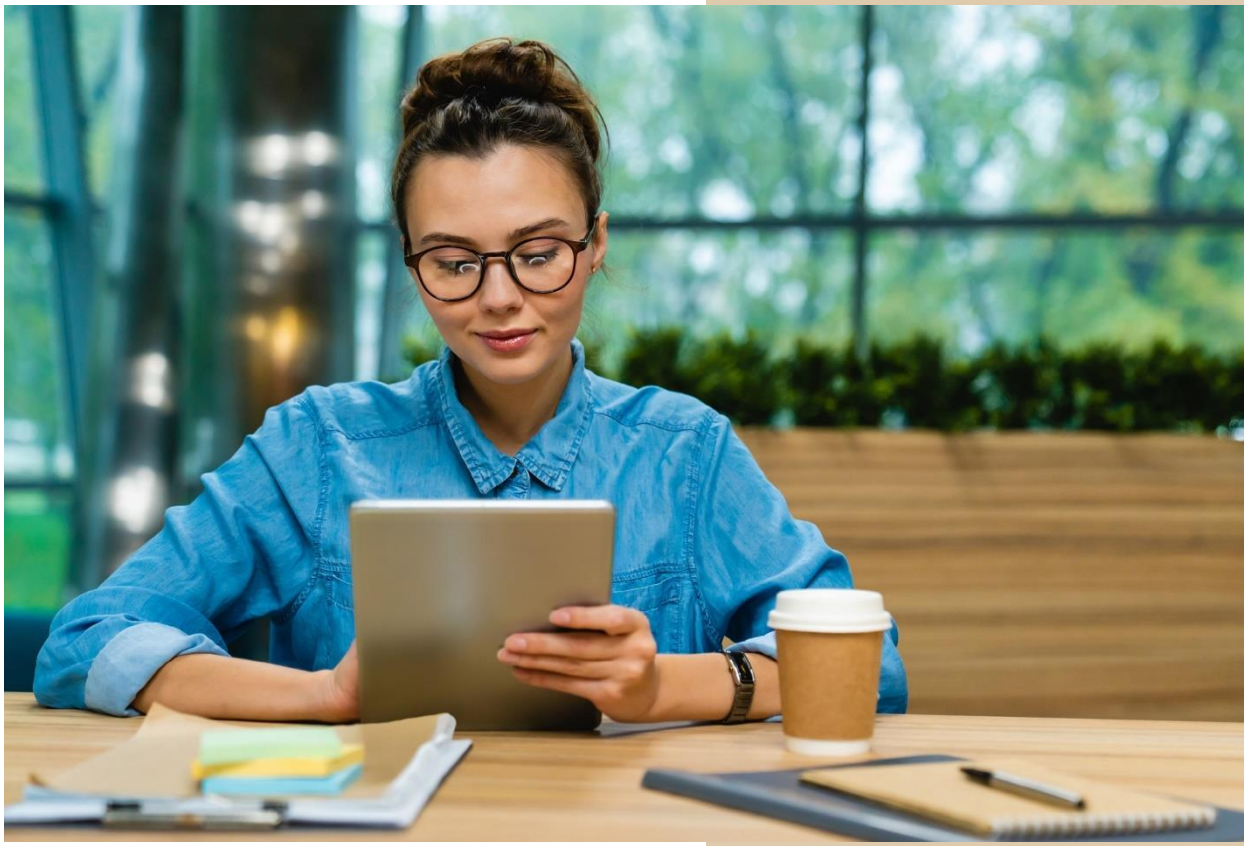
Employee Benefits Compliance Briefing

Spring 2025



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Acadia BENEFITS

This Issue

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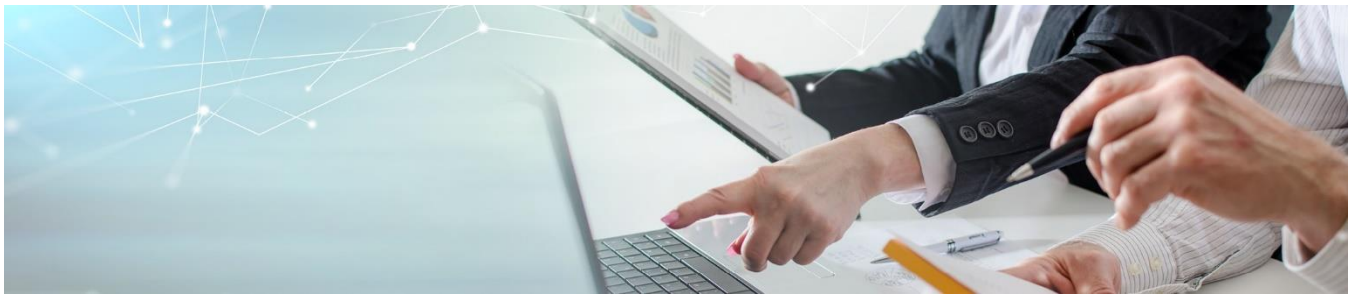


