Employee Benefits Compliance Briefing

Winter 2024

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Acadia BENEFITS

This Issue

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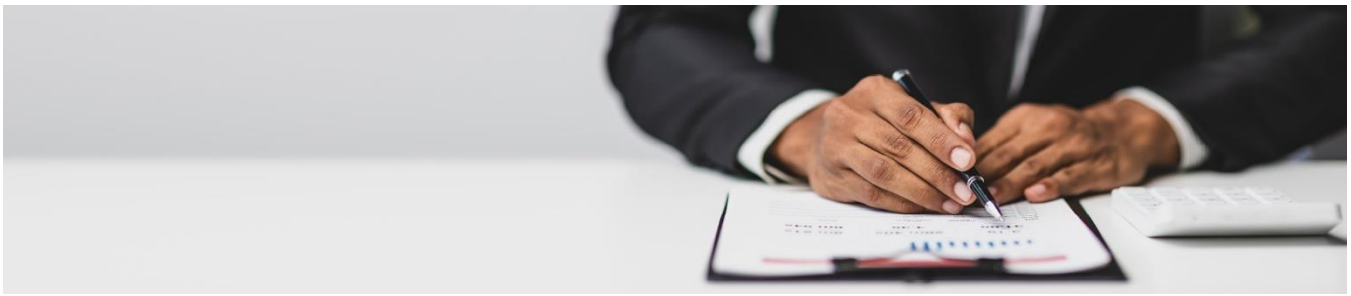


Fifth Ciruit Court Ruling on Benefits Denial

The recent ruling by the Fifth Circuit Court of Appeals in *Dwyer v. United Healthcare Ins. Co.* serves as a reminder for plan sponsors and insurers of the importance of adhering to both substantive and procedural requirements under the Employee Retirement Income Security Act (ERISA). In this case, a participant in an employer-sponsored group health plan challenged the health insurer's decision to terminate inpatient care benefits for his minor daughter, who was receiving treatment for anorexia nervosa. The court found that the insurer's denial of benefits was deficient on multiple fronts.

Case Overview

The case involved a 14-year-old dependent admitted to a residential treatment facility in February 2015 to treat her severe anorexia nervosa. Initially, the insurer covered her residential treatment, but by June 2015, the insurer concluded that the patient could transition to partial hospitalization, and it terminated her inpatient care benefits. The dependent's doctors disagreed, stating that she was "still not at the point of readiness" for outpatient treatment. Nevertheless, the insurer proceeded with the termination of in-patient benefits, leaving the family to continue treatment at their own expense.

The participant then sued in federal district court which ruled in favor of the insurer. The participant appealed to the Fifth Circuit.

The Fifth Circuit's Ruling

The Fifth Circuit reversed the district court's decision. The Fifth Circuit recognized that "[p]lans must provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant." In addition, ERISA requires plans to "afford a reasonable opportunity... for a 'full and fair review' of dispositions adverse to the claimant." The Fifth Circuit highlighted several areas where the insurer's actions were both substantively and procedurally flawed.

1. Substantively deficient denial of benefits:
   The court determined that the insurer's rationale for terminating inpatient care was not supported by medical evidence. Specifically, the insurer's claim that the dependent had achieved 100% of her ideal body weight and no longer needed inpatient care was contradicted by medical records.

2. Procedurally deficient claims process
   The Fifth Circuit also found that the insurer failed to provide the participant with a full and fair review as required by ERISA. The Court noted that the insurer did not engage in a meaningful dialogue, or any dialogue at all, with the participant. ERISA mandates that adverse determinations be communicated clearly, including the specific plan provisions and clinical judgments that form the basis for the decision. In this case, the insurer's denial letter lacked such specifics, making it procedurally insufficient.

Implications for Plan Sponsors

The *Dwyer* ruling underscores that plan sponsors are responsible for ensuring compliance with ERISA's claims procedures.

- Plan sponsors must ensure that benefits determinations are based on sound medical evidence, especially when it comes to complex cases such as those involving mental health or long-term care. If medical professionals involved in the case provide opinions that challenge the decision, those opinions must be fully addressed.
- Plan sponsors must ensure that participants are informed of the specific reasons for benefit denials and given a full and fair opportunity to appeal such decisions.

