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# HEALTH & WELFARE PLAN LUNCH GROUP

## April 10, 2025

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1. Health & Welfare Benefits Monthly Update Presentation

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**Health & Welfare Benefits**
MONTHLY UPDATE

# April 2025 Agenda

- Regulatory and Legislative Update
- Top 10 Cafeteria Plan and FSA Mistakes
- Electronic Delivery Requirements: Not enough of a good thing
- H&W Litigation Update



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# Regulatory & Legislative Update

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## Legislative Update-119th

- Telehealth Expansion Act of 2025 -- H.R. 1650 (119th) Rep. Arrington (R-TX-19)
  - Makes permanent the temporary extension allowing telehealth coverage for HSAs before the HDHP deductible is met.
  - If passed, this bill would be retroactively effective as of *January 1, 2025*--meaning there would be no gap.
- HSA Modernization Act - H.R. 548 (119th) Rep. Van Duyne (R-TX-24)
  - Individuals who were ineligible to contribute to an HSA due to being eligible for Medicare benefits, certain veterans' health benefits, and Indian Health Service benefits will be eligible to contribute to an HSA.
  - ACA Bronze and Catastrophic plans will be treated as a HDHPs.
  - Safe Harbor for pre-deductible mental health services up to $500 permitted for HDHPs.
  - HSAs established within 60 days of HDHP coverage start date will be treated as established on the date the HDHP coverage begins. This means qualified medical expenses incurred between HDHP coverage date and actual establishment of HSA (if within 60 days) can be reimbursed from the HSA.
  - Both spouses can make catch-up contribution to same HSA.
  - Increases the maximum contribution limit to an HSA to track the IRC limitations for HDHP deductible and OOP max.
  - Clarifies that amounts paid for QLTC are a qualified medical expense.

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## Legislative Update—119th

- The Chronic Disease Flexible Coverage Act - H.R. 919 (119th) Rep. Buchanan (R-FL-16)/ S 3224 (118th) Sen. Thune (R. SD)
  - Permits an HSA to cover as preventive care certain healthcare services that treat common chronic illnesses.
  - Codifies IRS Notice 2019-45.
  - H.R. 919 passed by the House on March 4, 2025.
  - Received in the Senate and read twice on Marche 5, 2025.
- Lowering Costs for Caregivers Act of 2025 - H.R. 138 (119th) Rep. Buchanan (R-FL-16) and Thompson (D-CA-4)
  - Allows individuals to use HSAs and FSAs on medical expenses for their parents or spouses.
- Association Health Plans Act – H.R. 2528 (119th) Rep. Walberg (R-MI-5)
  - Amends ERISA definition of "employer" to include an association of employers even if not part of the same industry, trade or profession.
  - Must be formed in "good faith" for purposes other than providing medical care.
  - Must be in existence for at least 2 years.



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## Legislative Update—119th

- Self-Insurance Protection Act – H.R. 2571 (119th) Rep. Onder (R-MO-3)
  - Amends ERISA to exclude stop-loss from definition of "health insurance coverage".
- Health Care Freedom and Choice Act- H.R. 379 (119th) Rep. Carter (R-GA-1)
  - Nullifies the 2024 Final Rule for "Short-Term, Limited-Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage"
- Hidden Fee Disclosure Act of 2025 - H.R. 2041 (119th) Rep. Courtney (D-CT-2)
  - Amends ERISA to broaden fee disclosure requirements for brokers/consultants.
    - Expands "Brokerage Services: to "Services (including brokerage services)" and strikes "Consulting" and replaces with "Other services".
  - Adds general and annual disclosure requirements for PBMs and TPAs.

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## Legislative Update—118th: Will These Make a Comeback?

