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HEALTH & WELFARE PLAN LUNCH GROUP

May 8, 2025

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May 2024 Agenda

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- Taxation of California Infertility Coverage
- Reimbursement of Medical Travel Expenses
- Life Insurance Eligibility Enforcement
- Top 10 COBRA Compliance Issues

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Grab Bag

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125 Issues, TIN Solicitation, 4980H Penalties, SCOTUS

- Is an event that causes a loss of coverage in accordance with the terms of the plan, such as divorce or child reaching the limiting age, a "change in status" under the 125 rules?
- Issues with TIN solicitations for ACA reporting
- ACA employer shared responsibility penalties may be a thing of the past.
- The impact of the Supreme Court's decision in *Cornell* on welfare plans

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Prescription Drug/PBM Round Up

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Specialty Drug Alternative Funding Arrangements

- *AbbVie, Inc. v. Payer Matrix, LLC,* 1:23-cv-02836 (N.D. Ill, Apr. 14, 2025)
  - Court declined to issue a preliminary injunction sought by AbbVie against Payer Matrix's program of assisting self-funded plan participants obtain specialty drugs via AbbVie's charitable programs for uninsured and underinsured individuals.
  - The court appeared to recognize that the alternative funding arrangements interfere to some extent with AbbVie's business but declined to issue an injunction due to length of time since the filing of the complaint, and Payer Matrix suspending applications for AbbVie's charitable programs.
  - Alternative funding arrangements raise potential legal issues (ERISA, tax, HIPAA nondiscrimination, and others).
  - The litigation is ongoing.

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State PBM Law Updates -Arkansas

- HB 1150 Signed into law on April 16, 2025, and is now Act 624
  https://arkleg.state.ar.us/Home/FTPDocument?path=%2FACTS%2F2025R%2FPublic%2FACT624.pdf
- Effective January 1, 2026 , Act 624 will prohibit:
  - Issuance of permits for pharmacies owned by or affiliated with a pharmacy benefit manager ("PBM").
  - Ban applies to retail, specialty, and mail-order pharmacies, including pharmacies that operate out of state and mail drugs to state residents.
  - Limited exception for certain rare, orphan, or limited distribution drugs that are otherwise unavailable in the market through September 1, 2027.
  - One PBM has already announced it will close 23 of its retail pharmacies in Arkansas.
- Similar bipartisan bills were introduced last year in Congress:
  - https://www.congress.gov/118/bills/s5503/BILLS-118s5503is.pdf
  - https://www.congress.gov/bill/118th-congress/house-bill/10362/text
- Takeaways for plan sponsors are to discuss with the plan's PBM regarding network pharmacy options for retail, specialty and mail order if PBM affiliated pharmacy is currently used.

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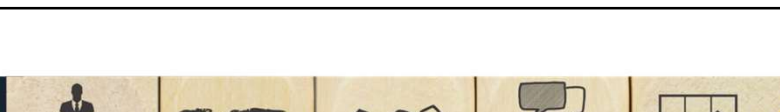

State PBM Laws - Florida

- The Florida Prescription Drug Reform Act of 2023 (SB 1550) requires the Florida Office of Insurance Regulation (FOIR) to perform regular state audits of PBMs every two years to determine the PBM compliance with SB 1550.
- FOIR is requiring PBMs to provide unredacted claims data for all prescription drugs filled in Florida in 2024 to contract examiners to determine the PBM's compliance with sections 626.8825 and 626.8827, Florida Statutes. This includes claims data from self-funded ERISA plans.
- Release of unredacted claims data, which is protected health information (PHI) under HIPAA, raises disclosure issues for self-funded plans covered by ERISA.
- FOIR claims that the disclosures are permitted under 45 CFR section 164.512(d)(1) as part of health oversight activities.
  - 45 CFR section 164.512(d)(1) only allows disclosure where the PHI is *necessary* for determining compliance with the law– is PHI necessary for determining compliance with SB 1550? Can de-identified data or a limited data set be disclosed instead?
  - Unclear whether a state agency has oversight authority of a self-funded ERISA plan.
  - Potential issue under HIPAA Privacy Reproductive Rights Rules for claims related to reproductive healthcare.
- SB 1550 authorizes audit only on the PBM: "The office [FOIR] shall examine the business and affairs of each pharmacy benefit manager." FOIR does not permit PBMs to use NDAs or other non-disclosure agreements with FOIR or the contract examiners.
- SB 1550 does not require plan reporting as state laws that require reporting by self-funded ERISA plans were found to be preempted by ERISA under *Gobeille v. Liberty Mut. Ins. Co.*, 577 U.S. 312, 136 S. Ct. 936, 194 L. Ed. 2d 20 (2016).
- Takeaways for self-funded ERISA plans are to discuss with the plan's PBM whether omission of the plan's claims data is possible.