2025 Deadlines for Plan Sponsors

It can be difficult to keep up with all of the compliance obligations and deadlines for group health plans. This overview of significant federal deadlines that apply to calendar-year group health plans will help you stay on track. This is not an exhaustive list and employers contact their benefits attorney if they have questions.

January

Deadline	Requirement	Additional Information
Jan. 31, 2025	Report health plan costs on Form W-2	While this deadline has passed, employers that have not yet furnished Forms W-2 to their employees should do this as soon as possible (unless an extension applies). Employers that filed more than 250 Forms W-2 from the previous calendar year must report the aggregate cost of employer-sponsored health plan coverage on employees' Forms W-2.
Jan. 31, 2025	Provide Forms 1095-B or 1095-C to employees who requested the form	The Paperwork Burden Reduction Act (PBRA) was eases the burden of ACA compliance obligations. Employers are no longer obligated to furnish Forms 1095-B and 1095-C (which would normally have been required by March 1 of each year). However, employees must receive clear, conspicuous, and accessible notice of their right to receive these forms upon request. If an employee requests a copy of either form it must be provided by the later of January 31 or 30 days after the request.

February

Deadline	Requirement	Additional Information
Feb. 28, 2025	Paper filing deadline for Forms 1095-B and 1095-C	Almost all employers subject to ACA reporting must file electronically.

March

Deadline	Requirement	Additional Information
March 1, 2025	Submit Medicare Part D Disclosures to CMS	Calendar year plans that provide prescription drug coverage to Medicare Part D eligible individuals must file a disclosure indicating whether the coverage was creditable or non-creditable to the Centers for Medicare & Medicaid Services (CMS) through the CMS website.
March 31, 2025	Electronic filing deadline for Forms 1094-B, 1095-B, 1094-C, and 1095-C	Applicable large employers (ALEs) must report using forms 1094/1095-C, and self-funded, non-ALEs must report using forms 1094/1095-B.

June

Deadline	Requirement	Additional Information
June 2, 2025	Submit the prescription drug data collection report to CMS for 2024	Many employers rely on third party administrators (TPAs) or pharmacy benefit managers (PBMs) to prepare and submit the report for their health plans. Employers should connect with their vendors to understand their obligations.

July

Deadline	Requirement	Additional Information
July 31, 2025	Pay Patient-Centered Outcomes Research Institute (PCORI) fee	Self-insured plans must file and pay the PCORI fee on IRS Form 720 for the previous plan year.
July 31, 2025	File Form 5500 or file for an extension to File form 5500	Employers with ERISA covered benefit plans are required to file an annual Form 5500. Employers may be granted an automatic extension using IRS Form 5558 instead of filing on this date.

September

Deadline	Requirement	Additional Information
Sept. 30, 2025	Provide Summary Annual Report (SAR) to covered participants and beneficiaries	Employers that are required to file Form 5500 must provide their participants with a summary of the information within Form 5500 by way of an SAR.

October

Deadline	Requirement	Additional Information
Oct. 3, 2025	Provide Individual Coverage Health Reimbursement Arrangement (ICHRA) Notice to plan participants	Employers that offer ICHRAs must provide a notice to eligible employees regarding the ICHRA's coverage at least 90 days before the beginning of each plan year.
Oct. 15, 2025	Provide Medicare Part D notices	Group health plans that provide prescription drug coverage to Medicare Part D eligible individuals must disclose whether that coverage is creditable or not creditable before the start of the annual coordinated election period for Medicare Part D.
Oct. 15, 2025	File Form 5500	For employers who requested an extension to file Form 5500, October 15 is the final day to file.

