2024 Compliance
Year in Review

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Single Coverage	9.02% of income
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FICA Tax Avoidance Wellness Program Viewed Unfavorably by IRS

PUBLISHED: JANUARY 19, 2024

In a recently released **Chief Counsel Memorandum**, the IRS weighed in on the tax treatment of a frequently marketed "insurance" product designed to reduce employer FICA taxes and employees' taxable wages. In short, the IRS views payments under a wellness indemnity product as wages, subject to FICA taxes.

Seyfarth Synopsis: Just like a bad penny, schemes promising employers ways to reduce their FICA tax burden, and maybe their employees' income tax burden at the same time, keep popping up with a slightly different burnish on the coin. The risks of such an approach have concerned tax practitioners and now the IRS has directly and definitively weighed in on the side of confirming there is no free lunch here.

BACKGROUND

Over the last ten years or so, various vendors and insurance carriers have sought to take advantage of the admittedly arcane insurance and tax rules to design a mechanism to convert otherwise taxable income to tax-free benefits. While the products all vary slightly, they generally follow the same playbook:

1. Employer enrolls employee in a wellness/fixed indemnity insurance product.

2. Employee pays the product premium (let's call it $1,200/month) on a pre-tax basis through the employer's Section 125 cafeteria plan.

3. On a monthly basis, the employee engages in a low-commitment "wellness" activity (e.g., call a nurse line, take blood pressure, fill out a health risk questionnaire).

4. The "reward" or "reimbursement" for participating in the wellness activity is a tax-free "reimbursement" in an amount roughly equivalent to the amount the employee paid for the premium (less taxes) (e.g., $1,000). So, the employee nets roughly equal and the employer avoids paying FICA taxes. [Earlier versions of this product also promised to fully reimburse employee for the pre-tax premium, resulting in the amount of the premium payment itself being income tax free.]

5. The product is usually also paired with a hospital indemnity/fixed indemnity insurance product that pays a set amount based on certain contingencies (e.g., hospitalization).

Over the years, the IRS has issued various memoranda (**here**, and **here**) opining that wellness payments are not tax-free simply because they are associated with a wellness plan (i.e., a cash reward is still taxable). While marketers of these products have attempted to circumvent this guidance by arguing this is a bona fide insurance product, recognized by state regulators, Seyfarth has continued to express concern that the payments under these types of products remained, at best, at risk of recharacterization as taxable income (and at worst, an abusive tax shelter).

2023 MEMORANDUM

In its recent guidance, the IRS focused on the FICA/FUTA tax exclusion relied upon by marketers of these products, which exempts "payments on account of sickness or accident disability". The IRS indicated that even though wellness payments issued from the insurance product may relate to sickness or accident disability, they remain wages subject to FICA/FUTA withholding as they are not made to reimburse medical or hospitalization expenses. The same analysis applies to payments made from the hospital indemnity program.

Similarly, the IRS focused on the income tax exclusion for sick pay and medical benefits, and concluded that payments under these wellness insurance and indemnity programs do not qualify for the exclusion.

The IRS does not address the outcome if the reimbursements were to be applied toward the employee's unreimbursed medical expenses, and whether they would be subject to FICA/FUTA or income tax withholding. But practically speaking, as proof of medical expenses are not required under this program an employer would have no meaningful way to ascertain how the funds would be applied, which appears to mean the IRS would almost always require the employer to pay (and withhold) FICA/FUTA and income taxes on reimbursements under these programs.

NAIL IN THE COFFIN?

While we have no doubt that some variation of this scheme will continue to live on in some form going forward, employers are cautioned to exercise extreme caution in implementing such a design, as the IRS continues to express an unfavorable opinion on the validity of these tax-avoidance arrangements.

ERISA Lawsuit Alleges Breach of Fiduciary Duty due to Mismanagement of Prescription Drug Benefits

PUBLISHED: FEBRUARY 22, 2024

A proposed **class action lawsuit** filed against Johnson & Johnson (J&J) alleges that the company breached its fiduciary duties under ERISA by mismanaging its prescription drug benefits plan. The complaint asserts that J&J violated ERISA's fiduciary duty of prudence in multiple ways and that this mismanagement cost the plan and its participants millions of dollars due to higher out-of-pocket costs for prescription drugs, higher premiums, and lower wages or limited wage growth.

This lawsuit highlights for employers the importance of adhering to their fiduciary duties when managing their health plans. Employers must prudently select and monitor their third-party service providers, including pharmacy benefit managers (PBMs). There may be more lawsuits like this one in the future, as the PBM industry faces increasing scrutiny and new transparency laws provide employees with more information regarding health care costs.

ERISA FIDUCIARY DUTIES

Individuals who have discretion in administering and managing an employee benefit plan are subject to ERISA's strict fiduciary standards. Significantly, ERISA requires fiduciaries to discharge their duties with respect to employee benefit plans:

- Solely in the interest of plan participants and beneficiaries;
- For the exclusive purpose of providing plan benefits, or for defraying reasonable expenses of plan administration; and
- With the care, skill, prudence and diligence that a prudent person in similar circumstances would use.

The duty to act prudently is one of a fiduciary's central responsibilities.

ERISA requires fiduciaries to prudently select and monitor plan service providers, considering various factors, including the service provider's fees and expenses.

FIDUCIARY BREACH LAWSUIT

The plaintiff, an employee of J&J, alleges that the company failed to exercise prudence with respect to its prescription drug benefit. Notably, the complaint alleges that J&J mismanaged the plan by agreeing to inflated prices from its PBM for generic specialty drugs. The complaint also alleges that the company agreed to terms that encouraged participants to use the PBM's own mail-order pharmacy, even though its prices were routinely higher than other pharmacies. In one example, J&J allegedly allowed its ERISA plans and beneficiaries to pay its PBM over $10,000 for a 90-day supply of teriflunomide (the generic form of Aubagio, used for multiple sclerosis treatment), despite the option for individuals to fill the prescription for between $28.40 and $77.41 from other pharmacies.

The plaintiff asserts that ERISA required J&J to make a diligent and thorough comparison of PBMs, to seek the lowest level of costs for services, and to continuously monitor plan expenses to ensure they remained reasonable, all things that J&J failed to do. The plaintiff requests a variety of types of relief, including that the company restore to the plan and its participants all losses resulting from each breach of fiduciary duty.

Health Plan Eligibility: Do's and Don'ts

PUBLISHED: MARCH 19, 2024

Employers sponsoring group health plans have some flexibility when deciding which groups of employees and dependents will be eligible for coverage. However, there are several crucial eligibility requirements employers should adhere to for health coverage. These rules can be categorized into important eligibility "do's" and "don'ts" for employers to follow.

