Prepare for Cooler Weather, Annual Enrollment, and 2025

by Christopher S. Lockman on August 29, 2024

Summer is ending and fall is rapidly approaching. For employee benefit professionals with calendar-year health and welfare benefit plans that means preparing for annual enrollment and year-end compliance requirements. This post provides a high-level overview of significant health and welfare benefits compliance issues new in 2024 that plan sponsors should consider as they prepare for annual enrollment and the 2025 plan year.

Medicare Part D Creditable Coverage Requirements

Summary

Under the Inflation Reduction Act of 2022, the out-of-pocket limit for the 2025 Medicare Part D standard plan was reduced from $8,000 to $2,000, effective in 2025. This will dramatically improve the actuarial value of the 2025 Medicare Part D standard plan and make it difficult for many employers' medical benefit options – in particular, their high deductible health plan options – to constitute "creditable coverage." A penalty for late enrollment in Part D will apply if a Medicare-eligible individual fails to maintain "creditable coverage" for 63+ consecutive days – for example, by remaining enrolled in employer coverage that is non-creditable. The penalty, which an employee will have to pay when they ultimately enroll in Medicare Part D, equates roughly to a 1% increase in the Medicare Part D premium for each month without creditable coverage.

Action Items

Employers should work with their third-party administrators and carriers to determine as soon as possible whether their projected 2025 medical benefit options will constitute "creditable coverage." If one or more benefit options will lose their creditable coverage status, employers should consider implementing plan design changes to enable the benefit option to retain this status. Alternatively, employers should begin work right away on a communication to employees explaining that they may incur a Medicare premium penalty if they maintain non-creditable coverage after attaining age 65. Employers should plan to distribute this communication and the Notices of Creditable (and Non-Creditable) Coverage before the October 15 deadline to ensure employees and their dependents have adequate time to consider enrolling in Medicare during the open enrollment window that runs from October 15 to December 7.

Final HIPAA Regulations Regarding Reproductive Health Care Information

Summary

The U.S. Department of Health and Human Services (HHS) and Office for Civil Rights (OCR) published Final Regulations under HIPAA's Privacy Rule introducing greater protections for information related to reproductive health care. The Final Regulations create a newly defined term "reproductive health care," and require all covered entities, including self-insured group health plans and business associates, to obtain, under certain circumstances, an attestation from anyone seeking information potentially related to reproductive health care. The Final Regulations are designed to protect the privacy of individuals who legally seek abortion care by prohibiting the use or disclosure of PHI where it is sought for the purpose of:

- conducting a civil or criminal investigation into any person for seeking, obtaining, providing, or facilitating reproductive health care;
- imposing civil or criminal liability on any person seeking, obtaining, providing, or facilitating reproductive health care; and
- identifying any person for the purpose of conducting an investigation or imposing liability for any purpose described above.

Action Items

Covered entities must comply with the new requirements in operation by December 24, 2024 and update their Notice of Privacy Practices to reflect the requirements by February 16, 2026. Employers should consider updating their HIPAA policies and procedures manual to reflect the new requirement and ensure they are requesting attestations when appropriate. Please refer to our recently published blog post for more detailed information about the requirements of the Final Regulation and the attestation required of persons or entities requesting the use or disclosure of reproductive health care information.

Fixed Indemnity Coverage Notice Requirement

Summary

The Department of the Treasury, Department of Labor, and Department of Health and Human Services published a Final Rule regarding short-term, limited-duration insurance (STLDI) changes and requirements for fixed indemnity coverage on April 3, 2024. Fixed indemnity coverage is generally defined as coverage where: (1) benefits are paid in a fixed dollar amount per period of hospitalization or illness and/or per service, and (2) there is no coordination between the fixed indemnity benefit and the exclusion of benefits under any other health coverage. Examples of fixed indemnity coverage include hospital indemnity and critical illness programs, which are popular supplemental benefit offerings among employers. Such benefits are intended to qualify as "excepted benefits" under HIPAA and the ACA.