- Primary Care Enhancement Act - H.R.3029 (118th) Rep. Smucker (R-PA-11) / S. 628 (118th) Sen. Cassidy (R-LA)
  - Coverage under a direct primary care arrangement will not cause an individual to be ineligible for an HSA.
  - A direct primary care arrangement can be offered with a HDHP.
  - An HSA can reimburse premiums/payments for the direct primary care arrangement.
- CHOICE Arrangement Act - (H.R. 3799) (118th) Rep. Hern (R-OK-1)
  - This codifies the three-agency regulatory guidance that established Individual Coverage Health Reimbursement Arrangements (ICHRAs).
- Improving Child Care for Working Families Act - H.R. 1421 (118th) Rep. Schier(D-WA-8), Fitzpatrick (R-PA-1)
  - The exclusion for dependent care assistance FSA plans would be increased from $5,000 to $10,500.



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## Regulatory Update

- Medicare and Medicaid Programs; Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (Final Rule scheduled to be published in the Fed. Reg. on April 15, 2025)
  - Finalizes the Biden-era proposed rule.
  - Drops proposed rule's coverage for anti-obesity medications.

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# Top 10 Cafeteria Plan and FSA Mistakes

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## Top 10 Cafeteria Plan and FSA Mistakes – Plan Document

- Plan document:
  - Does not exist
  - Has not been formally adopted or is not signed
    - No back dating!
  - Excludes affiliates that should be included *or* includes affiliates that should not be included
  - Includes impermissible benefits (for example, universal/whole life)
  - Is not followed and plan is not operated in accordance with its terms

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## Top 10 Cafeteria Plan and FSA Mistakes – Eligibility

- Employees aren't allowed to participate who should be
  - Plan excludes affiliates that should be included
- Employees are allowed to participate who shouldn't be
  - Plan includes affiliates that shouldn't be included
- Different entry dates under a single plan
  - For example, full time and part time



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## Top 10 Cafeteria Plan and FSA Mistakes – Non-Discrimination Testing

- Testing not completed annually
  - Test retroactively for prior years?
- Incorrectly testing
  - Cafeteria plan – eligibility test; contribution and benefits; key employee concentration test
  - Health FSA – eligibility test; benefits test
  - Dependent Care FSA – eligibility test; contribution and benefits test; more-than-5% owners concentration test; 55% average benefits test
- Failed testing
  - Re-test? Non-discrimination testing vendor might not run all available tests?
  - Restructure? Would restructuring as separate plans help?
  - Refund? If caught before the end of the year, can the testing failure be fixed by refunding contributions?

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## Top 10 Cafeteria Plan and FSA Mistakes – Withholding

- Too much salary withheld
  - Easier if caught before year-end
  - If caught after year-end, W-2 and Form 941 issues
- Not enough salary withheld
  - If caught before year-end, seek repayment. If not repaid, then report on W-2
  - If caught after year-end, it's more difficult
    - Withhold in the next year? After-tax or pre-tax?
- Pre-tax taken as after-tax; after-tax taken as pre-tax



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## Top 10 Cafeteria Plan and FSA Mistakes – Election Mistakes

- Rules do not allow changes based on a mistake by the employer or employee
  - Informally, IRS officials have said election change can be made when there is "clear and convincing" evidence of a mistake
    - For example, an employee with no dependents who elected the health FSA every prior year mistakenly elects the dependent care FSA and notifies the employer not long after the beginning of the year of the mistake
  - Notably, OPM uses the clear and convincing evidence standard for FSA election mistakes involving federal employees (https://www.opm.gov/retirement-center/publications-forms/benefits-administration-letters/2006/06-801.pdf).

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## Top 10 Cafeteria Plan and FSA Mistakes – ERISA

- Dependent care FSAs are not subject to ERISA, but health care FSAs offered by private employers are subject to ERISA
  - Exclusive benefit requirement
  - Trust requirement
    - Does the plan comply with Technical Release 92-01?
    - How is the FSA funded?
  - Plan document and SPD requirement
  - Claims and appeals procedures need to be followed
- Dependent care FSAs (and health FSAs offered by governmental and church employers) do *not* benefit from ERISA preemption



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## Top 10 Cafeteria Plan and FSA Mistakes – Unclaimed Property

- Are undisbursed benefit funds forfeited before the shortest applicable unclaimed property period?
  - Watch for ERISA's exclusive benefit rule
    - Offset administrative costs?
    - Participant dividend?
- Add a restoration feature?