A basic eligibility "do" is following the terms of the health plan's written plan document, including its eligibility rules. Also, to avoid potential penalties, applicable large employers (ALEs) should ensure they offer affordable coverage to their full-time employees. Other important "do's" include making coverage available for adult children up to age 26 and continuing to offer coverage for Medicare-eligible employees when the health plan is the primary payer.

Essential "don'ts" for health plan eligibility include offering coverage to nonemployees, such as independent contractors, and imposing waiting periods that exceed 90 days. Other crucial "don'ts" are overlooking applicable nondiscrimination requirements when establishing eligibility rules and excluding employees from coverage based on health status-related factors.

ELIGIBILITY DO'S

Do Follow the Terms of the Plan Document

To comply with ERISA, a health plan must have an official written plan document that contains the plan's rules for benefits and eligibility. These rules should identify the groups of employees and dependents (e.g., children, spouses and domestic partners) who are eligible to enroll in the plan. The plan document should also describe any waiting period or other conditions for enrollment. The plan document is often comprised of multiple documents, including benefit descriptions provided by an insurance carrier or third-party administrator, and a "wrap" document that combines multiple benefits under one welfare benefit plan and satisfies ERISA's documentation requirements.

LINKS AND RESOURCES

- ***IRS questions and answers on the ACA's pay-or-play rules for ALEs***
- ***Final rules on the ACA's age 26 requirement for young adults***
- ***Final rules on HIPAA's nondiscrimination rules related to health status-related factors***

Following the written plan document in the day-to-day operations of the plan is a fiduciary duty under ERISA. Employers should be familiar with their written plan document and periodically review the document to make sure it remains current. Deviating from the health plan's established eligibility rules may also raise concerns about impermissible discrimination or favoritism in the workplace. For insured health plans, going beyond the plan's established eligibility terms may inadvertently create self-insured liability for the employer if the carrier denies claims based on the individual's ineligibility for benefits.

Do Offer Affordable Coverage to Full-time Employees (ALEs Only)

The Affordable Care Act (ACA) requires ALEs to offer affordable, minimum-value health coverage to their full-time employees (and dependents) or potentially pay a penalty to the IRS. This employer mandate is also known as the "pay-or-play" rules. ALEs are employers that had, on average, at least 50 full-time employees, including full-time equivalent employees (FTEs), during the preceding calendar year. Small employers that are not ALEs are not subject to these rules and are not required to offer coverage to their full-time employees.

An ALE may be subject to a pay-or-play penalty if at least one full-time employee receives a premium tax credit for purchasing individual health coverage through an ACA Exchange (or Marketplace) and the ALE:

- Did not offer health plan coverage to at least 95% of full-time employees and their dependents;
- Offered health plan coverage to at least 95% of full-time employees but not to the specific full-time employee receiving the credit; or
- Offered health plan coverage to full-time employees that was unaffordable or did not provide minimum value.

Identifying which employees are full-time employees is central to the ACA's pay-or-play rules. A full-time employee is an employee who has, on average, at least 30 hours of service per week or at least 130 hours per calendar month.

Do Offer Coverage for Adult Children up to Age 26

The ACA requires health plans that provide dependent coverage for children to make the coverage available for adult children until they reach age 26. A "child" includes an employee's biological child, adopted child, stepchild or foster child. A health plan may not deny or restrict coverage for a child who is under age 26 based on whether the child is financially dependent on the participant, resides with the employee or with any other person, is a student, is employed, is unmarried, or any combination of these factors.

In addition, the terms of the plan providing dependent coverage of children, including premiums

charged, cannot vary based on age (except for children who are age 26 or older). This means that adult children must be offered all the benefit packages available to other plan participants and cannot be required to pay more for coverage.

Do Continue to Cover Medicare-eligible Employees

When individuals have Medicare coverage and employer-sponsored health coverage, each type of coverage is called a "payer." Medicare's coordination of benefits rules decide which payer pays first on a health care claim (that is, pays primary). For example, health plans sponsored by employers with 20 or more employees are typically the primary payers for individuals who are entitled to Medicare due to age.

The **Medicare Secondary Payer (MSP) rules** include requirements for employers that sponsor group health plans that are primary to Medicare. These requirements are intended to protect Medicare's secondary payer status. Employers with group health plans that are primary to Medicare must comply with the following requirements:

- The group health plan must provide a current employee (or a current employee's spouse) who is age 65 or older with the same benefits under the same conditions it provides employees and spouses under age 65;
- The employer cannot offer Medicare beneficiaries any financial or other benefits as incentives not to enroll (or terminate enrollment) in a group health plan; and
- The group health plan cannot consider the Medicare entitlement of an individual.

Thus, when an employer's group health plan is the primary payer, Medicare-eligible employees and spouses cannot be excluded from plan coverage or discouraged from enrolling in coverage. Also, employers cannot offer any financial or other incentive for an individual entitled to Medicare to not enroll (or terminate enrollment) in a group health plan that would pay primary.

ELIGIBILITY DON'TS

Don't Offer Coverage to Nonemployees

In general, employers should only offer health plan coverage to individuals who are their employees. Offering health coverage to nonemployees, such as independent contractors or directors, may inadvertently create a multiple employer welfare arrangement (MEWA). A MEWA is an arrangement that offers welfare benefits to employees of two or more employers that are not under common control or part of the same controlled group. Many states strictly regulate self-insured MEWAs, making these arrangements difficult to operate and administer. For example, to protect consumers from abusive MEWA practices, states may prohibit self-insured MEWAs from operating altogether or

impose insurance carrier funding and reporting requirements on these arrangements. Depending on the state, operating an unlicensed MEWA can expose an employer to civil and criminal penalties.

In addition, offering health coverage to independent contractors may undermine an employer's classification of these workers as nonemployees. Because independent contractors are typically ineligible for employee benefits, offering health plan coverage to independent contractors may indicate that these workers have been misclassified. Misclassifying workers can have serious financial and legal consequences for an employer, such as liability for unpaid wages and employment taxes as well as penalties and fines.

Don't Impose a Waiting Period Exceeding 90 Days

The ACA prohibits group health plans from applying any waiting period that exceeds 90 days. A waiting period is the period that must pass before coverage becomes effective for an individual who is otherwise eligible to enroll under the terms of the group health plan. All calendar days are counted beginning on the enrollment date, including weekends and holidays.

Other eligibility conditions that are not based solely on the lapse of time are generally allowed, such as being in an eligible job classification. In addition, employers may impose a requirement to successfully complete a reasonable and bona fide employment-based orientation period as a condition for eligibility for coverage under a plan. During an orientation period, an employer and employee can evaluate whether the employment situation is satisfactory for each party, and standard orientation and training processes can begin. However, any permitted orientation period may not exceed one month.

