Employee Benefits Compliance Briefing

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Acadia BENEFITS

This Issue

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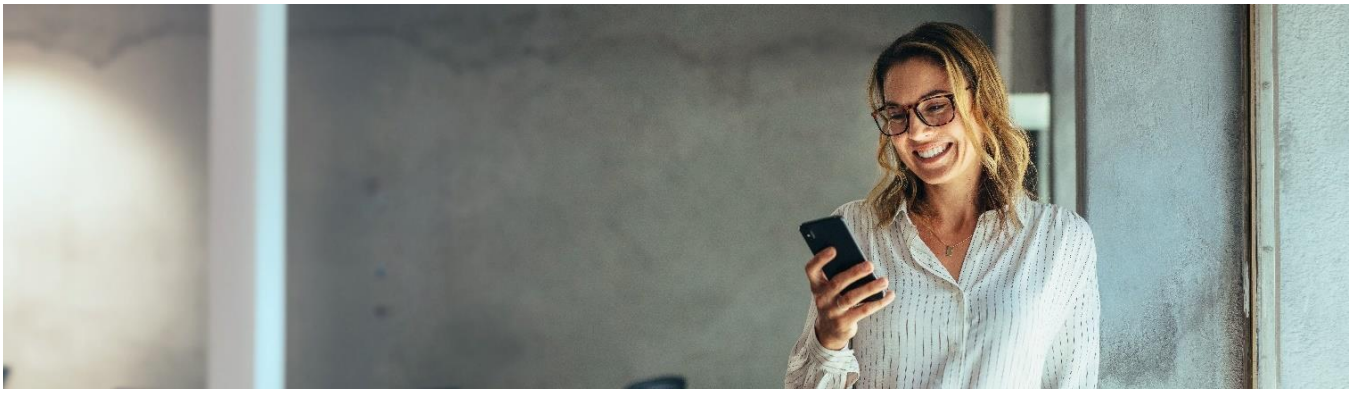

EEOC Issues Final Regulations for the Pregnant Workers Fairness Act

The Equal Employment Opportunity Commission (EEOC) has recently released extensive final regulations under the Pregnant Workers Fairness Act (PWFA). The regulations were published in the federal register on April 19, 2024, and will take effect on June 18, 2024. Here's what employers need to know.

Overview of PWFA

The PWFA took effect in June 2023. This law requires employers with 15 or more employees to consider employee or applicant requests for accommodation for pregnancy, childbirth, or other related conditions in the same way it would a request under the Americans with Disabilities Act (ADA). This includes going through the interactive process to determine an accommodation that works for both the employee and employer. Some examples of reasonable accommodations include, but are not limited to:

- Allowing workers to sit or drink water.
- Providing closer parking spaces.
- Offering flexible working hours.
- Providing appropriately sized uniforms and safety apparel.
- Allowing workers additional break time to use the bathroom, eat, and rest.
- Excusing workers from strenuous activities or activities that involve exposure to compounds not safe for pregnancy.
- Giving leave or time off to recover from childbirth.

Five key takeaways from the final regulations

1. The definition of "pregnancy, childbirth, or other related medical conditions" is broad and includes circumstances such as:

    - Termination of pregnancy – including via miscarriage, stillbirth, or abortion
    - Current, past, and potential pregnancy
    - Infertility and fertility treatment
    - The use of contraception

- Pregnancy-related sicknesses, ranging from nausea or vomiting to edema, from preeclampsia to carpal tunnel syndrome, and many other pregnancy-related conditions
- Lactation and issues associated with lactation
- Menstruation

In response to the huge number of comments received regarding abortion during the public comment period, the EEOC noted that "nothing in the PWFA requires, or forbids, an employer to pay for health insurance benefits for an abortion." The EEOC expects the most common accommodation here to be time off for related appointments or recovery.

There is currently no exemption for religious-based employers; however, should these employers face a charge of discrimination, the EEOC encourages the employer to raise a defense as early as possible and it will consider all matters on a case-by-case basis.

2. "Qualified employees" is defined broadly.

   Qualified employees covered under the PWFA include both those who can perform the essential functions of their position with or without reasonable accommodations *and* those whose inability to perform the essential functions of their role is only temporary (which generally means about 40 weeks).