December

Deadline	Requirement	Additional Information
Dec. 15, 2025	Provide SAR	For employers who requested an extension to file Form 5500, December 15 is the extension deadline for providing an SAR to participants.
Dec. 31, 2025	Submit gag clause attestation	Group health plans are required to submit attestations of compliance with the prohibition on gag clauses by Dec. 31 each year through this CMS website. Fully insured plans are not required to submit if the issuer submits an attestation; self-insurance plans can enter into an agreement with their TPAs to provide the attestation. Plans should consult with their vendors to determine responsibility.

Reporting Rules Ease Employer ACA Compliance Obligations

Two new federal laws passed at the end of 2024 bring welcomed updates to benefit plan sponsors. Under the Employer Reporting Improvement Act (ERIA) and the Paperwork Burden Reduction Act (PBRA) plan sponsors are no longer required to distribute Forms 1095-B and 1095-C to all covered individuals. The laws also offer employers new protections related to employer shared responsibility (ESR) penalty assessments.

Key Changes

Reporting Individual Coverage Information

The ERIA now allows employers and health insurance providers to submit spouses' and dependents' names and date of birth in lieu of their Tax Identification Number (TIN) on Form 1095-B and 1095-C filings if the TIN is not available.

Distribution of Forms 1095-B and 1095-C Upon Request

The PBRA no longer requires employers and health insurance providers to distribute Forms 1095-B and 1095-C to all covered individuals, so long as certain conditions are met. Beginning with 2024 returns, the PBRA permits employers to meet the ACA's furnishing requirement by:

- Providing "clear, conspicuous, and accessible notice" that any person who would otherwise be entitled to receive a copy of Form 1095-B or Form 1095-C may request a copy of the applicable form.
- Providing a copy of the form to any individual who requests it within 30 days of the request or, if later, by January 31 of the year following the reporting year.

The PBRA does not change the distribution requirements for states or jurisdictions with an individual health insurance mandate, including California, Massachusetts, New Jersey, Rhode Island, and Washington D.C.

- California: Forms 1095-B and 1095-C must be provided to employees by January 31 following the end of the plan year. The forms must be filed by March 31; however, no penalty will be imposed for forms filed by May 31.
- Massachusetts: Employers are responsible for issuing Form MA 1099-HC to employees no later than January 31 following the end of the plan year, but this is typically handled by carriers or third-party administrators. Be sure to check with your carrier or TPA concerning the furnishing of documents.
- New Jersey: Forms 1095-B and 1095-C must be provided to employees by March 3 following the end of the plan year and the forms must be filed by March 31.
- Rhode Island: Forms 1095-B and 1095-C must be provided to employees by March 3 following the end of the plan year and the forms must be filed by March 31.

- Washington D.C. does not require covered employers to furnish an additional annual statement of health coverage and has stated that compliance with the IRS requirements is sufficient.

Electronic Distribution of Forms

The ERIA allows employers and providers to electronically distribute Forms 1095-B and 1095-C to covered individuals. This codification of existing IRS practices helps streamline processes and reduce administrative costs associated with mailing the forms to employees.

Extended Response Time for Proposed IRS Assessments

The ERIA extends the response period for initial IRS proposed ESR penalty assessments from 30 days to 90 days. This added time provides employers with a more reasonable window to address discrepancies and respond to proposed penalties. It also alleviates the necessity of extension requests, which the IRS had been routinely granting.

Statute of Limitations on IRS Assessments

For Forms 1095-C that are due in 2025 or future years, the ERIA requires the IRS to assess ESR payments within six years of the later of the employer's due date for filing a Form 1095-C with the IRS or the date the return was actually filed.

However, this change only applies prospectively, so employers may still receive penalty assessments beyond the six-year statute of limitations for coverage failures tied to returns due in 2024 or prior years.

Employer Action Items

- Implement notice procedures. Establish a process to provide "clear, conspicuous, and accessible" notices about the availability of Forms 1095-B and 1095-C upon request, and train relevant staff to respond to requests within 30 days or by January 31, whichever is later.
- Streamline electronic distribution. Transition to electronic distribution of Forms 1095-B and 1095-C to reduce mailing costs, ensuring compliance with any applicable consent requirements including by drafting a consent form and obtaining employees' consent to electronic distribution.
- Monitor state-specific requirements. Stay compliant with state-specific reporting mandates for jurisdictions with individual health insurance mandates and coordinate with carriers or TPAs as needed.
- Know your new protections. If you are an ALE, the changes under the ERIA give you more time (90 days) to respond to IRS Letter 226-J and require the IRS to assess ESR penalty payments within a six-year statute of limitations.