Don't Overlook Nondiscrimination Requirements

Federal tax law imposes nondiscrimination requirements on certain types of employee benefits to ensure employers do not impermissibly favor their highly compensated employees. These rules currently apply to self-insured health plans and arrangements that allow employees to pay their premiums on a pre-tax basis, or Section 125 cafeteria plans. The nondiscrimination requirements for fully insured health plans have been delayed indefinitely.

In general, a health plan will not have problems passing any applicable nondiscrimination test when the employer treats all its employees the same for purposes of health plan coverage (for example, all employees are eligible for the health plan, and the plan's eligibility rules and benefits are the same for all employees). However, treating employees differently may make it more difficult for a health plan to pass the applicable nondiscrimination tests. The following are examples of plan designs that may cause problems with nondiscrimination testing:

- Only certain groups of employees are eligible to participate in the health plan (for example, only salaried or management employees);

- The health plan has different employment requirements for plan eligibility (for example, waiting periods and entry dates) for different employee groups; and

- The employer maintains separate health plans for different groups of employees.

Before implementing one or more of these plan designs, employers should confirm that the arrangement will comply with applicable rules prohibiting discrimination in favor of highly compensated employees. If a self-insured health plan or cafeteria plan is discriminatory, highly compensated employees will lose certain tax benefits under the plan.

Don't Exclude Employees Based on Health Factors

The Health Insurance Portability and Accountability Act (HIPAA) prohibits group health plans from discriminating against individuals regarding eligibility, premiums or coverage based upon a health status-related factor. Health status-related factors include an individual's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability. Group health plans may not discriminate with respect to eligibility between similarly situated employees based upon a health factor. Eligibility rules include those related to enrollment, the effective date of coverage and eligibility for benefit packages. In addition, under HIPAA, employers cannot:

- Require an individual to pass a physical examination to be eligible to enroll in health plan coverage;

- Exclude individuals from coverage because they participate in dangerous activities or have high health claims;

- Charge an individual within a group of similarly situated individuals a different premium rate based upon that individual's health factors; nor

- Delay enrollment in the health plan until an employee is actively at work (unless individuals who are absent from work due to any health factor are treated as if they are actively at work).

Final Rule Released on Short-term, Limited-duration Insurance and Fixed Indemnity Coverage

PUBLISHED: APRIL 29, 2024 | UPDATED: DECEMBER 6, 2024

On March 28, 2024, the U.S. Departments of Labor, Health and Human Services, and the Treasury (Departments) released a **final rule** on certain types of health coverage that are not subject to the Affordable Care Act's (ACA) consumer protections, namely short-term, limited-duration insurance (STLDI) and fixed indemnity coverage. This rule finalizes some of the changes included in a proposed rule from July 2023.

The Departments are making changes to STLDI and fixed indemnity coverage to help consumers distinguish them from comprehensive health coverage and increase consumer awareness of coverage options that include the ACA's consumer protections. These protections include, for example, the prohibition of discrimination based on health status, the prohibition of preexisting condition exclusions, and the prohibition of lifetime and annual dollar limits on essential health benefits.

STLDI

STLDI is a type of health insurance coverage designed to fill temporary gaps in coverage when an individual transitions from one plan or coverage to another. STLDI is specifically exempt from the definition of "individual health insurance coverage" and, therefore, is not subject to the ACA's requirements for comprehensive coverage.

Currently, STLDI is defined as coverage with an initial contract period of less than 12 months and a maximum total duration of up to 36 months, which includes renewals and extensions. Effective for coverage periods beginning on or after **Sept. 1, 2024**, the final rule limits the length of the initial contract period to no more than **three months** and the maximum coverage period to no more than **four months**, taking into account any renewals or extensions.

In addition, the final rule:

- Prohibits a practice known as "stacking," where the same insurer issues multiple STLDI policies to the same policyholder within a 12-month period; and

- Amends the consumer notice requirement to further clarify the differences between STLDI and comprehensive coverage and identify options for consumers to obtain comprehensive coverage. The notice must be prominently displayed on the first page of the policy, certificate or contract of insurance—including for renewals and extensions—and included in any marketing, application and enrollment (or reenrollment) materials.

The final rule also includes a reminder that coverage sold to individuals through a group trust or association, other than in connection with a group health plan, is not group coverage for purposes of federal law and must meet the federal definition of STLDI or it is subject to the federal consumer protections and requirements for comprehensive individual health insurance coverage.

FIXED INDEMNITY EXCEPTED BENEFITS COVERAGE

Certain categories of coverage—called "excepted benefits"—are not subject to certain federal consumer protections, including the ACA's requirement for comprehensive coverage. Fixed indemnity coverage is exempt from these protections because it is designed to provide a source of income replacement rather than full medical coverage.

Effective for plan years beginning on or after Jan. 1, 2025, the final rule required a consumer notice to be provided when offering fixed indemnity excepted benefits coverage in the group market to ensure that consumers can distinguish between this coverage and comprehensive medical coverage. Health plans and issuers were to prominently display the notice in marketing, application and enrollment (and reenrollment) materials. **However, this requirement was vacated by a federal court on December 4, 2024.**

In the July 2023 proposed rule, the Departments proposed new standards regarding the payment standards and noncoordination requirement for fixed indemnity excepted benefits. The Departments are **not finalizing these proposed standards at this time**, but they intend to address the issues in future rulemaking after additional study and consideration.

TAX TREATMENT OF FIXED INDEMNITY HEALTH COVERAGE

In the July 2023 proposed rule, the Departments proposed to clarify that payments from employer-provided fixed indemnity health insurance plans are not excluded from a taxpayer's gross income if the amounts are paid without regard to the actual amount of any incurred medical expenses and

where the premiums or contributions for the coverage are paid on a pre-tax basis. This rule also proposed to clarify that the taxpayer must meet substantiation requirements for reimbursements for qualified medical expenses from any employer-provided accident and health plan to be excluded from the taxpayer's gross income. To provide more time to study the issues and concerns raised by commenters, the Departments are **not finalizing these proposed changes at this time.**

IRS Addresses Tax Treatment of Work-life Referral Services

PUBLISHED: MAY 2, 2024

The IRS has issued **frequently asked questions** (FAQs) addressing the tax treatment of work-life referral (WLR) services employers provide to their employees. These FAQs provide that WLR services qualify as a de minimis fringe benefit for tax purposes and are thus **excluded from income and exempt from employment taxes.**

Because the FAQs are not official IRS guidance, the IRS cannot rely on them to resolve a specific taxpayer's case, and established tax laws control a taxpayer's liability if the FAQs are inconsistent with such laws. However, the FAQs provide helpful insight into the IRS' view on the tax treatment of WLR services.