3. "Limitations" don't have to be very limiting.

   Unlike the ADA, there is no threshold for the severity of the physical or mental conditions for accommodation requests under the PWFA. "Limitation" means any physical or mental condition related to, affected by, or arising out of pregnancy, childbirth, or related medical conditions – including impediments or problems that are modest, minor, or episodic. It could also include actions that need to be taken to maintain the worker's health or the health of their pregnancy, or even if the worker is simply seeking health care for their pregnancy, childbirth, or related medical condition.

4. The rules list more examples of possible reasonable accommodations, including:

   - Job restructuring
   - Schedule changes, part-time work, and paid and unpaid leave
   - Frequent breaks
   - Acquiring or modifying equipment, uniforms, or devices
   - Making existing facilities accessible or modifying the work environment
   - Allowing sitting or standing (and providing means to do so)
   - Light duty
   - Telework or remote work
   - Providing a reserved parking space
   - Temporarily suspending one or more essential function
   - Adjusting or modifying workplace policies

5. Employers can deny accommodations if they would pose an undue hardship on business operations.

   After working through the interactive process, employers may deny an accommodation if it would cause significant difficulty or expense for operations. It is worth noting that throughout the interactive process, an employer may

only request supporting documents to the extent they do not seek more information than is required to make a proper determination based on the claimed condition.

In determining whether an accommodation may cause an undue hardship, employers may consider:

- The length of time the employee or applicant will be unable to perform the essential function
- Whether there is work for the employee or applicant to accomplish
- The nature of the essential function, including its frequency
- Whether the employer has provided other employees or applicants in similar positions who are unable to perform essential functions with temporary suspension of those functions and other duties
- Whether there are other employees, temporary employees, or third parties who can perform or be temporarily hired to perform the essential function in question, if needed
- Whether the essential function can be postponed or remain unperformed for any length of time and, if so, for how long

Employer Action Items

- Review PWFA requirements to ensure you are already in compliance.
- Update HR training to familiarize your workforce with these new rules.
- Check for more stringent requirements in your state or locally.
- Work with legal counsel before denying any accommodation requests related to pregnancy, childbirth, or other related medical conditions.

Final Rules for Short-Term, Limited-Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage

On March 28, 2024, the Department of Labor, the Department of Health and Human Services, and Department of the Treasury (collectively, the "Departments") released final rules regarding short-term, limited-duration insurance (STLDI) and independent, noncoordinated excepted benefits coverage. While employers generally do not offer STLDI coverage as a group benefit, these rules will impact the coverage options available to non-benefits-eligible classes of employees. Accordingly, employers may want to familiarize themselves with the new limitations on STLDI coverage.

Coverage Review

STLDI is health insurance coverage designed to fill gaps in coverage when an individual is transitioning from one source of health insurance to another (i.e., gap in coverage from switching employers). STLDI is generally not subject to federal individual market consumer protections, such as prohibitions against discrimination based on health status, or requirements for comprehensive coverage. STLDI also typically has higher out-of-pocket costs and fewer covered services than traditional health insurance.

Hospital indemnity and other fixed indemnity insurance is traditionally used as a form of income replacement upon the occurrence of a covered event. This is paid, in cash, directly to the covered individual – not to a medical provider – to be used as the individual desires. In the group market, the payments must be made per day (or other period) of hospitalization or illness. Whereas, in the individual market, the payments may be made per day (or other period) or per service. If these standards are met, fixed indemnity insurance is considered independent, noncoordinated excepted benefits coverage and generally not subject to the federal requirements or consumer protections that apply to comprehensive coverage. Hospital indemnity and other fixed indemnity insurance is meant to supplement other coverage, not act as a substitute for comprehensive coverage.

Changes to Short-Term Limited-Duration Insurance

The final rules promulgated by the Departments changed the limitations or requirements for policies or contracts of STLDI sold or issued after September 1, 2024, in three ways:

1. The maximum initial contract term is limited to three months and the maximum coverage period cannot exceed four months. This is a significant change from the previous limits of 12 months and 36 months, respectively.