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## Top 10 Cafeteria Plan and FSA Mistakes – COBRA/FMLA

- Health FSAs are group health plans *and* subject to COBRA
  - Initial COBRA notice required
  - Special limited COBRA election for underspent accounts through the end of the year
    - Have COBRA notices, forms, plan terms, and SPD been modified for health FSA issues?
    - Are you offering COBRA longer than required?
    - Spouse and dependents can be qualified beneficiaries with their own election rights
- FMLA – pre-pay, pay-as-you-go, catch-up also applies to health FSAs



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## Top 10 Cafeteria Plan and FSA Mistakes – ACA and HIPAA

- Health FSAs must comply with excepted benefit rule to avoid ACA and HIPAA *portability*
  - Maximum annual benefit payable cannot exceed two times the participant's salary reduction election for health FSA benefits for the year (or, if greater, the amount of the participant's salary reduction election for the year plus $500)
  - Other nonexcepted employer group health plan coverage must be available
    - Watch out for employees who are not eligible for major medical coverage
- HIPAA privacy and security applies to health FSAs (even those that are excepted benefits)
  - Includes risk assessment; written policies and procedures; business associate agreement; breach notification
  - Dependent care FSAs are not subject to HIPAA, but state privacy laws often apply

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## Top 10 Cafeteria Plan and FSA Mistakes – Substantiation

- Failure to follow electronic substantiation rules for health FSA
  - IRS does not allow *de minimis* thresholds, sampling techniques, or automatic reimbursement of claims at certain favored providers or that appear to be from medical providers
  - Provider notes based only on self-reported health information may not be adequate and provider needs some familiarity with individual's medical condition
    - https://www.irs.gov/newsroom/irs-alert-beware-of-companies-misrepresenting-nutrition-wellness-and-general-health-expenses-as-medical-care-for-fsas-hsas-hras-and-msas
  - Is card shut off card if claims are not substantiated?



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## Electronic Delivery Requirements: Not enough of a good thing

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## General Rule-ERISA

- ERISA requires plan administrators to furnish documents required to be furnished by ERISA "by means reasonably calculated to ensure actual receipt".
- In early 2000s, DOL issued a safe harbor regulation for electronic delivery of such documents.
  - "Worksite" those reasonably expected to access the employer's electronic information system and who can access those documents where they work.
    - No consent required
  - Everyone else—affirmative consent meeting regulatory requirements is required
- The safe harbor is a "push"—not a "pull" (i.e. just dropping it on a website would not appear to satisfy the safe harbor)



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## Industry Standards

- Pension plan rules now allow documents to be posted so long as notice is provided to participants with information on how to access (and to provide paper upon request)
  - A hybrid push/pull
- This seems to be the industry standard for welfare plans
- Remember, the early 2000s rule is a "safe harbor"—you can presumably satisfy the general standard in other ways (but burden is on plan administrator to prove)

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# Application-ERISA

- Only applicable to documents required to be furnished
  - SPDs
  - SARs
  - Notices (e.g. WHCRA, COBRA, etc)
  - Adverse benefit determination notices
- Does not apply to SBCs (SBCs have a more expansive rule)
- Problem areas:
  - COBRA notices
  - Manufacturing plants
  - Claims and appeal procedures



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# Other documents/notices

- HIPAA privacy notice-consent always required
- Medicare Part D creditable coverage-follow ERISA safe harbor
- SBCs-included with enrollment materials if enrollment conducted electronically; otherwise follow ERISA safe harbor

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# H&W Litigation Update

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## Kennedy v. Braidwood Management, Inc.