WLR SERVICES

A WLR program is an employer-funded fringe benefit that helps employees locate resources for solutions to personal, work or family challenges through informational and referral consultations. For example, WLR programs may provide employees with support, information or referrals in connection with identifying health care or child care, using paid leave programs, navigating the health care system, and connecting with financial planning professionals.

WLR programs are often incorporated into an employee assistance program or may otherwise be bundled with other types of services or programs offered by an employer. WLR programs may be available to a significant portion of an employer's employees, but they are used infrequently by employees and only when an employee faces one of the challenges the programs are designed to address. WLR programs often rely on third-party providers that charge the employer a per-eligible-employee monthly fee, regardless of how many employees actually utilize the WLR services.

KEY POINTS

- ***IRS FAQs address the federal tax treatment of WLR services.***
- ***WLR programs provide employees with information or referrals to locate resources for solutions to personal, work or family challenges.***
- ***Although WLR programs may be available to a significant portion of an employer's employees, they are typically used infrequently.***
- ***According to the FAQs, WLR services qualify as a nontaxable de minimis fringe benefit.***

TAX TREATMENT

Federal tax law provides that all employee compensation is taxable unless a specific exemption applies. When compensation is taxable, it must be included in gross income on the employee's Form W-2 and is subject to federal employment taxes.

De minimis (or minimal) benefits are one type of nontaxable employee fringe benefit. A de minimis fringe benefit is one that, considering its value and the frequency in which it is provided, is so small that accounting for it would be unreasonable or administratively impracticable. The law does not specify a specific value or frequency threshold for benefits to qualify as de minimis. The determination will depend on facts and circumstances.

The IRS' FAQs provide that the use of employer-provided WLR services qualifies as a de minimis fringe benefit that is excluded from an employee's gross income and is not subject to employment taxes (such as FICA, FUTA and income tax withholding).

REGULATORY HIGHLIGHTS

In 2016, a final rule implementing Section 1557 provided (among other things) that sex discrimination includes discrimination on the basis of pregnancy, gender identity and sex stereotyping. However, a federal court enjoined these provisions.

Final rules issued in 2020 further limited the scope of the 2016 regulations. However, the Supreme Court subsequently ruled that employment discrimination based on gender identity or sexual orientation violates Title VII.

In 2021 and 2022, HHS issued guidance and proposed rules to revise and expand the final regulations from 2020. The guidance and proposal have become the subject of litigation, with numerous federal courts ruling differently on the issue. The current final rule is likely to trigger additional lawsuits.

HHS Final Rule on Nondiscrimination in Health Programs and Activities

PUBLISHED: MAY 6, 2024

On April 26, 2024, the U.S. Department of Health and Human Services' (HHS) Office of Civil Rights (OCR) issued a **final rule** under Section 1557 of the Affordable Care Act, which prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities. The final rule is scheduled to be published on May 6, 2024, and will take effect 60 days later. However, **effective dates vary** for certain provisions of the rule.

BACKGROUND

Prior rules and guidance that the OCR has published to implement Section 1557 **have been the subject of numerous lawsuits**, dating back to when initial regulations were issued in 2016. The litigation has primarily focused on:

- Which health programs and activities are subject to Section 1557's nondiscrimination requirements; and
- Whether sex discrimination includes discrimination based on gender identity, sexual orientation and termination of pregnancy.

Under final regulations from 2020, gender identity and pregnancy termination were not included in the definition of sex discrimination, and the scope of Section 1557 was narrower than the 2016 regulations (namely, health insurance issuers were generally not included).

HIGHLIGHTS OF THE 2024 FINAL RULE

The final rule expands the scope of prior 2020 regulations by providing that:

- Health insurance issuers **are** covered under Section 1557, and Section 1557 applies to **all** HHS-administered health programs and activities;

- Protections against sex discrimination **include** discrimination on the basis of sexual orientation and gender identity, as well as sex stereotypes, sex characteristics, and pregnancy or related conditions; and

- Nondiscrimination requirements apply to health programs and activities provided through **telehealth services.**

In addition, entities covered by the final rule are required to:

- **Notify individuals** that language assistance services and auxiliary aids are available if needed;

- Take steps to identify and mitigate discrimination when they use **patient care decision support tools;** and

- Implement and train their staff on **policies and procedures** to ensure compliance with the final rule.

ACTION STEPS

The final rule is likely to become the subject of more lawsuits. Plan administrators and issuers should monitor all legal developments in consultation with benefits counsel and work closely with their benefits advisors in complying with their Section 1557 obligations. The latest updates can be found on the **OCR Section 1557 webpage**.

HHS Finalizes Rule to Strengthen Reproductive Health Care Privacy

PUBLISHED: MAY 16, 2024

The U.S. Department of Health and Human Services (HHS) has issued a **final rule** that strengthens the HIPAA Privacy Rule by prohibiting the disclosure of protected health information (PHI) related to lawful reproductive health care in certain situations. According to HHS, these new protections are necessary to protect access to and privacy of reproductive health care following the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization.*

The HIPAA Privacy Rule sets strict limits on the use, disclosure and protection of PHI by health care providers, health plans, health care clearinghouses and their business associates (regulated entities). The Privacy Rule also allows regulated entities to use or disclose PHI for certain non-health-care purposes, including certain criminal, civil and administrative investigations and proceedings.

KEY DATES

- ***April 22, 2024: HHS releases the final rule.***
- ***Dec. 23, 2024: Regulated entities must comply with the final rule by this date, except as noted below.***
- ***Feb. 16, 2026: Regulated entities must update their HIPAA notice of privacy practices by this date.***

NEW PROTECTIONS

The final rule prohibits regulated entities from using or disclosing PHI for the criminal, civil or administrative investigation of (or proceeding against) any person in connection with seeking, obtaining, providing or facilitating reproductive health care **where such health care is lawful under the circumstances in which it is provided.** It also prohibits the identification of any person for the purpose of initiating such an investigation or proceeding. This prohibition applies where a regulated entity reasonably determines that:

- The reproductive health care is **lawful under the law of the state** in which such health care is provided (and under the circumstances in which it is provided); or
- The reproductive health care **is protected, required or authorized by federal law**, including the U.S. Constitution, regardless of the state in which such health care is provided.

Moreover, when a regulated entity did not provide the reproductive health care at issue, the final rule prohibits the use or disclosure of PHI when the person making the request does not provide sufficient information to overcome a presumption of legality. For example, this presumption can be overcome if the person making the request provides information showing a substantial factual basis that the reproductive health care was unlawful under the circumstances in which it was provided.

To implement the prohibition, when a regulated entity receives a request for PHI potentially related to reproductive health care, the regulated entity must obtain a **signed attestation** that the use or disclosure is not for a prohibited purpose.