IRS Releases 2025 Cost-of-Living Adjustments for Employee Benefits

Each year the IRS provides cost-of-living adjustments (COLAs) applicable to employee benefits. The following are the 2025 COLA limits for employer-sponsored welfare and fringe benefits, as well as steps employers can take to integrate these changes into their benefits packages.

Health Flexible Spending Accounts (FSAs)

	2024	2025
Maximum salary reduction contribution	$3,200	$3,300
Maximum carryover amount to the next plan year	$640	$660

Transportation Fringe Benefits

	2024	2025
Monthly parking benefit exclusion	$315	$325
Monthly transit and vanpooling limit	$315	$325

Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs)

	2024	2025
Maximum for self-only coverage	$6,150	$6,350
Maximum for family coverage	$12,450	$12,800

Adoption Assistance Exclusion and Adoption Credit

	2024	2025
Maximum exclusion from gross income	$16,810	$17,280
Maximum adoption credit	$16,810	$17,280
Phase-out begins at modified adjusted gross income (MAGI)	$252,150	$259,190
Phase-out ends at MAGI	$292,150	$299,190

Dependent Care Assistance Program (DCAP)

	2024	2025
Maximum benefit – single/married, filing separately	$2,500	$2,500
Maximum benefit – married, filing jointly	$5,000	$5,000

Small Business Health Care Tax Credit

	2024	2025
Phase-out begins at annual wage level	$32,400	$33,300
Maximum average wages for eligible small employers	$64,800	$66,600

Premium Tax Credit (PTC) for Excess Advance Credit Payments

	2024	2025
Unmarried individuals, household income < 200% of federal poverty line (FPL)	$375	$375
Unmarried individuals, household income 200-300% of FPL	$950	$975
Unmarried individuals, household income 300-400% of FPL	$1,575	$1,625
Other taxpayers, household income < 200% of FPL	$750	$750
Other taxpayers, household income 200-300% of FPL	$1,900	$1,950
Other taxpayers, household income 300-400% of FPL	$3,150	$3,250

Health Savings Accounts (HSAs)

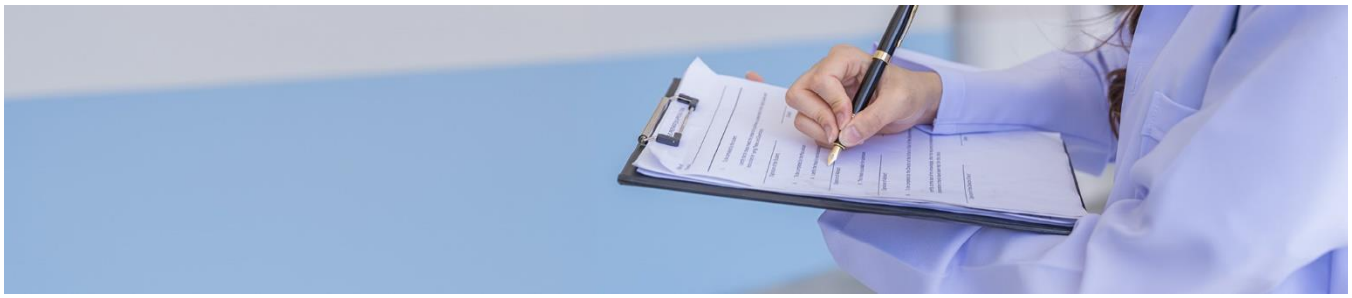
	2024		2025	
	Self-only	Family	Self-only	Family
Contribution limit	$4,150	$8,300	$4,300	$8,550
Minimum deductible	$1,600	$3,200	$1,650	$3,330
Out-of-pocket expense limit	$8,050	$16,100	$8,300	$16,600

	2024	2025
Catch-up contribution if 55 or older	$1,000	$1,000

Employer Action Items

- Review and update benefits materials.
  Ensure all documents, including cafeteria plans, reflect the 2025 limits for FSAs, transportation fringe benefits, QSEHRAs, and other programs.
- Coordinate with payroll and benefits providers.
  Collaborate with external payroll and benefits vendors to implement the updated limits into payroll systems, ensuring seamless compliance with the new caps on contributions and reimbursements.

- Communicate changes during open enrollment.
  Use the upcoming open enrollment period to educate employees on the new 2025 limits, highlighting how these changes may impact their benefits selections and tax savings for the year.
- Inform HR teams.
  Ensure that HR staff is updated and aware of the new limits and prepared to answer employee questions and properly administer benefits under the new guidelines.