Recent HIPAA Amendments and Proposed Regulations

In the last year, two significant HIPAA regulations were issued, impacting employer group health plans. This article summarizes the new rules – one under the privacy rule provisions and one under the security rule provisions – and what employers need to know about the current legal status of these rules and how to prepare for compliance.

HIPAA Privacy Rule Amendment

There has been significant ongoing litigation surrounding the 2024 reproductive healthcare amendment to the HIPAA Privacy Rule regulations (the "2024 Rule") issued by the Department of Health and Human Services (HHS) under the Biden administration. Effective June 24, 2024, the 2024 Rule restricts the disclosure of lawfully provided reproductive healthcare information, particularly when sought to investigate or impose liability on individuals or entities merely for seeking, procuring, or facilitating lawful reproductive healthcare. In early January, a Texas court issued an injunction preventing the HHS from enforcing the 2024 Rule against a physician so that she could continue to report cases of child abuse to Child Protective Services. On January 17, 2025, 15 states filed suit to get the regulation completely overturned.

The lawsuit alleges that the rule hindered state investigations into matters such as Medicaid fraud, child and elder abuse, and insurance-related malfeasance by limiting access to reproductive healthcare records. HHS, however, maintains that the 2024 Rule is essential to protect individuals' privacy considering the evolving legal landscape following the *Dobbs v. Jackson Women's Health Organization* decision which overturned *Roe v. Wade*. While the lawsuits targeted activities of medical providers, group health plan sponsors are equally responsible for compliance with the rule, which is already in effect.

What to Expect

The legal challenges to the 2024 Rule raise questions about its future enforceability. Possible scenarios for handling the challenges include:

- The administration could decline to defend the litigation, potentially allowing courts to overturn the 2024 Rule.
- The Trump administration could issue executive orders limiting enforcement of the rule.
- HHS could initiate new rulemaking to modify or repeal the 2024 Rule, which will likely take some time.

Proposed HIPAA Security Rule Amendment

HHS has proposed significant updates to the HIPAA Security Rule (the "Proposed Rule"), aimed at enhancing the protection of electronic protected health information (ePHI) against escalating cybersecurity threats. These changes, if finalized, will require covered entities, including group health plans, to adopt more stringent cybersecurity measures and compliance protocols.

Key Proposed Changes Impacting Group Health Plans

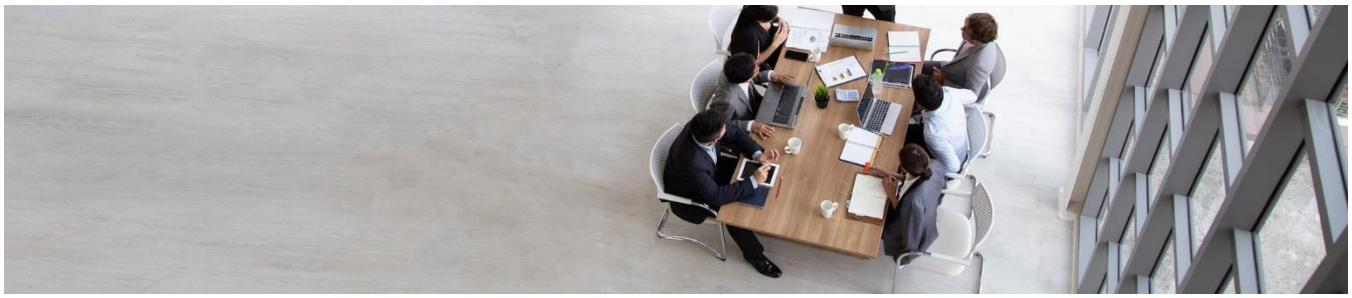
1. Increase in required obligations. The current Security Rule separates all requirements into two categories – "required" or "addressable," which are only required in certain circumstances. Under the Proposed Rule, all implementation specifications will now be mandatory.
2. Technology asset inventory and network map. Regulated entities will be required create and maintain a detailed inventory of technology assets and a network map to track the movement of ePHI under the Proposed Rule.
3. Annual risk analysis and risk management plans. The Proposed Rule heightens the standards for the annual risk analysis covered entities must conduct. The Proposed Rule also requires entities implement detailed risk management plans to address identified vulnerabilities.
4. Incident and disaster response. Entities will be required to develop, test, and update incident response and disaster recovery procedures annually, with a requirement to restore critical IT systems and data within 72 hours.
5. Restrict terminated employee access. Entities will be required to implement strict procedures to revoke access to ePHI for terminated employees.
6. Annual compliance audits and training. Regulated entities will be required to conduct annual audits to ensure compliance and provide annual security awareness training for all personnel with ePHI access.
7. Update Business Associate Agreements (BAAs). Plans will be required to update BAAs to require 24-hour notifications for contingency plan activation and annual compliance certifications by business associates.
8. Miscellaneous requirements. Regulated entities must also adopt additional measures, such as:
    - Encrypting all ePHI
    - Using multi-factor authentication
    - Conducting vulnerability scanning biannually and annual penetration testing
    - Employing anti-malware protections, and network segmentation
    - Establishing separate technical controls for ePHI backup and recovery

