $8,050 Family: $16,100**	**Self Only: +$250 Family: +$500**

ACA MOOP Limits: Non-HSA Plans

- Maximum Out of Pocket (MOOP) for ACA
  - Includes copayments, deductibles, and coinsurance amounts
- 2025 ACA Cost Sharing (OOP) Dollar Limits for Essential Health Benefits are:
  - $9,200 for self-only coverage
  - $18,400 for family coverage
- A decrease of 2.6% from the 2024 limits of:
  - $9,450 for self-only coverage
  - $18,900 for family coverage

ACA PENALTIES DECREASING

- For tax year 2025:
  - Penalty A—failure to offer MEC to 95% of FT, benefit-eligible employees—$2,900 ($241.67/month)
    - 2024 was $2,970($241.67/month)
  - Penalty B—failure to provide affordable, MV coverage to a benefit-eligible employee—$4,350 ($362.50/month)
    - 2024 was $4,460 ($371.67/month)

Expected Benefits HRA Limit

- 2025 Maximum Employer Contribution to Excepted Benefit HRA is $2,150
  - Restricted to dental, vision or similar benefits that are not covered by the primary group health plan

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New Regulations Handling PHI Relating to Reproductive Healthcare

PHI Relating to Reproductive Healthcare

HHS recently finalized the HIPAA Privacy Rule to Support reproductive health care privacy (rPHI)

- Prohibits disclosure of PHI related to lawful reproductive health care
- Most healthcare providers, health plans, and business associates must specifically safeguard the privacy of information related to reproductive health care and set limits and conditions on the uses and disclosure of rPHI
- Prohibits the use or disclosure of rPHI when it is sought to investigate or impose liability on individuals, health care providers or others who seek to obtain, provide, or facilitate reproductive health care that is lawful under the circumstances in which it is provided or to identify persons for such activities

PHI Relating to Reproductive Healthcare

- When a request for rPHI is received, must obtain a signed attestation that certain requests for rPHI potentially related to reproductive health care are not for these prohibited purposes (applies for health oversight activities, judicial and administrative proceedings, law enforcement purposes, and disclosures to coroners and medical examiners.
- Requires an updated notice of Privacy Practices to support reproductive health care privacy and to address proposals made in the Notice of Proposed Rulemaking for the Confidentiality of Substance Use Disorder Patient Records
- Business Associates Agreements must be updated

Mental Health Parity Regulations on Non-Quantitative Treatment Limitations

Mental Health Parity

- Mental Health Parity and Addiction Equity Act (MHPAEA)
- Requires parity in financial requirements, quantitative treatment limitations and non-quantitative treatment limitations (NQTLs)
  - E.g., prior authorization requirements, step therapy, provider network participation standards, methodologies to determine provider reimbursement rates
- CAA 2021 requirement that all plans perform comparative analysis of NQTLs and produce analysis to regulators on request
  - No plans have met regulators’ standard for analysis

Mental Health Parity

- Regulations proposed in July 2023
  - Clarify that autism spectrum disorders and eating disorders are considered mental health conditions under the law
  - Detailed requirements for content of each comparative analysis
  - Standards for analysis
    - No more restrictive
    - Design and application
    - Outcomes data
- Reasonable action to remedy network insufficiency
- Failure to provide sufficient comparative analysis result in loss of ability to impose NQTL until plan can demonstrate compliance with MHPAEA

Mental Health Parity

- Fully-insured plans
  - Confirm with carrier that analysis has been done and will be provided to plan if regulator requests
- Self-funded plans
  - Perform comparative analysis– rely on collaboration with PBM, TPA, network provider
  - Tool or vendor?
- NAIC
  - Evaluating tools and methodologies for developing evidence-based care guidelines for MH/SUD

ERISA Preemption and Legislation Impacting PBMs

Prescription Drug Coverage

- ERISA preemption and regulation of PBMs
  - *Rutledge v. PCMA*– ERISA does not preempt all state regulation of PBMs
    - *PCMA v. Mulready*
    - *PCMA v. Wehbi*
- Significant uncertainty regarding how far states can go in regulating PBMs
- Significant interest in addressing rising drug costs

Prescription Drug Coverage

- Vocabulary
  - Copay accumulator plan
  - Spread pricing
  - Step therapy
  - Rebate and rebate pass-through
  - NADAC