New CMS Rules on Medicare Reporting Penalties

The Centers for Medicare & Medicaid Services (CMS) recently issued final rules outlining the penalties for responsible reporting entities (RREs) that fail to meet Medicare Secondary Payer (MSP) reporting obligations. The regulations were applicable as of October 11, 2024, and enforcement will begin in October 2025. The penalties for non-compliance are steep.

Background on Medicare Secondary Payer (MSP) Rules

Medicare acts as a secondary payer in specific situations where an employer's group health plan provides primary coverage. These scenarios include:

1. Individuals and their spouses who are age 65 or older and covered by a group health plan if the employer has 20 or more employees.
2. Disabled individuals covered through a spouse who is actively employed, and the employer has 100 or more employees.
3. Individuals with end-stage renal disease during the "coordination period."

MSP rules require group health plans to report details about individuals enrolled in both Medicare and the employer's health plan. The "record" of an individual's coverage is required to be reported within one year of the latter of either the effective date of the coverage or the date when the individual became a Medicare beneficiary. CMS uses this information to ensure that Medicare only pays after the appropriate primary payer has made payments.

Who is the responsible reporting entity (RRE)?

Under the MSP rules, the obligation to report rests with the RRE. For group health plans, an RRE may include:

- The insurer of the plan
- A third-party administrator (TPA) that handles claim payments or adjudications
- The plan administrator in cases of self-insured and self-administered plans

Employers do not qualify as RREs and are therefore not directly responsible for reporting unless they self-insure and self-administer their health plans. Even in this case, employers may contract with an agent to act as their RRE. However, employers are expected to provide the RRE with accurate information to facilitate proper reporting to CMS.

Penalties for Noncompliance

CMS's final regulations stipulate steep daily penalties for RREs that fail to meet the MSP reporting requirements. CMS has adopted a tiered approach of penalties per individual, per day:

- $250 per day if the record is reported 1 to 2 years after the required date.
- $500 per day if the record is reported 2 to 3 years after the required date.
- $1,000 per day if the record is reported 3 or more years after the required date.

The total penalty for any one individual will not exceed $365,000 per year. Penalties will be adjusted annually for inflation.

CMS clarified that these penalties will be applied prospectively, with enforcement beginning on October 11, 2025. Penalties will not be applied retroactively for past noncompliance. If an RRE believes extenuating circumstances prevented timely reporting, it can appeal the penalty assessment. CMS may waive penalties for "good faith efforts" at reporting.

Employer Action Items

Although employers may not be directly responsible for reporting, they play a critical role in ensuring compliance.

- Identify your plans.
  Identify your group health plans subject to the MSP reporting rules.
- Identify your RRE.
  If you are self-insured and self-administered, ensure that you and your appointed agent are aware of reporting requirements.
- Communicate with your RRE.
  If your group health plan is administered by a third-party insurer or TPA, confirm they understand the MSP reporting rules and are prepared to comply.
- Provide accurate information.
  Ensure that your organization supplies the RRE with accurate and timely information regarding individuals enrolled in both Medicare and your health plan.
- Monitor compliance.
  Establish an internal point of contact responsible for overseeing compliance with MSP rules.
- Stay informed on regulations.
  Keep track of updates from CMS to ensure ongoing compliance and avoid unexpected penalties.

Changes to Medicare Part D Call for a Reexamination of Creditable Coverage

Every year, group health plans are required to notify their Medicare-eligible policyholders whether their prescription drug coverage is "creditable coverage." Drug coverage is creditable if it is as good or better than the Medicare drug benefit. If a Medicare-eligible individual is not enrolled in creditable coverage, they may incur late enrollment fees for every month they are not enrolled in Medicare part D.

There are two primary notice requirements for entities that offer prescription drug coverage:

1. Annual disclosure to Medicare-eligible individuals covered by the plan by no later than October 15 of each year.
2. Annual reporting to the Centers for Medicare & Medicaid Services (CMS) of creditable coverage status of their prescription drug plan within 60 days prior to the beginning of the plan year (Nov. 1 for calendar year plans), 30 days of the termination of a prescription drug plan, or 30 days after any change in creditable coverage status.