The public comment period is currently open until March 7. HHS is soliciting input, particularly on the impact of making all specifications mandatory and how to best regulate emerging technologies like AI and quantum computing. However, President Trump recently directed federal agencies to pause all rulemaking activity for 60 days.

Employer Action Items

- Remain compliant with HIPAA Privacy Rule. Until further notice, this new Rule remains in effect. Plan sponsors and their business associates should ensure they comply with the restrictions on reproductive healthcare disclosures but should be ready for change. It is unlikely that the Trump administration will make enforcement of the 2024 Rule a priority, and plan sponsors should anticipate future action regarding the scope and enforcement of the 2024 Rule.

- Review the proposed Security Rule and submit public comments. Plan sponsors should begin steps to assess the operational and financial impact of the proposed changes on your plan and consider providing feedback on specific aspects of the proposed rule, such as the removal of "addressable" specifications or challenges related to emerging technologies. If finalized, regulated entities will have 180 days to comply with the revised Security Rule. Engage legal counsel or compliance experts to navigate the complexities of the rule and ensure timely implementation of necessary changes.



Impact of Executive Order on Sex and Gender Identity

On January 20, 2025, the Trump administration issued an executive order redefining the terms sex, gender identity, and related concepts as they pertain to federal law and policy. These changes will affect compliance requirements across various employee benefit provisions and related regulations.

Key Provisions of the Executive Order

Revised Definitions

The Executive Order revised the definition for many terms related to sex and gender, including most notably the concept of gender ideology.

- Sex: "An individual's immutable biological classification as either male or female" which is determined "at conception" and expressly excludes "gender identity."
- Gender Identity: "A fully internal and subjective sense of self, disconnected from biological reality and sex and existing on an infinite continuum, that does not provide a meaningful basis for identification and cannot be recognized as a replacement for sex."
- Gender Ideology: A concept that "replaces the biological category of sex with an ever-shifting concept of self-assessed gender identity, permitting the false claim that males can identify as and thus become women and vice versa, and requiring all institutions of society to regard this false claim as true. Gender ideology includes the idea that there is a vast spectrum of genders that are disconnected from one's sex."

Mandates for Federal Agencies

In addition to calling on Congress to codify the revised definitions within 30 days of the Executive Order, it directs federal agencies to:

- Use these new definitions when interpreting or applying statutes, regulations, or guidance and in all other official agency business, documents, and communications.
- Replace "gender" with "sex" in all policies, forms, and communications.
- Remove and refrain from issuing materials that promote or incorporate "gender ideology" including by ceasing to use materials that request an individual's gender identity instead of or in addition to their sex.

Recission of Prior Policies

Several executive orders from the Biden administration expanding protections based on gender identity and sexual orientation have been revoked, including:

- Executive Order 13988: Preventing and Combatting Discrimination on the Basis of Gender Identity or Sexual Orientation
- Executive Order 14075: Advancing Equality for LGBTQI+ Individuals

Implications for Employers

The Executive Order marks a significant policy shift that may affect federal agency interpretation of nondiscrimination rules for employers and group health plan administration. This will immediately affect ACA Section 1557 nondiscrimination testing and policies. During the Biden administration, the Department of Health and Human Services (HHS) interpreted Section 1557 nondiscrimination on the basis of sex to include sexual orientation and gender identity. Under May 2024 final regulations, insurers were prohibited from providing or administering coverage, denying or limiting coverage, or designing plans that discriminated on the basis of sex – including sexual orientation and gender identity. Current nondiscrimination policies may soon require review and revision to align with the federal definitions.