2. "Stacking" of STLDI insurance is prohibited. This means that the same insurer cannot issue multiple STLDI policies to the same policyholder within a 12-month period.
3. The federal notice requirements have been amended to require insurers to use concise and easy-to-understand language that helps consumers understand the differences between STLDI and comprehensive coverage. This notice must be prominently displayed on the first page of the policy, certificate, or contract and included in any marketing, application, and (re)enrollment materials.

Changes to Fixed Indemnity Excepted Benefits Coverage

Beginning on January 1, 2025, the final rules require plans and insurers to amend their consumer notice for fixed indemnity excepted benefits coverage in the individual market and include the notice in the group market. The notice should highlight the differences between fixed indemnity coverage and comprehensive coverage. The notice must be prominently displayed in the marketing, application, and (re)enrollment materials in the individual *and* group market and in the policy, certificate, or contract of the insurance in the individual market.

Group Health Plan Fiduciaries are the Subject of New ERISA Class Actions

Retirement plan fiduciaries are no stranger to ERISA class action lawsuits. These lawsuits typically allege that imprudent processes and lack of oversight led to excessive fees for investment options, recordkeeping services, and investment management services. Similar class actions are beginning to find their way to group health plan fiduciaries thanks to new disclosure requirements and transparency laws.

Lewandowski v. Johnson & Johnson et. al.

Lewandowski v. Johnson & Johnson (the "J & J class action") was filed in the District Court of New Jersey on February 5, 2024. The J & J class action targets group health plan fiduciary obligations under ERISA and focuses on the "duty of prudence" when selecting and monitoring health plan vendors. The lawsuit alleges that the plan participants and beneficiaries were harmed by paying increased plan costs because of fiduciary breaches.

Specifically, the lawsuit alleges that the health plan fiduciaries mismanaged the plan's prescription drug benefits. That mismanagement allegedly cost the plan and its employees "millions of dollars in the form of higher payments for prescription drugs, higher premiums, higher deductibles, higher coinsurance, higher copays, and lower wages or limited wage growth."

The participants alleged the plan's fiduciaries failed to:

- Pay the lowest possible costs for the offered drugs
- Obtain competitive bids from other prescription drug service providers
- Monitor plan expenses
- Negotiate the prescription drug contract with its pharmacy benefit manager (PBM), especially given its bargaining power as a Fortune 50 employer
- Fully inform participants about the mail-order program, where drug prices were routinely higher than options at retail pharmacies
- Protect the health plan's assets

Fee Disclosures and Transparency Laws

The Consolidation Appropriations Act, 2021 (CAA-21) and the Transparency in Coverage (TiC) Rule are the most comprehensive health plan legislation and reforms since the passage of the Affordable Care Act. The CAA-21 and TiC

place new obligations on group health plans and health insurance companies regarding plan fee disclosures and pricing transparency. Such obligations may contribute to a rise in class actions against health plan fiduciaries.

Service Provider Disclosure Requirements under CAA-21

In 2020, the CAA-21 broadened the definition of "covered plan" for Section 408(b)(2) under ERISA to include group health plans (it had previously only included retirement plans). This created new obligations for service providers, which includes health insurance brokers, to make certain disclosures to plan fiduciaries. Under ERISA Section 408(b)(2), any contract related to a group health plan is not reasonable (meaning it's a prohibited transaction) unless the direct or indirect compensation received by a health plan service provider that equals $1,000 or more is disclosed in writing to the plan fiduciary before entering into the contract or extending the contract. Because disclosures prior to entering into a contract, they may include estimates or formulas that address anticipated compensation.

The required disclosures are designed to provide group health plan fiduciaries with sufficient information to help determine whether the fees are reasonable, as required by ERISA's fiduciary rules. Additionally, this law has enhanced cost awareness among health plan participants.

It is likely that Plaintiffs' attorneys are seeking information regarding these disclosures (or lack thereof) to support participant claims against ERISA health plan fiduciaries and their service providers.

New Transparency Rules for Group Health Plan Fiduciaries

The federal government also issued the TiC final rule in 2020, with rolling effective dates from 2022 through 2024. This rule requires group health plans to disclose machine-readable data describing payment rates for in-network healthcare items and services, out-of-network allowable amounts, and prescription drug costs. These data files are intended to make healthcare pricing information accessible to participants, helping them know the cost of a covered item or service before receiving care.

