Employee Benefits Compliance Briefing

Fall 2024

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Acadia BENEFITS

This Issue

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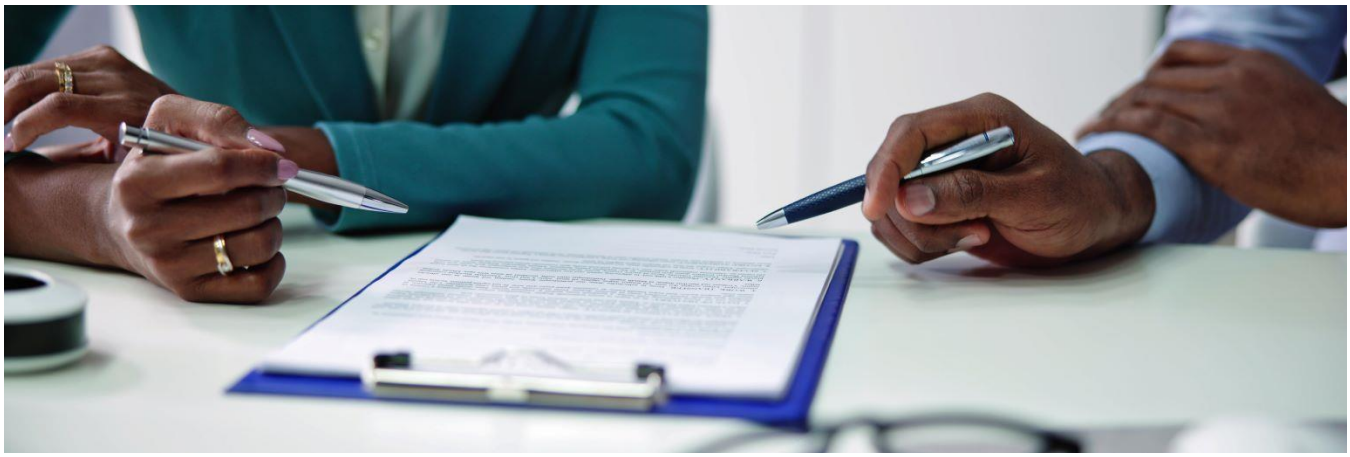

What Health Plan Sponsors Need to Know about the New Fiduciary Rule

The Department of Labor (DOL) recently released a final rule, expanding the definition of "investment advice" under the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code. While the rule is aimed at retirement plans, the final rules failed to provide an exception for health and welfare plans that include health savings accounts (HSAs), resulting in the potential for fiduciary compliance obligations for employers and health plan sponsors.

The New Rule

The final rule, which becomes effective on September 23, 2024, replaces the current five-part test under ERISA defining when an individual is an "investment advice" fiduciary. The new rule classifies an individual as an investment advice fiduciary if:

1. They make an investment recommendation to a retirement investor,
2. The recommendation is provided for a fee or other compensation, such as commissions, and
3. The financial services provider holds itself out as a trusted adviser by
    - specifically stating that it is acting as a fiduciary under Title I or II of ERISA, or
    - making the recommendation in a way that would indicate to a reasonable investor that it is acting as a trusted adviser making individualized recommendations based on the investor's best interest.

This new rule closes what the DOL considered the "one-time advice" loophole, which practically may bring an HSA provider under ERISA fiduciary rules if the provider recommends an HSA investment or strategy and receives a commission. However, providing "investment education" such as the features or benefits of an HSA or the benefits of increasing contributions will not grant fiduciary status upon a provider or employer.

Employer Action Items

In light of this new rule and to avoid fiduciary status, health plan sponsors should:

- Avoid making recommendations regarding how employees and HSA account holders should invest their HSA funds.
- Maintain thorough documentation of all communications and recommendations related to HSAs.

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- Ensure that all communications to employees about HSAs are clear, factual, and do not constitute investment advice.
- Provide training for HR and employee benefits personnel to ensure they understand this new rule and the effect of providing HSA investment information.
- Review and amend, if necessary, investment service agreements to include fiduciary status for service providers.