NOTICE OF PRIVACY PRACTICES

The final rule requires regulated entities to **revise their notice of privacy practices** to support reproductive health care privacy. Regulated entities may also need to update their business associate agreements and HIPAA policies and procedures for the final rule's changes, depending on their terms.

Medicare Part D Changes May Impact Creditable Coverage Status of Employer Plans

PUBLISHED: MAY 23, 2024

The Inflation Reduction Act of 2022 (IRA) includes several **cost-reduction provisions** affecting Medicare Part D plans, which may impact the **creditable coverage status** of employer-sponsored prescription drug coverage beginning in 2025. Creditable coverage means that the employer's prescription drug coverage is at least as good as Medicare Part D coverage.

Employers are not required to offer coverage that is creditable – yet employers that provide prescription drug coverage to individuals who are eligible for Medicare Part D must inform these individuals and the Centers for Medicare and Medicaid Services (CMS) whether or not their prescription drug coverage is creditable.

CREDITABLE COVERAGE DETERMINATION

A group health plan's prescription drug coverage is considered creditable if **its actuarial value equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage**, as demonstrated through the use of generally accepted actuarial principles and in accordance with **CMS guidelines.** In general, this actuarial determination measures whether the expected amount of paid claims under the group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the Medicare Part D prescription drug benefit. For plans that have multiple benefit options (for example, PPOs, HDHPs and HMOs), the creditable coverage test must be applied separately for each benefit option.

Under existing CMS guidance, there are a few different ways for an employer to determine whether its prescription drug coverage is creditable:

- As a first step, employers with insured prescription drug plans should ask their carriers whether they have determined whether the plan's coverage is creditable.

- For self-insured plans, or where the carrier for an insured plan has not made a determination about whether the plan is creditable, employers may use a **simplified determination**—as long as the coverage meets certain design requirements. If it doesn't, the employer must use an **actuarial determination method.**

Previously, CMS stated in its Draft Part D Redesign Program Instructions that the "simplified determination" method would no longer be valid as of calendar year 2025, given the significant changes made to Medicare Part D by the IRA. However, according to the ***Final Part D Redesign Program Instructions****, CMS will continue to permit the use of the simplified determination methodology, without modification, for calendar year 2025 for group health plan sponsors who are not applying for the retiree drug subsidy. In future guidance, CMS will reevaluate the continued use of the existing simplified determination methodology or establish a revised one for calendar year 2026.*

As a practical matter, most plans are not eligible to use the simplified determination method. One of the requirements to use the simplified determination method is to have a prescription drug deductible (or a combined medical and prescription drug deductible) that is no greater than $250. Because most plans have a deductible amount that is higher than this, most plans will need to use the actuarial determination method if their insurance carrier doesn't make the determination.

IMPACT OF THE MEDICARE PART D CHANGES

Because the IRA is making improvements to Medicare Part D coverage, the actuarial value of Medicare Part D coverage will increase—meaning the benchmark that employer group health plans will be compared to is changing. Therefore, some employer plans that were creditable in the past will no longer be considered creditable, as measured against the improved Medicare Part D coverage.

More information and resources on the IRA's changes to Medicare Part D are available on CMS' **Part D Improvements webpage.**

DISCLOSURE TO INDIVIDUALS

While employers are not required to offer coverage that is creditable, plan sponsors must provide creditable coverage disclosure notices to individuals each year before Oct. 15—the start date of the annual enrollment period for Medicare Part D. The disclosure notice alerts individuals as to whether their plan's prescription drug coverage is creditable or non-creditable.

If the coverage is non-creditable and Medicare-eligible individuals fail to enroll in Part D during their

initial enrollment period, they can be subject to a higher Part D premium if they enroll in Part D at a later date.

Model notices are available for employers to use to notify individuals whether the coverage is creditable or non-creditable.

DISCLOSURE TO CMS

The disclosure to CMS is due within **60 days** after the start of each plan year. For calendar year plans, this deadline is March 1 of each year (Feb. 29 for leap years). Plan sponsors are required to use CMS' online disclosure form.

ENFORCEMENT

There is no penalty or fee for the employer for offering prescription drug coverage that is non-creditable. Non-creditable prescription drug coverage can still be a valuable benefit for employees.

There are also no specific penalties for employers that fail to comply with the Medicare Part D disclosure requirements, except for employers that are claiming the Retiree Drug Subsidy. However, by not providing creditable coverage disclosure notices, employers may trigger adverse employee relations issues. In addition, noncompliant employers may indirectly face consequences under other federal laws (such as the Employee Retirement Income Security Act's fiduciary duty provisions).

EMPLOYER ACTION ITEMS

Employers should begin looking at their current plan design to determine how likely it is to be considered creditable in 2025. Based on that assessment, employers may consider whether plan design changes should be evaluated.

As stated above, employers are not required to offer coverage that is creditable – yet some employers may want to offer creditable coverage regardless.

Once it has been determined whether their health plans' prescription drug coverage for 2025 will be creditable or non-creditable, employers should prepare to send the appropriate Medicare Part D disclosure notices. Employers with plans that will go from creditable to non-creditable status may wish to provide further education to employees. In doing so, employers should be mindful to not appear as steering employees toward taking Medicare, as this would run afoul of the Medicare Secondary Payer Rules.

5th Circuit Requires Health Plans to Continue Providing Free Preventive Care

PUBLISHED: JULY 9, 2024

HIGHLIGHTS

- ***In March 2023, a federal District Court struck down a key part of the ACA's preventive care coverage mandate and issued a nationwide injunction.***
- ***On June 21, 2024, the 5th Circuit upheld the District Court's ruling but held there was no basis for a nationwide injunction.***
- ***Due to this ruling, health plans and issuers must continue to cover the full range of free preventive care for now.***
- ***An appeal to the U.S. Supreme Court is expected.***

On June 21, 2024, the 5th U.S. Circuit Court of Appeals **ruled** that a key component of the Affordable Care Act's (ACA) preventive care mandate is unconstitutional. However, in a decision it referred to as a "mixed bag," the 5th Circuit limited its ruling to the plaintiffs in the case, a small group of individuals and businesses from Texas. This means that, for now, **health plans and health insurance issuers must continue to provide first-dollar coverage for the full range of recommended preventive health services.**

This decision impacts the requirement to cover, without cost sharing, a wide range of preventive care services, including screenings for colorectal, lung and cervical cancers, medications for chronic conditions such as cardiovascular disease, screening for HPV, depression and anxiety screenings, and Hepatitis B and C virus screenings.

It is expected that the U.S. Supreme Court will ultimately be asked to review the 5th Circuit's decision.