The CAA-21 expanded upon the TiC rule by requiring group health plans to provide more expansive prescription drug and medical cost reporting. With many large, self-insured plans, these costs lie with third-party providers, like PBMs. Like the fee disclosures, this TiC data is also helpful in determining whether plan fees are reasonable under ERISA's fiduciary rules, potentially supporting excessive fee litigation.

Action Items for Group Health Plan Fiduciaries

1. Review existing group health plan service provider agreements to determine if fees have been disclosed.
2. Ensure third-party agreements are detailed enough for you to determine and monitor any fees or costs.
3. Establish a process to monitor group health plan fees and ensure they are reasonable for the services you are receiving.
4. Periodically run your group health plan vendors through a "request for proposal" process to help you determine if you are receiving the best services at reasonable costs.
5. Acquire fiduciary liability insurance.
6. Document your policies and procedures for hiring or monitoring a plan vendor.

Employers May Face New Challenges with IVF Coverage after Alabama Decision

Plan sponsors have been faced with challenges for the nearly two years since the Supreme Court issued its decision in *Dobbs v. Jackson Women's Health Organization*, which overturned federal abortion protections established by *Roe v. Wade*. The Dobbs decision caused many employers to reconsider the types of reproductive care they would offer to their employees under their group health plan. On February 16, 2024, in the first of its kind decision since Dobbs, the Alabama Supreme Court issued a decision giving personhood status to unimplanted human embryos. In light of this decision, employers may want to revisit their group health plan offerings in Alabama and states with similar personhood laws.

LePage v. Center for Reproductive Medicine

Lepage was brought by three couples who received in vitro fertilization (IVF) at the Center for Reproductive Medicine (the "Center") in Mobile, Alabama. Each of the couples stored some of their created embryos in cryogenic storage at the Center. These stored embryos were destroyed by a hospital patient who entered the Center through an unsecured entrance. The three couples brought claims of wrongful death and negligence under Alabama's Wrongful Death of a Minor Act (the "Act"), which was initially passed in 1872. After being dismissed by the trial court, the case ultimately made its way to the Alabama Supreme Court, which held that frozen embryos are considered children under the Act.

The decision immediately affected access to fertility care throughout the state as fertility centers were uncertain as to their potential liability for even routine treatment of embryos. However, the state legislature quickly responded and passed legislation protecting IVF patients and providers from liability under the Act. While these immediate effects were addressed, the ruling in this case may inadvertently affect liability for IVF providers, health plans that cover IVF, and employers who offer employees IVF services through their plans throughout the country.

Personhood Statutes

Currently 19 states, either in civil or criminal code, extend personhood status to encompass fetuses, with even more states introducing similar personhood bills. Some states, such as Montana, clearly define personhood at "viability." However, others, as in the case of Alabama, have interpreted personhood to include a fetus "at any stage in pregnancy." This has caused some to worry that attorneys general in such states could invoke accomplice liability in potential wrongful death charges to reach health plans and employers that offer IVF or other reproductive coverage in a similar way they have for abortion care.

Employer Action Items

While it is unclear how these laws will ultimately be interpreted and enforced, employers should be aware of the Alabama decision to classify unimplanted frozen embryos as a child for the purpose of their wrongful death statute and other state laws relating to personhood when evaluating IVF programs. The landscape regarding reproductive rights and benefits is challenging for employers attempting to offer broad based support to employees in this area. To best navigate this unsteady landscape of state and federal reproductive laws, employers should:

1. Stay informed of legal developments concerning reproductive health in the states in which you have employees and covered dependents.
2. Review health plan and IVF benefits and coverage to ensure they align with state and federal laws.
3. Consult with legal counsel to understand potential risks and liabilities of offering or not offering certain reproductive care, particularly in states with broad personhood statutes.