- The U.S. Preventive Services Task Force (USPSTF), which sits within the Public Health Service of the Department of Health and Human Services (HHS), issues clinical recommendations for preventive medical services.
- Under the ACA, health insurance issuers and group health plans must cover certain preventive care services recommended by the USPSTF without imposing any cost-sharing requirements on patients under 42 U.S.C. section 300gg-13(a)(1).
- On March 30, 2023, U.S. District Court for N.D. of Texas issued an opinion and order invalidating certain of the ACA preventive care requirements recommended by the USPSTF.
- Initially, all actions taken by Agencies to enforce or implement the preventive care coverage requirements in response to an "A" or "B" recommendation by the USPSTF made *on or after March 23, 2010* were vacated and the agencies were enjoined from enforcing, but the 5th Circuit granted the government a partial stay of the injunction pending appeal.
- On appeal, the 5th Circuit affirmed the district court's judgment to the extent that it enjoined the Agencies from enforcing the USPSTF's recommendations with respect to the named plaintiffs; reversed the district court's judgment to the extent it imposed a nationwide injunction; and remanded to the district court for further proceedings. *See,* 104 F.4th 930 (5th Cir. 2024), petition for cert. filed, (U.S. Sept. 19, 2024) (No. 24-316). On August 28, 2024, the district court entered a stay pending proceedings in the Supreme Court.
- Supreme Court will hear oral arguments on April 21, 2025.

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## Kennedy v. Braidwood Management, Inc.

- Issue before the Supreme Court is whether the structure of the USPSTF violates the Appointments Clause of Article II of the U.S. Constitution, and whether the 5th Circuit erred in declining to sever the ACA provision to insulate the USPSTF from the Secretary's supervision.
- On February 18, 2025, HHS filed a brief defending the ACA requirements and arguing that USPSTF members are inferior officers because the Secretary of HHS - a quintessential principal officer- remains responsible for final decisions about whether the USPSTF's recommendations will be legally binding, and can remove USPSTF members at will, for any reason. 20250218171629934_24-316tsUnitedStates.pdf
- HHS recommends that at a minimum, the Supreme Court reverse the severability holding to allow the USPSTF to make recommendations that will have legal effect only under appropriate supervision by the Secretary.
- If the district court's holding in *Braidwood* is upheld, the following ACA preventive services mandates would be unenforceable: screenings for breast, cervical, colorectal, lung and skin cancer; screenings for diabetes, depression, hepatitis and vision problems in children; screening and treatment for HIV, including PrEP; and care for those who are pregnant and breastfeeding and care for their young children. *See,* ACA FAQs Parts 59 and 68.



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## Tennessee PBM Litigation

- In *McKee Foods Corporation v. BFP, Inc. d/b/a Thrifty Med Plus Pharmacy, et al.* (No. 1:21-cv-279; E.D. Tennessee, 3/31/25), the court held the following provisions of Tennessee's PBM Law have an impermissible connection with ERISA plans, and are preempted by ERISA to the extent they attempt to govern self-funded ERISA plans:
  - the any willing provider requirements in Tenn. Code Ann. §§ 56-7-2359, 3120(b)(1), 3121(a)-(b) and
  - the incentive and disincentive provisions for network and preferred pharmacies in Tenn. Code Ann. §§ 56-7-3120(a); (b)(2); and 3121(c).
- The court rejected Tennessee's argument that the law does not have a connection with ERISA plans because the laws do not dictate the benefits that a plan must provide or require a plan to adopt any substantive scheme of coverage.
- The court agreed with the 10th Circuit in *Mulready* that the scope of a plan's pharmacy network is a key aspect of how the plan structures and designs benefits and that Tennessee's restrictions "require providers to structure benefit plans in particular ways."
- The court noted that the any-willing provider restrictions limit the plan's discretion to shape benefits such as the choice to offer beneficiaries more or fewer pharmacy options based on age, geographic distribution, or significant discounts by directing beneficiaries to smaller number of pharmacies.

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# Tennessee PBM Litigation

- The court also noted how the incentive and disincentive provisions require plans to structure benefits in certain ways by dictating how the plan's copay obligations must be structured.
- The law functionally mandates that plans charge plan participants the same copays and/or fees in a given network as forbidding different cost-sharing structures is the same as requiring identical structures.
  - The law forbids McKee and its PBM from encouraging plan participants to use specific pharmacies through either the carrot of lower copays and other incentives or the stick of higher copays and additional fees.
  - The law prevents McKee from offering lower copays to participants who use a pharmacy owned by McKee.