ACA'S PREVENTIVE CARE MANDATE

The ACA requires non-grandfathered health plans and issuers to cover a set of recommended preventive services without imposing cost-sharing requirements, such as deductibles, copayments or coinsurance, when the services are provided by in-network providers. The recommended preventive care services covered by these requirements are:

- Evidence-based items or services with an A or B rating in recommendations of the U.S. Preventive Services Task Force (USPSTF);

- Immunizations for routine use in children, adolescents and adults recommended by the Advisory Committee on Immunization Practices (ACIP);
- Evidence-informed preventive care and screenings in guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; and
- Other evidence-informed preventive care and screenings in HRSA-supported guidelines for women.

COURT DECISIONS

In March 2023, the U.S. District Court for the Northern District of Texas **struck down** a key component of the ACA's preventive care mandate. The District Court ruled that the preventive care coverage requirements based on an A or B rating by the USPSTF on or after March 23, 2010, the ACA's enactment date, violate the U.S. Constitution. More specifically, the District Court concluded that members of the USPSTF had not been appointed in a manner consistent with the Constitution's Appointments Clause. The District Court also issued a nationwide injunction, prohibiting the Biden administration from enforcing the affected preventive care mandates against any health plans or issuers.

The Biden administration appealed the District Court's ruling to the 5th Circuit, which covers Texas, Louisiana and Mississippi. The 5th Circuit put the District Court's decision on hold pending its ruling, which means health plans and issuers have been required to fully comply with the ACA's preventive care mandate without interruption.

The 5th Circuit agreed with the District Court that members of the USPSTF had not been validly appointed under the U.S. Constitution. However, the 5th Circuit limited its relief to the plaintiffs in the case and held that there was no basis for a nationwide injunction. The plaintiffs also challenged the appointments of the two other administrative bodies behind the ACA's preventive care mandates, the ACIP and HRSA. The 5th Circuit remanded these challenges back to the District Court for further consideration.

IMPACT OF DECISION

Due to the 5th Circuit's ruling, health plans and issuers must continue to cover the full range of recommended preventive care items and services without cost sharing. Only the plaintiffs in the case are exempt from a portion of the ACA's preventive care mandate. However, the future of the ACA's free preventive care mandate remains uncertain as this case moves through the legal system. The 5th Circuit's decision also opens the door to further litigation seeking an exemption from the mandates. Employers should continue to watch for developments on this issue, as it is likely that the 5th Circuit's decision will be appealed to the U.S. Supreme Court.

EBSA Confirms Cybersecurity Guidance Applies to Health and Welfare Plans

PUBLISHED: OCTOBER 16, 2024

Through **Compliance Assistance Release No. 2024-01**, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) is confirming that the cybersecurity guidance it issued in April 2021 generally applies to all employee benefit plans, including health and welfare plans.

BACKGROUND

In 2021, EBSA issued cybersecurity guidance to help plan sponsors, fiduciaries, service providers, and participants in employee benefit plans safeguard plan data, personal information and plan assets. However, in the years since, health and welfare plan service providers have told fiduciaries and EBSA investigators that this guidance only applies to retirement plans. Thus, it was recommended in 2022 that EBSA clarify that the guidance also applies to health benefit plans.

UPDATED GUIDANCE

The Compliance Release clarifies that the cybersecurity guidance applies to all types of plans covered by the Employee Retirement Income Security Act of 1974 (ERISA), including health and welfare plans and all employee pension benefit plans. EBSA is providing the following updated guidance:

- **Tips for Hiring a Service Provider:** This guidance helps plan sponsors and fiduciaries prudently select a service provider with strong cybersecurity practices and monitor their activities, as required by ERISA.

- **Cybersecurity Program Best Practices:** This guidance assists plan fiduciaries and recordkeepers in their responsibilities to manage cybersecurity risks.

- **Online Security Tips:** This guidance offers plan participants and beneficiaries who check their retirement accounts or other employee benefit information online basic rules to reduce the risk of fraud and loss.

ERISA FIDUCIARY OBLIGATIONS

Plan fiduciaries of ERISA-covered pension plans and health and welfare plans have an obligation to ensure proper mitigation of cybersecurity risks.

Employers and other sponsors of health, welfare, 401(k) and other types of pension plans often rely on service providers to maintain plan records and keep participant data confidential and plan accounts secure. Plan sponsors should use service providers that follow strong cybersecurity practices.

ADDITIONAL RESOURCES

The U.S. Department of Health and Human Services also offers publications that may help health plans and their service providers maintain good cybersecurity practices, as follows:

- **Health Industry Cybersecurity Practices: Managing Threats and Protecting Patients**
- **Technical Volume 1: Cybersecurity Practices for Small Healthcare Organizations**
- **Technical Volume 2: Cybersecurity Practices for Medium and Large Healthcare Organizations**

Final Rule Makes Extensive Changes to Mental Health Parity Requirements

PUBLISHED: OCTOBER 23, 2024

On September 23, 2024, the Departments of Labor, Health and Human Services, and the Treasury (Departments) published a **final rule** under the Mental Health Parity and Addiction Equity Act (MHPAEA).

Significantly, the final rule **adds protections against more restrictive nonquantitative treatment limitations (NQTLs).** For example, the final rule requires group health plans and health insurance issuers to collect and evaluate data related to the NQTLs they place on mental health and substance use disorder (MH/SUD) care and make changes if the data shows they are providing insufficient access.

MHPAEA

MHPAEA requires parity between a group health plan's medical/surgical (M/S) benefits and MH/SUD benefits. MHPAEA's parity requirements apply to:

- **Financial requirements**, such as deductibles, copayments and coinsurance;
- **Quantitative treatment limitations**, such as day or visit limits; and
- **NQTLs**, which generally limit the scope or duration of benefits, such as network composition, out-of-network reimbursement rates, and medical management and prior authorization requirements.

MHPAEA's parity requirements apply to group health plans sponsored by employers with more than 50 employees. However, due to an Affordable Care Act reform, insured health plans in the small group market must also comply with federal parity requirements for MH/SUD benefits.

The Consolidated Appropriations Act of 2021 amended MHPAEA to require health plans and health insurance issuers to conduct **comparative analyses of the NQTLs** used for M/S benefits compared to MH/SUD benefits. These analyses must contain a detailed, written and reasoned explanation of the specific plan terms and practices at issue and include the basis for the plan's or issuer's conclusion that the NQTLs comply with MHPAEA.

COMPLIANCE PROBLEMS

The Departments have continued to receive and investigate complaints that health plans and issuers fail to comply with MHPAEA by restricting access to benefits for mental health conditions and substance use disorders in more onerous and limiting ways than those restricting access to medical or surgical care. This noncompliance is especially evident in the design and application of NQTLs that apply to MH/SUD benefits.