Overview of Creditable Coverage Changes

The Inflation Reduction Act (IRA) made several changes to Medicare Part D, including capping out-of-pocket expenses at $2,000 for individuals with Medicare Part D starting in 2025 (this cap is indexed for following years). This is a significant change compared to the out-of-pocket maximum of $8,000 for 2024. This shift, with the other changes made by the IRA, will make it more difficult to meet the creditable coverage criteria, particularly for high deductible health plans.

What About Non-Calendar Year Plans?

The new Medicare Part D benefits affect plans' creditable coverage determinations for calendar year plans beginning in 2025. Determination of creditable coverage for non-calendar year plans is not required until the plan renews in 2025. For example, if a plan renews on June 1, 2025, creditable coverage tested against the 2025 Medicare Part D parameters is not required to be evaluated and reported to CMS until April 1, 2025.

Employer Action Items

- Review your coverage. If you have not already reviewed your coverage prior to the October 15 notification deadline, do so as soon as possible. Calendar year plans should be testing against the 2025 parameters and non-calendar year plans should be testing against the 2024 parameters until its CMS reporting is required prior to its 2025 plan year (60 days before the start of the plan year).
- Notify CMS of creditable coverage changes within 30 days of determination.

Compliance with Mental Health Parity and Addiction Equity Act Final Rules

The U.S. Departments of Health and Human Services (HHS), Labor (DOL), and the Treasury (IRS) (collectively, the "Departments") released new final rules implementing the Mental Health Parity and Addiction Equity Act (MHPAEA). The final rules aim to ensure that health plans treat mental health and substance use disorder (MH/SUD) benefits on a par with medical and surgical (M/S) benefits.

At the core of the new regulations is the emphasis on nonquantitative treatment limitations (NQTLs)—the non-financial aspects of a health plan, such as medical necessity criteria and provider admission to network guidelines that impact access to MH/SUDs. The final rules require that NQTLs be analyzed and documented annually to ensure they are applied equitably to MH/SUD and M/S benefits.

Highlights of the Final Rules

1. Prohibition on greater restrictions for MH/SUD benefits.
   Health plans must not impose more restrictive limitations on MH/SUD benefits compared to M/S benefits. If greater restrictions are found, plans must make necessary changes to achieve parity.
2. Comparative analyses requirement.
   As mandated by the Consolidated Appropriations Act of 2021, group health plans must conduct and document comparative analyses of NQTLs annually. These analyses need to be thorough, including descriptions of the NQTLs, how they are applied, and any disparities between MH/SUD and M/S benefits. Plans must also collect data to demonstrate the actual impact of these NQTLs on behavioral health access.
3. Meaningful benefit requirement.
   If a plan offers any benefits for MH/SUD conditions, it must offer meaningful benefits across all classifications where M/S benefits are provided. This ensures that MH/SUD benefits are not token offerings but substantive and comparable in all areas of the plan.
4. End of opt-out for governmental plans.
   The final rules end the ability of self-funded non-federal governmental plans to opt out of MHPAEA compliance, meaning more plans are now required to follow these parity standards.
5. Use of independent standards.
   The rules shift the definition of M/S and MH/SUD benefits to generally recognized independent medical standards, rather than relying on state-level guidelines. This change creates a more consistent national standard for evaluating benefits.

Comparative Analysis Requirement

The comparative analysis requirement is already in effect, having been introduced in February 2021. Employers and plan sponsors need to ensure their plans can demonstrate compliance both "as written" and "in operation." This includes:

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 the way 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.
6. Findings and conclusions.

Employers must ensure they have robust processes in place to collect, document, and maintain these analyses and be prepared to present them upon request by the Departments, state regulators, or plan participants. The final rules set forth the steps the Departments will follow to request and review a plan's or issuer's comparative analysis of an NQTL. The Departments have established strict timelines for responding to requests for these analyses, making it essential for employers to stay prepared.

Important Deadlines

The final rules will take effect for group health plans starting on January 1, 2025. However, the meaningful benefits standard, the prohibition on discriminatory factors and evidentiary standards, the relevant data evaluation requirements, and the related requirements in the provisions for comparative analyses apply on the first day of the first plan year beginning on or after January 1, 2026.