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New Executive Order on Prescription Drugs

- Executive Order 14273 of April 15, 2025, Lowering Drug Prices by Once Again Putting Americans First https://www.govinfo.gov/content/pkg/FR-2025-04-18/pdf/2025-06837.pdf
- Highlights of the EO for ERISA Plans:
  - Section 2 of the EO states that it is the policy of the United States that Federal health care programs, intellectual property protections, and safety regulations are optimized to provide access to prescription drugs at lower costs to American patients and taxpayers.
  - Section 10 directs the Secretary of Health and Human Services within 90 days of the date of the EO to streamline and improve the statutory program that permits the importation of drugs from Canada to make it easier for states to obtain approval to do so.
  - Section 12 directs the Secretary of Labor to propose regulations pursuant to ERISA section 408(b)(2)(B) within 180 days of the order to improve employer health plan fiduciary transparency into the direct and indirect compensation received by pharmacy benefit managers (PBMs).
    - CAA '21 added a new compensation disclosure section to ERISA section 408(b)(2)(B) for "Brokers and Consultants" if they receive $1,000 or more in total annual direct and indirect compensation.
    - Does the DOL have authority to issue such regulations regarding PBM compensation?
    - Does CAA '21 limit the DOL's authority by narrowing the scope of entities (those providing brokerage and/or consulting services) required to disclose?
    - Impact of *Loper Bright*?

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Compliance Reminder: Rx Reporting

- Prescription Drug Data Collection (RxDC) is due June 1, 2025, for the 2024 reference year.
- Group health plans file Data File P2 and Files D1-D8.
- D1 collects combined information about a plan's medical and pharmacy benefits such as the average number of members for the reporting year and the cost of coverage.
- Can the plan's reporting vender fully complete the D1?
- CMS reporting instructions suggest that multiple D1 files are permitted but one file is preferred.
- Information on reporting is available at https://www.cms.gov/marketplace/about/oversight/other-insurance-protections/prescription-drug-data-collection-rxdc

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Kennedy v. Braidwood Management, Inc.

Update (if you use that term loosely)

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Kennedy v. Braidwood Management, Inc.

- 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.
- 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.
- Supreme Court heard oral arguments on April 21, 2025 then issued order requesting additional briefing.
- 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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Taxation of California Infertility Coverage

213 will regulate

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213(d) and Common Infertility Treatments and Services

Plans that offer infertility benefits need to be mindful of which treatments and services are qualified medical expenses under 213(d) and which are not. IRS guidance tends to focus in the "infertility" of the covered person, while plans offer "fertility" benefits even to covered individuals who may not be infertile (e.g., same-sex couples, singles). Courts and the IRS have not always aligned, and more guidance from the IRS in this area would be welcome.

- Not qualifying under 213(d):
  - Treatments and services for a surrogate who is not a covered person under the plan.
- May qualify under 213(d) if preparatory to a procedure performed on a participant/spouse, or other person whose expenses are eligible for tax-free reimbursement as medical care:
  - Egg donor fees and expenses
  - Infertility treatments (*e.g.*: IVF, surgery, shots, treatments, and gamete intrafallopian transfer)
- Potentially Qualifying under 213(d):
  - Fees for "temporary" storage of eggs, sperm, and embryo storage
    - "Temporary" storage implies short-term storage; may not be a qualified expense for long-term storage.
  - Legal expenses that bear "a direct or proximate relationship to the provision of medical care to the taxpayer."
    - In PLR 200318017, the legal fees (and other expenses) were qualified medical care because the care could not have been provided without legal assistance and the expenses were preparatory to the taxpayer's own medical procedure

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Taxation of California Infertility Coverage

- Effective for *insurance policies* amended or issued after July 1, 2025, California requires infertility coverage
  - No regulations yet, but appears that coverage is required regardless of a diagnosis of fertility
  - Without a diagnosis of infertility, benefits are taxable under IRS interpretation of Code 213(d)
  - If taxable, who reports and withholds?