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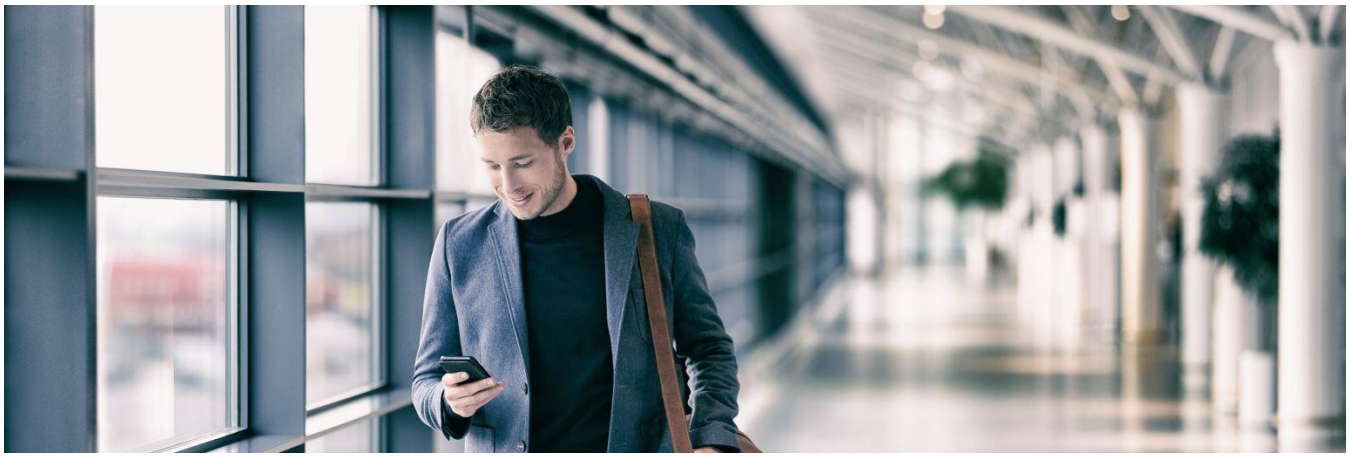

Health Plan Exclusion of Gender-Affirming Care Violated Title VII

The U.S. Court of Appeals with jurisdiction over federal cases originating in the states of Alabama, Florida and Georgia (the 11th Circuit Court of Appeals) recently held that an employer's health insurance plan wrongly excluded coverage for gender-affirming care in violation of federal civil rights law – offering a warning to employers across the country when it comes to supporting transgender workers. The exclusion drew a line between gender-affirming surgery and other operations and intentionally carved out an exclusion based on one's transgender status, which the 11th Circuit Court of Appeals found violated Title VII of the Civil Rights Act of 1964. What do employers and benefit plans need to know about the decision?

Anna Lange v. Houston County, Georgia

Anna Lange is a transgender woman who, throughout most of her life, experienced symptoms of gender dysphoria – a condition characterized by feelings of discomfort and distress because of the incongruence of one's gender identity and their sex assigned at birth. Because of her diagnosed gender dysphoria, her doctor determined gender-affirming surgery was medically necessary, and Lange turned to her health insurance plan to cover the costs. However, her employer's – the Houston County Sheriff's Office – health plan excluded coverage for claims it considered not medically necessary – including services and supplies for a sex change operation – and thus denied Lange's insurance claim.

She filed claims against the Sheriff's Office and the county and requested relief under Title VII, the Americans with Disabilities Act (ADA), and the Equal Protection Clause of the United States Constitution.

The lower court ruled in Lange's favor on the Title VII claim and found the exclusion of services and supplies for a sex change was facially discriminatory as a matter of law. It found that Lange's gender was inextricably tied to the denial of coverage and pointed to the Supreme Court's 2020 *Bostock v. Clayton County* decision that held that discrimination because of an individual's sexual orientation or gender identity — including being transgender — is unlawful discrimination "because of sex" under Title VII.

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The case proceeded to trial to determine damages and a jury awarded Lange $60,000. After the trial, the court permanently blocked the employer from further enforcing the exclusion.

The Appeal

The Sheriff's Office and County appealed the decision, but the 11th Circuit Court of Appeals agreed with the lower court. It expressly held that the exclusion was a facially discriminatory policy and further said that a blanket denial of gender-affirming surgery punished transgender employees based upon their perceived gender non-conformity.

While a dissenting judge tried to defend the employer's decision in part on the fact that the health plan was a no-frills policy that excluded many other types of procedures, the Court of Appeals did not buy that argument. It concluded the decision by saying, "cost savings do not excuse discrimination, nor may they be used to circumvent liability under Title VII."

Other Key Takeaways

This case provides a few good reminders for employers:

1. No further proof of adverse intent is needed to establish a Title VII violation when a policy or practice discriminates against a protected characteristic.
2. Health benefits are considered a form of compensation and fall under Title VII's purview.
3. The definition of an employer is liberally construed, and courts may consider the totality of the employment relationship in determining whether an entity is an employer. In this case, the delegation of administering a health plan was enough to qualify the County as an agent and employer under Title VII.

Employer Action Items

In light of this ruling, employers across the country – especially those in Georgia, Florida, and Alabama – should consider taking steps to ensure they are in compliance with the current interpretation of Title VII.