HIPAA Privacy Rule to Support Reproductive Health Care Privacy

Following the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, which overturned *Roe v. Wade* and its constitutional protection of abortion, many states adopted extreme abortion bans and other restrictions on reproductive health care. Along with these new laws came concerns from both patients and providers that protected health information (PHI) could be used to expose them to both civil and criminal liability under the new state laws. On April 22, 2024, the Department of Health and Human Services (HHS) finalized new regulations aiming to protect PHI relating to reproductive health care. This final rule aims to allay fears of these patients and providers by prohibiting the use and disclosure of PHI related to lawful reproductive health care under certain circumstances.

HIPAA Privacy Rule Refresher

The HIPAA Privacy Rule (the "Privacy Rule") serves to protect an individual's PHI. The Privacy Rule applies to "covered entities" which include health care providers, health plans, and health care clearinghouses and their business associates (collectively, "regulated entities"). The rule generally prohibits regulated entities from using or disclosing PHI and sets limits on how PHI can be used or disclosed without an individual's express authorization. The rule also gives individuals the right to examine their own health records, direct a covered entity to transmit their records to a third party, and request corrections to their records.

Prohibitions

This new rule focuses on patient confidentiality and the prevention of the use of PHI against an individual or their provider for seeking, obtaining, or providing lawful reproductive health care. The final rule defines reproductive health care to mean health care "that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes." This includes, but is not limited to contraception, preconception screening and counseling, management of pregnancy and related conditions, prenatal care, miscarriage management, pregnancy termination, fertility and infertility diagnosis and treatment, and treatment of conditions that affect the reproductive system.

The final rule prohibits regulated entities from using or disclosing PHI:

- To investigate or penalize, in the civil, criminal, or administrative context, an individual seeking, obtaining, or providing lawful reproductive healthcare.
- To identify any person for the purposes of investigating or imposing such criminal, civil, or administrative liability.

The prohibition applies where a regulated entity has reasonably determined that:

- The reproductive health care is lawful in the state in which it was provided.
- The reproductive health care is protected, authorized, or required by federal law.
- The reproductive health care was provided by a person other than the regulated entity that received the request for PHI and the presumption of lawful reproductive health care applies.

Presumption

The final rule includes a presumption that reproductive health care provided by a person other than the regulated entity who receives a request for PHI was lawful. The presumption that such reproductive health care was lawful may be rebutted if:

- The regulated entity knows the care was unlawful, or
- The regulated entity receives factual information, forming a "substantial factual basis," from the individual making the request that the reproductive health care was unlawful in the circumstances in which it was provided.
- Where a request for PHI is made to the regulated entity that provided the reproductive health care, it is up to that entity to determine whether such health care was lawful and thus if disclosure is permitted.

New Attestation Requirements

The final rule creates a new requirement for regulated entities who receive a request for PHI potentially related to reproductive health care to obtain a written and signed attestation that the use and disclosure is not for a prohibited purpose.

An attestation is required when a request is made for:

- Health oversight activities
- Judicial and administrative proceedings
- Law enforcement purposes
- Disclosures to coroners and medical examiners

A valid attestation must include:

- The name of the individual whose PHI is sought
- The name of the person requesting the PHI
- The name of the person to whom the disclosure is to be made

- The clear statement that the PHI is not for a prohibited purpose
- A statement that a person who knowingly and in violation of HIPAA obtains or discloses individually identifiable health information may be subject to criminal penalties

HHS plans to publish sample attestation language before the compliance date of this final rule.

Notice of Privacy Practices

Under the current Privacy Rule, covered entities are generally required to provide a Notice of Privacy Practice (NPP) to individuals to inform them how a covered entity may use or disclose their PHI and explain their individual rights under the Privacy Rule. Covered entities must now revise their NPPs to explain to individuals how their PHI related to reproductive health care may be used or disclosed under the newly issued final regulations. NPPs must be updated and revised by February 16, 2026.

Employer Action Items

While employers are not regulated by HIPAA directly, employers who provide health benefits or who handle health information in any capacity should stay informed of the implications of this rule. To best navigate the complicated and rapidly changing landscape of state and federal reproductive health law, employers should:

1. Stay up to date on guidance released from HHS concerning the updates to the Privacy Rule.
2. Update NPPs and ensure employees are provided with updated NPPs.
3. Consult with legal counsel should you receive a request for information potentially related to an employee's PHI or their reproductive health care.