Among other things, the Final Rule modifies the content and presentation requirements for the small and individual market consumer protection notice and requires that the notice be provided for fixed indemnity plans offered in the group market. A model notice is included in the Final Rule and is intended to inform consumers and employees that fixed indemnity coverage is not the same as comprehensive health insurance coverage. To comply with the Final Rule, plans and carriers must prominently display the notice (in at least 14-point font) in all "marketing, application, and enrollment or reenrollment" materials and websites regarding the fixed indemnity product and on the first page of any fixed indemnity policy, certificate, or contract of insurance. A particular challenge for employers is providing the notice in their enrollment materials, since most enrollment occurs online. The challenge is heightened by guidance in the preamble to the Final Rule that states the notice must be visible when displayed on a website "without requiring the viewer to click on a link to view the notice."

Action Items

Due to the specific requirements regarding the content and presentation of the required fixed indemnity notice, employers should identify whether they offer fixed indemnity plans to their employees and, if so, begin working to incorporate the notice as part of their annual enrollment materials. This may require coordination with their benefit administration and HRIS system vendors right away to ensure the notice can be integrated into the annual enrollment portal. There is pending litigation in the Eastern District of Texas that seeks to vacate the notice requirement altogether, but employers should not count on the lawsuit being resolved before annual enrollment materials are required to be distributed.

Fiduciary Governance for Health & Welfare Benefits

Summary

Fiduciary governance issues for health and welfare benefit plans remain in the headlines as the result of a second lawsuit by employees alleging their employer breached its fiduciary duties under ERISA with respect to the employer's prescription drug benefit. The lawsuit is *Navarro v. Wells Fargo & Co.,* Case No. 0:24-cv-03043 (Complaint, D. Minn., Jul. 30, 2024), and it contains many of the same allegations that appear in the pending lawsuit filed in February, *Lewandowski v. Johnson & Johnson,* Case No. 3:24-cv-00671 (Complaint, D.N.J., Feb. 5, 2024). As with the J&J lawsuit, the Wells Fargo suit alleges that Wells Fargo and the individual fiduciaries responsible for its prescription drug plan caused the plan to pay the plan's pharmacy benefit manager (PBM) unreasonably high prices for generic prescription drugs. The Wells Fargo lawsuit also alleges that the defendants caused the plan to pay excessive administrative fees to the PBM.

It is important for health and welfare benefit plan fiduciaries to be aware of their fiduciary status, understand their responsibilities as fiduciaries, and engage in and document a prudent process when making fiduciary decisions. Selection of a PBM, a TPA, and other service providers who will be paid from health and welfare benefit plan assets is a fiduciary function. Many employers are in the process of onboarding new vendors prior to the commencement of annual enrollment and should consider and document the process for selecting those vendors, as well as ensure

compensation paid to those vendors is reasonable. In addition, employers who may have new broker or benefits consultant relationships, or are renewing their broker/benefits consultant contracts for 2025, should ensure they receive timely broker compensation disclosures as required by the Consolidated Appropriations Act 2021 and that compensation paid to such professionals is "reasonable."

Action Items

We have discussed the allegations in the J&J case in prior blog posts available here and here. In addition, we have consistently recommended (see 2021 blog post) that employers take the following actions, among others, to shore up fiduciary governance with respect to their health and welfare benefit plans:

- Establish a group health plan fiduciary committee that maintains a Charter, holds regular meetings, and takes meeting minutes.
- Ensure that the terms of the employer's fiduciary liability insurance policy extend to group health plan fiduciary activities.
- Use an RFP process to assure competitive pricing and quality service from all vendors.
- Request and carefully review broker and benefits consultant compensation disclosures and monitor their fees.
- Collect and review the terms of all administrative services and PBM agreements.
- Review and benchmark fees and costs for medical and prescription drug goods and services to the extent comparison data is available.

Employers who act now can have a group health plan fiduciary committee in place for 2025 that will aid in accomplishing many of the action items described above on an ongoing basis and can serve as the legally designated "plan administrator" for the employer's health and welfare benefit plans.

If you have questions about any of the topics or actions items described above, please contact a member of Verrill's Employee Benefits & Executive Compensation Group.

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