- Review your health plan with counsel and determine if any exclusions are discriminatory on their face.
- Review your employee handbook and policies to ensure that there are no policies excluding employees based upon their gender identity. Assess your dress and appearance policies to ensure that they are gender-neutral and do not include standards based upon gender stereotypes. Transgender employees should be allowed to follow standards that align with their gender identity and expression.

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- Train managers on company policies on equal employment opportunity and transgender issues. Managers should know the steps to take if an employee informs them that they plan to transition to another gender. For example, managers should understand if reasonable accommodations need to be provided to the transgender employee or the steps needed to be taken if the employee desires to change their pronouns.

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What Overturning Chevron Deference Means for Group Health Plans

In a landmark decision on June 28, 2024, the U.S. Supreme Court overturned the decades-old *Chevron* Doctrine, significantly reducing the power of federal regulators and handing that power to judges. This decision will inevitably have significant and far-reaching impacts on every sector, including the administration and regulation of health and welfare plans. As plan sponsors and employers, it is crucial to understand how this change may affect your administration and compliance responsibilities.

Understanding *Chevron* Deference

Chevron deference originated from the 1984 Supreme Court case *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.,* where the Court held that in the case of an ambiguous statute, courts should defer to the federal agency's interpretation so long as that interpretation was reasonable. The rationale behind this deference is that agencies and those who work within them possess expertise and are better suited than Congress or the Courts to interpret and implement complex statutory schemes. While this deference has provided stability, some have argued that it has given agencies outsized power to set regulations.

What Now?

As a result of the Supreme Court's 6-3 decision, if agency action is challenged in court, courts will continue to respect the agency's authority if it has been properly delegated by statute. However, if a law is ambiguous, courts will now get to decide whether an agency has acted within its statutory authority – rather than yielding to the agency. This shift in judicial approach will lead to increased judicial scrutiny of agency regulations and decisions, especially paired with a companion SCOTUS case that says the six-year statute of limitations to contest regulatory actions doesn't begin until a party is actually injured by the regulation.

Implications for Plan Sponsors and Employers

Within a week of *Chevron* being overturned, courts reviewed regulations touching on the Department of Labor's overtime rule, the Federal Trade Commission's restriction on non-compete agreements, and the Department of Health and Human Services' interpretation of the word "sex." Some court rulings have applied nationwide, while others only

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applied statewide or to the entities bringing the suit. Being plunged into such fragmented and regulatory environment can make it difficult to ensure compliance with rules that may be in a constant state of flux.

Increased litigation is a near certainty following this ruling. With courts no longer deferring to agency interpretations, stakeholders may be more inclined to challenge agency regulations and decisions. Employers and plan sponsors should prepare for the reality of more legal disputes concerning the interpretation and application of health plan regulations.

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IRS Answers Questions Regarding Tax-Favored Educational Assistance Programs

Employers can leverage educational assistance programs to enhance their workforce's skills while providing tax benefits. On June 17, 2024, the IRS answered frequently asked questions related to educational assistance programs.

Overview of Educational Assistance Programs

An educational assistance program (EAP) is a written benefits plan provided by an employer to offer educational assistance to its employee. Benefits of up to $5,250 per year provided under an EAP may be excluded from the employee's gross income, resulting in no tax to the employee on that benefit. EAP benefits can include payments for tuition, books, supplies, and equipment for either undergraduate or graduate coursework. EAP benefits may also include principal or interest payments on qualified education loans. The amounts paid under a valid EAP are generally also deductible as a business expense by the employer.

An EAP must be established in a written plan. The IRS provided a sample plan for employers to tailor to their needs, including setting its own conditions for eligibility, participation, and proration of benefits for part-time employees. However, an EAP cannot set conditions or requirements for its plan that discriminates in favor of officers, shareholders, self-employed, or highly compensated employees. Specifically, no more than 5% of the total benefits paid under the EAP can go to shareholders and owners.

Educational Loan Payments

Inclusion of educational loan payments in an EAP can provide a significant benefit to employees. However, the FAQs outline the strict criteria for properly establishing loan payment assistance:

1. Payments must be made for a "qualified" loan at an eligible educational institution as determined by the Department of Education and generally includes any college, university, vocational school, or other postsecondary educational institution.
2. Payments must be made between March 27, 2020, and January 1, 2026 (unless extended by future legislation).
3. Payments may be made directly to a third party, such as a loan servicer, or directly to the employee.
4. The EAP plan generally must explicitly include educational loan payments.

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5. The educational loan payments must be for the exclusive benefit of the employee. Payments made to loans for the employee's spouse or dependents cannot be excluded from the employee's gross income.

Implementation of an EAP

Employers looking to enhance their employee benefit plans may choose to establish an education assistance program. Implementation requires careful planning and communication so that the employer and participants can take advantage of the of the favorable tax treatment associated with the benefits. To establish and manage an effective EAP, employers should:

1. ### Develop a Clear Written Plan
   Detail the eligibility, benefits, and administration of the program. The plan should explicitly state the types of educational assistance provided, including loan repayments if applicable. Employers should also ensure that the plan complies with Section 127 requirements and non-discrimination rules.