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# Fiduciary Breach Litigation

- Two lawsuits filed in 2024 in federal district courts in New Jersey and Minnesota allege claims for fiduciary breaches for failure to monitor PBMs and negotiate lowest prescription drug prices. Both lawsuits alleged harm to the plan as a whole, resulting in not only higher out-of-pocket drugs costs to individuals but higher premiums for all participants, even lower wages. Both plans are funded through a trust.
- The complaint in the lawsuit filed in New Jersey was dismissed without prejudice for lack of standing on January 24, 2025.
  - The court held that the plaintiff had not suffered an injury in fact by alleging that she paid more in premiums due to the plan sponsor's purported breach of fiduciary duty as the plaintiff did not include any allegation or evidence of premiums on other plans or that the plan sponsor's specific conduct resulted in higher premiums.
  - The court also dismissed plaintiff's claim that the plan sponsor's conduct resulted in higher out of pocket costs because the plaintiff's injury was not redressable because the plaintiff reached prescription drug OOP cap. A favorable decision would not compensate the plaintiff for money she already paid. Any reimbursements would be owed to the plan for expenditures on other drugs that same year.
  - In a footnote the court stated that the opinion does not address standing of a hypothetical plaintiff in the same situation who has not reached the annual OOP max.
- On March 10, 2025, the plaintiff filed an amended complaint with an additional plaintiff, a retiree, who has not met the annual OOP max.
- The amended complaint also cites a Federal Trade Commission Report concluding that inflated drug costs result in higher premiums, and a CBO study that higher health care costs are passed on to employees in the form of lower wages and higher benefit costs. https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf
- The amended complaint also includes further attempts to attribute increased plan costs with higher employee contributions by citing the plan's historical ratio of employee to employer contributions. It alleges that the plan sponsor will continue to maintain the same ratio as costs increase, which will lead to increased employee contributions.

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# Fiduciary Breach Litigation

The complaint in the Minnesota lawsuit was dismissed without prejudice for lack of standing on March 25, 2025.

- Court found the connection between participant contributions and OOP costs, and administrative fees paid to the PBM is tenuous at best. The court also rejected the plaintiff's theory on the historical ratio between employer and employee contributions remaining constant and causing participant contributions to increase as plan costs rise.
  - The plan vested the plan sponsor with ***sole discretion*** to set participant contribution rates and nothing in the plan required the plan sponsor to maintain the same employer/employee contribution ratio.
  - The plan authorized the plan sponsor to require participants to fund ***all*** plan expenses not just expenses related to the participant's own individual benefits.
  - Terms of the plan were clear that participant contributions were impacted by several factors that had nothing to do with prescription drug benefits such as tobacco use, coverage level –single, employee plus children, family- and compensation category.
  - Court noted that even if the plaintiff prevailed, the plan sponsor could still increase their contributions under the plan terms.
- Court also noted that selective allegations regarding the markup on a subset of prescription drugs among the thousands in the plan's formulary, which itself represents only a subset of the total benefits whose costs participant contributions may be used to cover, are not sufficient to establish a causal connection between increased costs and PBM fees.
- The court also held that the plaintiffs lacked standing to request prospective relief as they were no longer participants in the plan.



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# Fiduciary Breach Litigation

- On March 13, 2025, a new lawsuit was filed by the same plaintiff firm in the Southern District of New York alleging similar claims for fiduciary breaches for failure to monitor PBMs and negotiate lowest prescription drug prices resulted in higher drug costs to participants, higher premiums, out-of-pocket costs and depressed wages.
- The complaint also alleged a prohibited transaction for paying excessive compensation.
- Plaintiffs include both current and former employees who did not meet their OOP max.
- Additional allegations in this complaint:
  - Plan steered participants into using higher priced drugs manufactured by the PBM owned entity
  - Plan sponsor ignored the advice of its trade organizations when contracting with the PBM
  - Plan sponsor placed its own business interests over the plan participants by offering financial services to the PBM

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# Questions

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