Any change in administration brings policy differences and changes in compliance focus; however, the new administration has issued policy changes more rapidly and employers need to stay abreast of the changes to avoid compliance pitfalls, and conflict between federal and state law requirements. Employers should also expect legal challenges to these Executive Orders and possible legislation or regulatory updates.

Employer Action Items

- Monitor agency guidance. Continue current compliance efforts while monitoring additional guidance on implementing the new definitions and compliance requirements for Section 1557.
- Compliance and reporting. Prepare for new compliance requirements, particularly in benefits administration and nondiscrimination testing.
- Communicate with vendors. Engage with your benefits consultants and third-party vendors to evaluate any necessary changes to health plan designs, coverage offerings, or compliance measures.
- Educate your teams. Provide training to HR and compliance teams on the new federal definitions and how they impact workplace policies and benefits administration as new guidance arises.
- Stay prepared for litigation risks. Be aware of potential legal challenges, especially in jurisdictions where state or local laws conflict with the new federal policies.

Navigating Employer Leave under Federal FMLA and State Family and Medical Leave Programs

Employers are increasingly faced with the challenge of managing time-off policies amid a complex web of state, local, and federal laws – specifically the interplay between state paid family and medical leave (PFML) programs and the federal Family and Medical Leave Act (FMLA). An opinion letter issued by the U.S. Department of Labor's (DOL) Wage and Hour Division (WHD) on January 14, 2025, offers crucial guidance on these overlapping requirements.

Background

The FMLA grants eligible employees of covered employers up to 12 weeks of unpaid, job-protected leave per year for specified family and medical reasons, with an extended entitlement of up to 26 weeks for employees caring for a covered servicemember with a serious illness or injury. FMLA leave is unpaid, but the statute permits employees to elect—or employers to require—the substitution of accrued employer-provided paid leave, such as vacation or sick leave, to run concurrently with FMLA leave, thereby mitigating financial hardship.

However, when an employee is receiving payments under a disability benefit plan or workers' compensation program while on FMLA leave, the leave must be designated as FMLA leave, but neither the employer nor the employee can require the substitution of employer-provided paid leave. Employers and employees may mutually agree, where state law permits, to supplement disability or workers' compensation benefits with employer-provided paid leave to bridge income gaps. This aligns with the FMLA's statutory purpose, which ensures minimum protections while encouraging employers to offer more generous leave policies.

Key Takeaways

State PFML Programs and FMLA

Thirteen states and the District of Columbia have mandatory PFML programs, which provide income replacement for employees absent for family or medical reasons. These programs often overlap with the unpaid leave provisions of the FMLA, creating administrative challenges for employers.

Employers must carefully assess whether an employee's leave qualifies under both PFML and FMLA. If the leave is covered by FMLA,

- It must be designated as FMLA leave.
- Notice must be given to the employee of this designation.
- The leave should be counted against the employee's FMLA leave entitlement.

If an employee's leave under a PFML program does not qualify for FMLA, the employer cannot count it against the employee's FMLA entitlement.

Substitution of Paid Leave Under FMLA

FMLA regulations allow employees to elect—or employers to require—the use of accrued employer-provided paid leave (e.g., vacation or sick leave) during unpaid FMLA leave.

However, when an employee receives compensation through a state PFML program or other benefit programs, employers cannot require the concurrent use of employer-provided paid leave. Where state law permits, the employer and employee may agree to the use of accrued paid leave to supplement PFML payment.

If PFML benefits are exhausted before the employee's FMLA leave entitlement is fully used, the remaining FMLA leave can be unpaid or supplemented by accrued paid leave under the FMLA substitution rules.

Practical Application

The DOL provides the following example to illustrate these principles.

Scenario: Yvette takes eight weeks of FMLA leave to care for her mother following surgery. Her employer designates the full eight weeks as FMLA leave. Yvette also qualifies for her state's PFML program, which pays two-thirds of her salary for up to six weeks.

During the First Six Weeks: Yvette cannot be required to use her accrued vacation or other paid leave to supplement her state-paid PFML benefits unless state law permits, and Yvette agrees. If allowed, she could use one-third of her vacation time weekly to make up the remaining one-third of her salary.