2. ### Communicate with Employees
   Inform employees about the availability and benefits of the educational assistance program and provide clear guidelines on participation, the types of expenses covered, and the process for receiving benefits. Regular communication ensures that employees are aware of the program and can take full advantage of the benefits and favorable tax treatment.

3. ### Keep Records
   Maintain thorough records of all educational assistance payments and related documentation. This includes receipts, invoices, and proof of qualified education loan payments. Accurate record-keeping is essential for compliance and can help resolve any future tax-related audits or assessments.

4. ### Review and Update the Plan
   Periodically review the educational assistance program with legal counsel to ensure it remains compliant with current tax laws and regulations. Update the plan as necessary to reflect changes in the law or company policies. Be sure to keep plan participants informed of any changes to the program.

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The Importance of a Wrap Plan

The Wrap Plan

Section 402 of the Employee Retirement Income Security Act (ERISA) requires that every health and welfare plan must have a written plan document. A wrap plan is a document that bundles or "wraps" ERISA health and welfare benefits (medical, dental, and vision, for example) into a single plan. It is an important component of the ERISA required documentation which includes summaries of benefits and coverage, insurance agreements, enrollment materials, and a Summary Plan Description.

A wrap plan and accompanying Summary Plan Description should contain at least the following provisions:

- A description of eligibility for benefits
- An outline of administrative powers including who has authority to interpret the plan provisions
- The benefits available to participants (which are usually detailed in other documents)
- Claims and appeals procedures
- A reservation of the right to amend or terminate the plans and benefits
- Legally required information (such as notices under HIPAA, USERRA, COBRA, ERISA, etc.)

The 5500 Filing

All health and welfare benefit plans, unless a specific exception applies such as a fully insured plan having fewer than 100 participants, are required to file IRS Form 5500. Without a wrap plan, Form 5500 would have to be filed for each component plan – medical, dental, vision. A wrap plan can significantly reduce the administrative burden associated with annual reporting by filing just one Form 5500.

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Employer Action Items

If you don't already have a wrap plan, work with your employee benefit broker or third-party administrator for assistance in preparing one.

If you have a wrap plan, review it at least every two years to ensure that it reflects the current legal requirements and any changes that may have been made to component plans.

Ensure that you are properly and timely filing Form 5500. If participation in the plan increased to more than 100 employees, you will now be required to file.

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A Cybersecurity Reminder for Plan Sponsors

A costly cyberattack on a health care claims processor is an important reminder about the practical steps you should take to meet your cybersecurity responsibilities.

The Attack

Earlier this year, cyber criminals accessed Change Healthcare's computer systems, encrypted vital data, and claimed to have stolen six terabytes of sensitive information, including personally identifiable information and medical records. In response to the attack, Change Healthcare disconnected its systems – paralyzing hospital and pharmacy systems, claims approvals, and billing and payment systems across the country. It was arguably the most significant cybersecurity disruption to healthcare in U.S. history. In its 2024 first-quarter report, UnitedHealth Group, parent of Change Healthcare, reported a loss of $872 million in "unfavorable cyberattack effects."

The U.S. Department of Health and Human Services (HHS) Office of Civil Rights (OCR) opened an investigation into the Change Healthcare attack. OCR oversees and enforces the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy, security, and breach notification rules that apply to "covered entities" – such as healthcare providers, clearinghouses, and health plans – and their business associates.

Employer Action Items

Ensure compliance with HIPAA.

If you are acting as a HIPAA business associate, ensure you are compliant with all regulatory obligations and responsibilities and have executed current business associate agreements. Even if not acting as a business associate, your privacy policies should follow HIPAA guidelines to limit the amount of personal health information (PHI) you receive and provide the minimum necessary information only to those with a genuine need to know.

Implement cybersecurity best practices.

Although geared toward ERISA plan sponsors and fiduciaries, the Department of Labor's Cybersecurity Program Best Practices serves as an excellent framework for anyone working in the health and welfare plan space. Key features include adopting a formal, well documented cybersecurity program; conducting regular risk assessments; having strong access controls procedures; and establishing an effective business resiliency program.

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Respond immediately and appropriately to any security breach.

Ensure that timely notice of a breach is made to participants, regulators, and in some cases the media as required by the HIPAA Rules. Keep in mind that you could have additional obligations under other federal, state, or local laws. Take steps to mitigate any potential harm as soon you become aware of the attack. Work with your counsel to ensure that you satisfy any requirements that you, your employees, or third-party service providers might have. You may need to engage a crisis communication expert to help respond to questions.

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