According to the Departments, because of these failures, people seeking coverage for MH/SUD care continue to face greater barriers when seeking these benefits than when seeking M/S benefits. The final rule's changes are intended to strengthen MHPAEA's requirements and provide guidance to health plans and issuers on how to comply with the law's requirements.

FINAL RULE'S CHANGES

To comply with the final rule's requirements, health plans and issuers must:

- Define whether a condition or disorder is a MH condition or SUD in a manner that is consistent with the most current version of the International Classification of Diseases (ICD) or Diagnostic and Statistical Manual of Mental Disorders (DSM);
- Offer meaningful benefits (including a core treatment) for each covered MH condition or SUD in every classification in which M/S benefits (a core treatment) are offered;
- Not use factors and evidentiary standards to design NQTLs that discriminate against MH conditions and SUDs;
- Collect and evaluate relevant outcomes data and take reasonable action, as necessary, to address material differences in access to MH/SUD benefits as compared to M/S benefits; and
- Include specific elements in documented comparative analyses and make them available to the Departments, an applicable state authority, or individuals upon request.

NQTL Data Requirements

Under the final rule, a plan or issuer may not impose any NQTL with respect to MH/SUD benefits in any classification that is more restrictive, as written or in operation, than the predominant NQTL that applies to substantially all M/S benefits in the same classification. To ensure that an NQTL is not more restrictive in operation, the final rule requires plans and issuers to collect and evaluate relevant data in a manner reasonably designed to assess the impact of the NQTL on relevant outcomes related to access to MH/SUD benefits and M/S benefits.

If the relevant data suggests that the NQTL contributes to material differences in access to MH/SUD benefits as compared to M/S benefits, that will be considered a strong indicator of an MHPAEA violation. Differences in access are material if, based on all relevant facts and circumstances, the difference in the data suggests that the NQTL is likely to have a negative impact on access to MH/SUD benefits as compared to M/S benefits. If material differences in access exist, the plan or issuer must take reasonable action, as necessary, to address them to ensure compliance with MHPAEA in operation.

Comparative Analysis of NQTLs

The final rule establishes minimum standards for developing comparative analyses to assess whether each NQTL, as written and in operation, complies with MHPAEA's requirements. The final rule requires health plans and issuers to collect and evaluate data related to the NQTLs they place on MH/SUD care and make changes if the data shows they are providing insufficient access.

The final rule requires the comparative analysis to contain, at a minimum, six content elements:

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

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

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

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

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

6. Findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH/SUD benefits and M/S benefits within each classification, as well as and the relative stringency of their application, both as written and in operation.

Upon request, plans and issuers must provide a written list of all NQTLs imposed by the plan to the Departments. The final rule also requires health plans and issuers to submit comparative analyses to the Departments within **10 business days** of a request. If a comparative analysis is determined to be deficient, health plans and issuers have 45 days to make corrections. If the comparative analysis is still deficient after this 45-day period, the plan or issuer may be required to notify all covered persons of the MHPAEA violation and stop applying the problematic NQTLs until the plan is compliant.

Fiduciary Certification

In addition, for health plans subject to ERISA, the comparative analysis must include a **plan fiduciary's certification** confirming they engaged in a prudent process to select one or more qualified service providers to perform and document the plan's comparative analysis and have satisfied their duty to monitor those service providers.

For this purpose, the Department of Labor expects that a plan fiduciary making such a certification will, at a minimum, take the following steps:

- Review the comparative analysis prepared by or on behalf of the plan with respect to an NQTL applicable to MH/SUD benefits and M/S benefits;
- Ask questions about the analysis and discuss it with service providers, as necessary, to understand the findings and conclusions documented in the analysis; and
- Ensure that a service provider responsible for performing and documenting a comparative analysis provides assurance that, to the best of its ability, the NQTL and associated comparative analysis complies with MHPAEA.

EFFECTIVE DATE

The final rule generally applies to group health plans and group health insurance coverage for plan years beginning on or after January 1, 2025. However, the provisions implementing the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, required use of outcomes data, and certain related comparative analysis requirements apply for plan years beginning on or after January 1, 2026.

IRS Expands List of Preventive Care Benefits for HDHPs

PUBLISHED: NOVEMBER 13, 2024

On October 17, 2024, the IRS issued **Notice 2024-75** to expand the list of preventive care benefits permitted to be provided by a high deductible health plan (HDHP) without a deductible (or with a deductible below the minimum deductible) to include:

- **Over-the-counter (OTC) oral contraceptives,** including OTC birth control pills and emergency contraceptives, for individuals potentially capable of becoming pregnant, regardless of whether they are purchased with a prescription; and
- **Male condoms**, regardless of whether they are purchased with a prescription and regardless of the gender of the individual covered by the HDHP who purchases them.

The Notice also clarifies that the following items and services qualify as preventive care for HDHP purposes:

- **All types of breast cancer screenings**, not just mammograms, for individuals who have not been diagnosed with breast cancer;
- **Continuous glucose monitors** for individuals diagnosed with diabetes; and
- **Selected insulin products**, regardless of whether they are prescribed to treat an individual diagnosed with diabetes or prescribed for the purpose of preventing the exacerbation of diabetes or the development of a secondary condition.

HDHPS AND PREVENTIVE CARE

Individuals must be covered by an HDHP (and have no disqualifying health coverage) to be eligible to contribute to a health savings account (HSA). To qualify as an HDHP, a health plan cannot pay benefits—**except for preventive care benefits**—until the required minimum deductible has been satisfied.

An HDHP may apply a low deductible (or no deductible) to its coverage of preventive care without jeopardizing individuals' HSA eligibility. Note that the Affordable Care Act (ACA) requires non-grandfathered health plans to cover specific recommended preventive care services on a "first-dollar basis" (that is, without any copayments, deductibles or other cost sharing). Currently, the ACA's preventive care mandate requires health plans to cover OTC preventive products without cost sharing only when they are prescribed by a health care provider.

EFFECTIVE DATES

The Notice's changes for HDHPs have different retroactive effective dates. The IRS' new guidance for OTC oral contraceptives and male condoms is effective for plan years beginning on or after December 30, 2022. Other effective dates include April 12, 2004, for breast cancer screenings; July 17, 2019, for continuous glucose monitors; and plan years beginning after December 31, 2022, for selected insulin products.

NEXT STEPS

Employers with HDHPs should review their plans' design and consider whether to extend coverage to these items without a deductible.

Proposed Rule Would Expand ACA's Contraceptive Coverage Mandate

PUBLISHED: NOVEMBER 13, 2024

On October. 21, 2024, the Departments of Labor, Health and Human Services, and the Treasury released a **proposed rule** that, if finalized, would **expand access to contraceptive coverage without cost sharing** under the Affordable Care Act's (ACA) preventive care mandate. Notably, the proposed rule would require most health plans and health insurance issuers to cover over-the-counter (OTC) contraceptives without imposing cost sharing (e.g., deductibles, copayments or coinsurance) or requiring a prescription.