Prescription Drug Coverage

- Copay Accumulator Programs
  - Practice of not counting manufacturers coupon toward out-of-pocket maximum
    - Prior tri-agency guidance indicated practice ok, unless state law prohibited
  - 2023 decision U.S. District Court for DC in *HIV and Hepatitis Policy Institute v. U.S. Department of Health and Human Services*
  - Awaiting new regulatory guidance
  - 19 states have banned copay accumulators

Prescription Drug Coverage—PBM Bills

- Continued pressure to regulate PBMs
  - 27 bills before Congress
  - Letter from 39 State AGs– highlights 3 bills
- Lower Costs, More Transparency Act
  - Requires PBMs to semi-annually provide employers with detailed data on prescription drug spending
  - PBMs that contract with Medicaid Managed Care Organizations (MCOs) from spread pricing. States would reimburse PBMs contracting with MCOs for an administrative fee for managing the pharmacy benefit for Medicaid beneficiaries.
  - Strengthens requirements that PBMs and TPAs disclose compensation to plan fiduciaries.

Prescription Drug Coverage—PBM Bills

- DRUG Act
  - Prohibits PBMs from charging or receiving fees from any entity for services provided. Flat fees are allowed if it is included in an agreement between the PBM and the entity.
- Protecting Patients Against PBM Abuses Act
  - Establishes responsibilities for PBMs including not deriving income above flat service fees from drugs provided under Medicare Part D. Any flat fee cannot be based on the price of the drug, or discounts, rebates, or fees with respect to the drug.
  - Increases PBM transparency by requiring PBMs to provide information on the aggregate dollar amount of rebates and administrative fees.

Prescription Drug Coverage– States

- Notable new state laws:
  - **Idaho:** Bans spread pricing, requires 100% rebate pass-through, requires 60-day continuity of care following formulary changes
    - Language similar to statute in *Rutledge*; unclear extent of impact on self-funded plans
  - **Illinois:** Health Care Protection Act bans step therapy, bans prior authorization for in-patient adult and children's mental health care
    - Does not apply to self-funded plans
  - **Kentucky:** Requires pharmacy reimbursement at NADAC + dispensing fee, applies to self-funded plans
  - **Pennsylvania:** Requires 95% rebate pass-through, does not impact self-funded plans
  - **Vermont:** Prohibits spread pricing, does not impact self-funded plans
  - **Washington:** prohibits spread pricing, impacts self-funded government plans

Prescription Drug Coverage—States

- 23 states have pending legislation regulating PBMs
  - **California SB 966:** Prohibits spread pricing, requires passthrough pricing, prohibits PBM compensation from plan other than flat fee, requires cost sharing not to exceed cost of drug. Does not apply to self-funded plans.
  - **North Carolina H. 246:** Prohibits spread pricing, prohibits PBM from reimbursing pharmacy less than NADAC + dispensing fee, carves out HDHP from copay accumulator unless member has exhausted deductible. Likely does not apply to self-funded plans.
  - **Ohio HB 505:** Requires reimbursement of pharmacy's actual acquisition cost. Applies to self-funded MEWAs but not other self-funded.
  - **Rhode Island HB 7139:** Prohibits spread pricing

State Legislation on Dental Plan MLR

Dental MLR

- ACA MLR requirement
- NCOIL Model Act
- 11 states introduced dental MLR legislation in 2024
  - California AB 2028– Dental MLR of 85%
  - Illinois HB 2070– Require reporting of dental MLR
  - New York SO7030/A7852– Dental MLR of 82%
  - Pennsylvania HB 1457– Require reporting of dental MLR