Employer Action Items

- Review current compliance.
  Work with your advisors to ensure your health plans are already compliant with existing MHPAEA rules, with a specific focus on NQTLs. Pay attention to common noncompliance warning signs, such as more restrictive medical management practices for MH/SUD benefits.
- Ensure comparative analyses are ready.
  Ensure that your plan's comparative analyses are completed and comprehensive. Plans that offer generalized statements of compliance or fail to provide adequate data or explanations have been frequently flagged for noncompliance.
- Coordinate with TPAs or ASOs.
  For self-insured plans, confirm that your third-party administrators (TPAs) or administrative services only (ASO) providers are involved in preparing the necessary documentation. Although the employer is legally responsible, TPAs or ASOs can provide valuable support in gathering and analyzing data.

- Collect supporting documentation.
  Work with service providers to gather all the relevant documents for the NQTL comparative analysis, including the evidentiary standards, factors, and rationale used to apply these limitations.
- Educate yourself and your team.
  The Department of Labor offers a Self-Compliance Tool that can assist employers in understanding the detailed requirements of the MHPAEA and the process for conducting NQTL analyses. This is a valuable resource for staying informed and prepared.

Wellness Programs and Smokers' Penalties under Scrutiny

A recent lawsuit involving Macy's Inc. and the U.S. Department of Labor (DOL) is bringing attention to the way companies structure their wellness programs—particularly those that impose penalties on employees who smoke. This case highlights the potential risks for employers who charge higher health premiums to smokers and raises questions about how courts will interpret wellness plan regulations following the Supreme Court's *Loper Bright* decision.

The Macy's Lawsuit and ERISA's Wellness Program Rules

The DOL's lawsuit against Macy's claims that the retailer's wellness plan violates the Employee Retirement Income Security Act (ERISA) by charging smokers higher premiums without offering a reasonable alternative to avoid the penalty. Specifically, Macy's imposes a surcharge of $35 to $45 per month for employees who smoke, but the penalty is not fully waived for those who attempt but fail to quit smoking, even after participating in a smoking cessation program.

ERISA prohibits health plans from charging different premiums based on health-related factors, such as tobacco use, but allows exceptions for wellness programs that promote health. According to DOL regulations, surcharges for smokers are permitted if the wellness plan offers a reasonable alternative—like a smoking cessation program—that fully waives the penalty, even if the employee is unsuccessful in quitting.

Loper Bright's Impact

The recent *Loper Bright Enterprises v. Raimondo* decision has introduced a new layer of complexity to wellness program disputes. The Supreme Court's ruling in *Loper Bright* rejected the Chevron deference doctrine, which for decades allowed courts to defer to federal agencies' interpretations of ambiguous statutes. Instead, courts must now apply the "best read" of a statute.

Macy's argues that this decision is relevant to its case, claiming that under the "best read" of ERISA, smokers must actually quit smoking to avoid the penalties. Macy's contends that the DOL's interpretation of ERISA—which requires penalties to be waived for anyone who participates in a smoking cessation program, regardless of success—should no longer be followed now that courts are not required to defer to agencies' interpretations.

However, the DOL has argued that *Loper Bright* is not applicable in this case. The Department contends that the dispute is not about statutory interpretation but about the application of the DOL's wellness program regulation. Macy's, the DOL claims, is misrepresenting the issue as a statutory one when it is really about following established regulations, which clearly require surcharges to be waived based on participation in a cessation program, regardless of success.

Why This Matters for Employers

This case is just one of many recent challenges to wellness programs that penalize tobacco use. Companies like Walmart, Bass Pro Group, and others have also faced lawsuits over similar issues. As courts reconsider the boundaries of agency interpretation in light of *Loper Bright*, employers should be cautious in the way they design wellness programs, especially those that impose financial penalties based on employee health behaviors.

Employer Action Items

With these legal challenges in mind, employers should take steps to ensure compliance and mitigate potential risks.

- Review wellness program policies for compliance.
  Conduct a thorough review of wellness programs, particularly those with penalties for tobacco use. Ensure that any surcharges or penalties comply with ERISA and DOL wellness program regulations, which require offering reasonable alternatives to avoid penalties.
- Understand the "reasonable alternative" requirement.
  The DOL requires that wellness programs with financial penalties, such as smoker surcharges, provide a reasonable alternative to avoid the penalty. For tobacco use, this means offering a smoking cessation program that waives the penalty regardless of the employee's success in quitting.
- Update wellness program documentation.
  Ensure that your wellness program documentation is clear and compliant. Include details about the availability of reasonable alternatives to avoid penalties, and make sure employees understand their options.