CONTRACEPTIVE COVERAGE MANDATE: PROPOSED CHANGES

The ACA requires non-grandfathered health plans and issuers to cover certain preventive care services without cost sharing; this includes contraceptives, as outlined in specific guidelines. Exemptions are available to religious employers and eligible employers that object to providing contraceptive coverage based on their sincerely held religious beliefs or moral convictions.

Currently, health plans and issuers are only required to cover OTC preventive products without cost sharing when they are prescribed by a health care provider. In July 2023, the U.S. Food and Drug Administration (FDA) approved the first OTC daily oral contraceptive, which is now widely available across the country.

The proposed rule would require health plans and issuers to do the following:

- Cover recommended **OTC contraceptive items** without requiring a prescription and without imposing cost sharing;
- Cover every **FDA-approved contraceptive drug or drug-led combination product** without cost sharing, unless the plan also covers a therapeutic equivalent of the drug or drug-led combination product without cost sharing; and

- **Disclose to plan participants that OTC contraception is covered without a prescription and without cost sharing.** This disclosure would be required as part of any Transparency in Coverage self-service tool search for covered contraceptives and would need to include a phone number and internet link to where a participant could learn more about the coverage.

These changes are proposed to be applicable for plan years beginning on or after January 1, 2026, if they are finalized.

HSAS, HEALTH FSAS AND HRAS: CURRENT OPTIONS

Individuals can pay for OTC medicines, including contraceptives, using their health savings accounts (HSAs). In addition, health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs) can be designed to reimburse all OTC drugs. Thus, although health plans and issuers are not currently required to cover OTC contraceptives without cost sharing, consumers may be able to use their HSAs, health FSAs or HRAs to pay for this medication.

Deadline Extensions for Benefit Plans and Participants Affected by Hurricanes Helene and Milton

PUBLISHED: NOVEMBER 20, 2024

On November 8, 2024, federal agencies issued **deadline relief** and **Notice 2024-01** to ensure that employee benefit plans, participants, beneficiaries, qualified beneficiaries and claimants in disaster areas are not further adversely affected by Hurricane Helene, Tropical Storm Helene and Hurricane Milton.

This relief extends to **employee benefits plans if any of the following were located in one of the disaster areas** at the time of the hurricane or tropical storm:

- The principal place of business of the employer that maintains the plan
- The office of the plan or the plan administrator
- The office of the primary recordkeeper serving the plan

Relief also applies to **individuals who resided, lived or worked in one of the designated disaster areas** at the time of the hurricane or tropical storm—**or their coverage was under an employee benefit plan that was directly affected** (as described above).

VARYING RELIEF PERIODS

The relief period begins on varying dates (depending on location) and ends on May 1, 2025.

Covered Disaster Area	Relief Period
Helene declared disaster areas in FL	9/23/24 through 5/1/25
Helene declared disaster areas in GA	9/24/24 through 5/1/25
Helene declared disaster areas in NC, SC, VA	9/25/24 through 5/1/25
Helene declared disaster areas in TN	9/26/24 through 5/1/25
Milton declared disaster areas in FL (not already included in the Helene FL disaster areas above)	10/5/24 through 5/1/25

EXTENSION OF PARTICIPANT TIME FRAMES

The relief periods grant ERISA-covered participants additional time to meet certain deadlines related to COBRA continuation coverage, special enrollment periods, and claims for benefits. Like the COVID 'outbreak period' relief provided in 2020, these relief periods must be disregarded when calculating these deadlines for participants in ERISA-covered plans. Specifically, the relief extends:

HIPAA Special Enrollment

- 30-day or 60-day period to request special enrollment

COBRA Periods

- 60-day election period for COBRA
- Date for making COBRA premium payments
- Date for individuals to notify the plan of a COBRA qualifying event or determination of disability

Claims Deadlines

- Date for filing a claim under the plan's claims procedure
- Date claimants may file an appeal of an adverse benefit determination under the plan's claims procedure
- Date claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination
- Date a claimant may file information to perfect a request for external review upon a finding that the request was not complete

DEADLINE EXTENSION FOR PLAN ADMINISTRATORS

COBRA Election Notice
The relief extends the time frame for group health plan sponsors and administrators to provide a COBRA election notice, by disregarding the applicable relief period.

ERISA Notices and Disclosures
Many ERISA notices and disclosures due to be furnished during the relief period must be provided as soon as administratively practicable. The Relief Period will be disregarded if the plan acts in good faith and furnishes the notice, disclosure, or document as soon as administratively practicable under the circumstances.

Good faith acts include use of electronic alternative means of communicating with plan participants and beneficiaries who the plan fiduciary reasonably believes have effective access to electronic means of communication, including email, text messages, and continuous access websites.

This includes item such as the following:

- Summary Plan Description (SPD)
- Summary of Material Modification (SMM)
- Summary of Benefits and Coverage (SBC)
- Notice of Payment Protections
- Disclosure of Grandfathered Status
- Wellness Program Disclosure (HIPAA)
- Employer CHIP Notice
- Newborns' and Mothers' Health Act Notice
- Women's Health and Cancer Rights Act Notice

Form 5500 Filing Deadline
Affected plans that have a Form 5500 filing deadline during the relief period had their filing deadline extended to May 1, 2025.

In some cases, this relief extends to all areas in a state—not just those areas identified as a disaster

area. This includes the entire state of Alabama (beginning on September 22, 2024), even though the other time frame extensions do not apply in Alabama.

For detailed information on Form 5500 filing extensions, visit the IRS' **Tax relief in disaster situations website.**

APPLICATION TO NON-FEDERAL GOVERNMENTAL PLANS

While the extension of time frames included in the guidance is not mandatory for non-federal governmental plans, plan sponsors of non-federal governmental plans and health insurance issuers offering group or individual health insurance coverage subject to the Public Health Service Act are **encouraged** by the Centers for Medicare & Medicaid Services (CMS) to provide similar relief to participants, beneficiaries, enrollees, qualified beneficiaries and claimants affected by these natural disasters.

In addition, CMS will not consider these plans or issuers in designated disaster areas to be in violation of the law for a failure to timely furnish a notice, disclosure or document that must otherwise be furnished during the relief period, if the plan acts in good faith and furnishes the notice, disclosure or document as soon as administratively practicable under the circumstances.

ADDITIONAL RESOURCES

The Employee Benefits Security Administration provides additional resources on its **Disaster Relief Information for Employers and Advisors** webpage.