State Paid Leave

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State Paid Leave

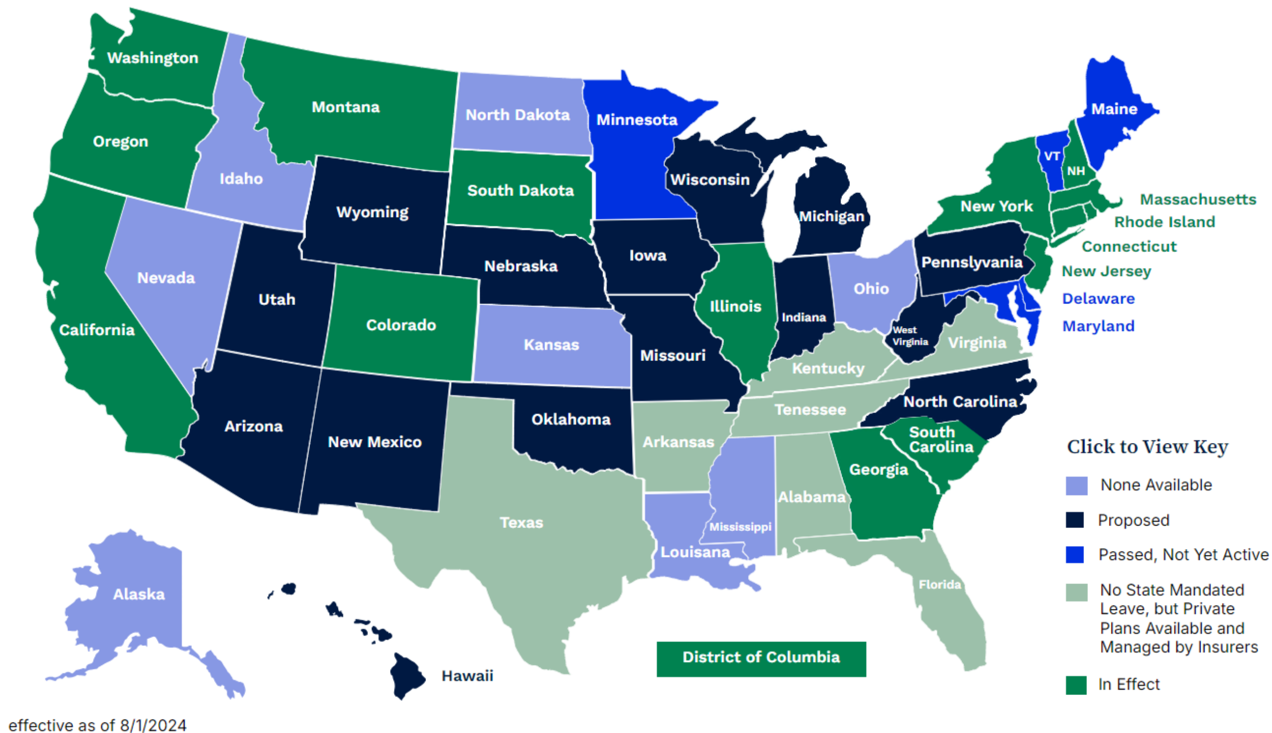
- Delaware Healthy Delaware Families Act (Eff. 1/1/25, benefits begin 1/1/26)
- Illinois Paid Leave for All Workers Act (PLAWA, Eff. 1/1/24)
  - Up to 40 hours paid leave/year for any reason (one hour for every 40 worked)
  - Exemptions include employees of school districts, certain railroad, airline and higher education employees
- Maine Paid Family Medical Leave (Eff. 1/1/25, benefits begin 1/1/26)
  - Up to 12 weeks paid leave
  - Delayed impact for collectively bargained plans

State Paid Leave

- Maryland Family and Medical Leave Insurance (FAMLI Eff. 7/1/26)
  - Up to 12 weeks of paid leave
- Minnesota (Eff. 1/1/26)
  - Up to 20 weeks of paid leave
  - Limited exception for certain seasonal workers
- Vermont (Eff. 1/1/23 with phase-in. Fully eff. 1/1/25)
  - Up to 6 weeks paid leave

State Paid Leave

- Proposed in Arizona, Hawaii, Indiana, Iowa, Kentucky, Missouri, New Mexico, Oklahoma, Pennsylvania, South Dakota, Utah, West Virginia, Wisconsin



Compliance Calendar

2024-25 Compliance Calendar

Date	Requirement
September 30, 2024	Summary Annual Report (SAR) for calendar year plans
September 30, 2024	MLR rebate, if any
October 14, 2024	Creditable Coverage Notice
December 15, 2024	SAR distribution, if 5500 was extended
December 31, 2024	Gag Clause Attestation
January 31, 2025	Annual reporting of aggregate cost of employer-sponsored group health coverage on W2
February 28, 2025	Section 6055 and 6056 Reporting (April 1, if filing electronically; also state deadlines may vary)
February 28, 2025	Medicare Part D Disclosures to CMS

2024-25 Compliance Calendar

Date	Requirement
March 1, 2025	Form 1095-C or 1095-B Annual Statements to individuals
March 1, 2025	Form M-1 filing with DOL
March 31, 2025	Forms 1094/95-C and/or 1094/95-B to the IRS – (April 1 if filing electronically)
June 1, 2025	RxDC– Drug Cost Reporting to CMS
July 31, 2025	PCORI Fee – Deadline for filing IRS Form 720 and paying fees for the previous year
July 31, 2025	Form 5500 – Can be automatically extended 2.5 months by filing form 5558

2024-25 Compliance Calendar

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Questions?

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Thank You!