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Taxation of California Infertility Coverage

- The Code requires every employer to deduct and withhold income and employment taxes on wages, including taxable fringe benefits, because "wages" include the cash value of all remuneration for services.
  - "Wages" include benefits paid in cash or a medium other than cash unless a statutory exclusion applies.
  - "Employer" generally means the person for whom an individual performs any service as an employee.
    - However, if the person for whom the individual performs the services does not control the payment of the employee's wages, then the "employer" for withholding and reporting purposes is the person who has legal control of the payment.
    - For example, the trust is the employer where wages are paid by a trust and the person for whom the services were performed (e.g., the common law employer) has no legal control over the payment of the wages.

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California Infertility Coverage

- Whether or not a third party is in control of the payment of wages is based on the facts and circumstances.
  - The IRS will generally find that a third party is in control of payment "if the payment is not contingent upon, or proximately related to, the third party having first received funds from the employer."
  - However, if the payment is contingent on or proximately related to the common law employer's transfer of funds to the third party, the IRS considers the common law employer to be in control of the wages and it retains the responsibility for withholding, reporting, and paying employment taxes.

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California Infertility Coverage

- In other contexts involving payments to employees by insurers, such as when an insurer makes payments under a retirement plan, the IRS has determined that the insurer making the payment has control over the payment and, as a result, is the employer for withholding and reporting purposes.
  - Likewise, where a trust provides taxable health benefits to an employer's employees, such as domestic partner benefits, the IRS has determined that the trust has control over the payments and is the employer for withholding and reporting purposes.
- Typically, the IRS requires these insurers and trusts to report the income on Form W-2 and withhold applicable employment and income taxes.

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Reimbursement of Medical Travel Expenses

Buck ease for employees

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Taxation of Travel – Transportation Costs

- "Medical care" includes the diagnosis, cure, mitigation, treatment, or prevention of disease. Expenses paid for "medical care" includes those paid for the purpose of affecting any structure or function of the body ***or for transportation primarily for and essential to medical care***.
  - Travel to another location must be necessary to receive the medical care needed.
  - Travel to another location to receive medical care merely for personal reasons is not considered a medical care expense.
  - The cost of necessary medical travel can be reimbursed tax-free. This includes the cost of air transportation, an auto reimbursement based on actual expenses, or an auto mileage using the standard mileage rate ($.21 per-mile for 2025).

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Taxation of Travel – Transportation Costs

- Does **not** include meals and lodging while away from home
  - For example, if a doctor prescribes that a taxpayer go to a warm climate to alleviate a specific chronic ailment, the cost of meals and lodging while there would not be deductible.
- Does **not** include travel for general improvement of health
- Does **not** include travel for purely personal considerations to another locality (for example, a resort town) for operations or other medical care
  - Meals and lodging could be reimbursed as part of a hospital bill

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Taxation of Travel –Lodging

- Amounts paid for lodging that is not lavish or extravagant while away from home primarily for and essential to medical care are reimbursable *up to $50 per night per individual* if:
  - The care is provided by a physician ***in licensed hospital or in a medical care facility which is related to, or the equivalent of, a licensed hospital)***;
  - there is no significant element of personal pleasure, recreation, or vacation; and
  - the expense is legal under both federal law and applicable state law.
    - After *Dobbs*, this may require an examination of the laws both where the service is rendered, where the participant resides, and where the plan is located
    - In some states both civil and criminal laws might need to be considered
- May include a companion who accompanies a patient for medical reasons.

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Taxation of Travel –Interesting Examples

- **Foreign travel expenses** for medical treatment may qualify if the primary purpose is not personal and expense is not for cosmetic surgery.
  - *Note:* might not include medications obtained in other countries.
- **Travel to Medical Conference** about *dependent's* chronic disease are reimbursable if they are primarily essential to the dependent's medical care (Rev. Rul. 2000-24). Local transportation allowed; meals and lodging are not allowed. Social and recreational activities must be secondary to attendance
- **Disabled individual's transportation costs to and from work** do not meet "primarily for and essential to medical care" or "but for" tests *unless* the employment itself is explicitly prescribed as therapy to treat a medical condition (and other medical care requirements are met) (*Weinzimer v. Comm'r*, T.C. Memo. 1958-137 (1958)).
- **Rideshares,** including tips and gratuities are not addressed, but likely okay if otherwise reimbursable.