During the Final Two Weeks: After Yvette exhausts her state PFML benefits, her leave becomes unpaid. Under FMLA, she can elect—or her employer can require—the use of her accrued paid leave to receive compensation for this period.

Employer Action Items

- Understand state PFML laws: Familiarize yourself with PFML programs in the states where you operate, as they vary widely in eligibility, payment structures, and coordination with FMLA.
- Review leave policies: Ensure your leave policies are compliant with both state PFML and federal FMLA requirements, particularly concerning the substitution of paid leave.
- Communicate with employees: Provide clear, timely notices to employees about FMLA leave designations and how their leave interacts with state or local PFML programs.
- Train HR and managers: Equip your HR teams and managers with the latest DOL guidance to handle leave requests appropriately.

When is a Plan an ERISA Plan? Key Takeaways from *Hansen v. Laboratory Corporation of America*

A short-term disability (STD) plan is not automatically covered under ERISA just because it's included in an employer's benefits package. Even if an employer treats the plan like an ERISA plan – such as including it in a wrap plan or on Form 5500 – it may not qualify as an ERISA plan if it meets the payroll practice exemption under ERISA. This means an employer's STD plan would need to meet state law requirements. A recent federal case in Wisconsin highlights this reminder to employers to make sure to properly classify their STD plan as an ERISA plan or payroll practice subject to state laws.

Background

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that provides minimum standards for covered benefits for employees and generally preempts state laws that relate to employee benefit plans. ERISA covers health and welfare benefits such as disability insurance and retirement benefits. However, not all employee benefit plans and programs are covered by ERISA.

A significant exemption from ERISA is the payroll practice exemption which often applies to employer payments of wages during periods of missed work due to health or disability issues. If an STD plan qualifies for this exemption, it is not covered by ERISA, which means that state wage and leave laws apply to the STD benefits.

A plan qualifies as an ERISA exempt payroll practice if it:

- Pays employees their normal wages during leave,
- Is funded directly from the employer's general assets, and
- Covers absences due to medical reasons (e.g., illness, pregnancy).

Hansen v. Laboratory Corporation of America

In *Hansen v. Laboratory Corporation of America* (Labcorp), an employee sued her employer in state court, claiming that she was owed STD benefits under Labcorp's STD plan. Labcorp argued that ERISA required the case to be filed in federal court and the STD policy was an ERISA plan because:

- It was represented as part of the employer's benefits package (e.g. open enrollment materials).
- It was included in the summary plan description (SPD) for the wrap plan.
- Employees were informed of their rights under ERISA.
- The plan was reported on Form 5500.

However, the court ruled that:

- An employer's labeling of a plan as ERISA-covered does not guarantee that the plan is *actually* covered under ERISA.
- Because the STD plan met the payroll practice exemption criteria, it remained exempt from ERISA and subject to state law regardless of the employer's intent.
- Compliance with certain ERISA requirements (i.e., Form 5500 filings) does not override the payroll practice exemption.

The court remanded the case to state court for further proceedings.

Employer Action Items

Employers should not assume that an STD plan is protected by ERISA just because they categorize it that way. If the plan meets the payroll practice exemption criteria, the plan is likely subject to state laws instead.

The *Hansen* decision highlights several actionable considerations for employers managing STD plans.

- Understand the payroll practice exemption. Review whether your STD plan meets the payroll practice criteria (e.g., funded from general assets, constitutes normal compensation, and applies due to medical leave). If it does, recognize that the plan is likely subject to state law, not ERISA. Note that the use of a third-party administrator (TPA) does not cause an ERISA exempt disability plan to lose that exemption so long as the criteria for the payroll practice exemption is met.
- Avoid mischaracterizing non-ERISA plans. Be cautious about labeling an STD plan as ERISA-covered in SPDs, Form 5500 filings, or employee communications unless it truly qualifies.
- Review compliance practices. Conduct periodic audits of benefit plans to ensure accurate classification under ERISA or state law and consult legal counsel to determine whether updates to plan documentation or reporting are necessary.
- Prepare for state law implications. If your STD plan falls under state law, ensure compliance with relevant state regulations, including claim handling and appeals processes.
- Seek legal counsel for disputes. If disputes arise regarding STD benefits, consult with legal counsel to assess whether the plan falls under the payroll practice exemption or qualifies as an ERISA plan. This analysis can influence litigation strategy and jurisdictional considerations.