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Life Insurance Eligibility Enforcement

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Life Insurance Eligibility Enforcement

- Dependent Class Action Settlement
  - A participant in a group-sponsored life insurance plan filed a life insurance claim for her deceased adult son. Despite the employer having continued to deduct premiums for the coverage, he was no longer eligible for the coverage as a dependent child because of his age. The participant then filed suit against the life insurance provider on behalf of a class of similarly situated employees.
  - The U.S. District Court for the Eastern District of Pennsylvania approved a settlement in the case.
  - The court required all administrators of ERISA-covered Plans providing or offering dependent child life insured by the defendant insurers at any time during August 25, 2015 – March 14, 2025 to send a Class Notice to current and former policyholders.

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DOL Settlement Agreements

- Insurance companies should no longer deny claims for a reason relating to evidence of insurability (EOI) if premiums have been received for coverage requiring EOI for 90 days or more prior to receiving the claim.
- Therefore, if a plan sponsor, or a hired third-party administrator, collects premiums from any employee for coverage requiring EOI without first confirming with the insurance company that the insured has been approved, the **plan sponsor may be liable for the benefit**.

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Recommendations for Plan Sponsors Collecting Premiums

- Audit:
  - Dependent child life insurance age limits, student status, and disability provisions
  - Spouse dependents to ensure marital status
  - Life insurance amounts above guaranteed issue limits to ensure that evidence of insurability (EOI) has been received and approved by the insurance provider
  - Any other coverages that require EOI
- Communicate:
  - Send participant notices regarding conversion rights in advance of when dependents are no longer eligible for coverage, and
  - Answer any eligibility questions from participants.

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Top 10 COBRA Mistakes

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Top COBRA Mistakes—Content of Election Notice

- DOL Model Notice is no guarantee against lawsuits
- Failure to explain how to enroll in COBRA
- Failure to explain the consequences of electing COBRA (e.g., special enrollment period for the Exchange or other plans)
- Failure to identify the Qualifying Event, each Qualified Beneficiary, and date coverage will end.
- Failure to clearly state the qualified beneficiary's obligations to provide timely notice of secondary qualifying events
- Failure to clearly describe maximum coverage period and what circumstances might result in coverage terminating prior to the expiration of that period

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Top COBRA Mistakes—Failure to Identify Plans Subject to COBRA

- What Plans Are Subject to COBRA?
  - Definition of "group health plan" varies slightly in ERISA from the Internal Revenue Code and Public Health Service Act, but generally a plan that provides medical care and is maintained by an employer is subject to COBRA.
- Often overlooked group health plans:
  - Wellness Programs/EAPs—footprint may be larger than the major medical GHP footprint
  - Health FSA and HRAs
  - On-site Clinics
- Small employer exception: Applies to employer that sponsors the group health plan had fewer than 20 employees on 50% of its business days in the preceding calendar year.
  - Controlled group or affiliated service group rules apply.
  - This can be complicated in the M&A context.

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Top COBRA Mistakes—Failure to Recognize a QE in Connection with Leave

- Reduction of hours that results in a loss of coverage is a qualifying event.
- Increase in premium due to a reduction in hours due to a leave of absence is a loss of coverage for purposes of COBRA.
- Employers that continue eligibility under the group health plan during a leave of absence (other than FMLA) but increase the premium must also offer COBRA in connection with the leave/increase in premium.

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Top COBRA Mistakes—Failure to Furnish Initial or Election Notice to QBs

- Must be furnished in a manner consistent with the DOL's generally applicable disclosure regulations. Generally:
  - First, second, or third-class mail (other requirements apply)
  - Hand-delivery
    - But hand-delivery only to the employee does not satisfy delivery to the spouse, and hand-delivery is hard to prove for purposes of record retention.
  - Electronic delivery, if those rules are followed
    - But will email to the employee satisfy delivery obligations to the spouse and other QBs?

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Top COBRA Mistakes—Failure to Timely Furnish Election Notice

- Employer has 30 days to notify plan administrator of the qualifying event.
- Plan administrator must furnish the election notice within 14 days of being notified of the qualifying event.
- If the employer and plan administrator are the same entity, then it has 44 days from the qualifying event to furnish the election notice.
- Delayed Employer Notice Rule: The date coverage ceases (rather than the date of the triggering event) is treated as the date of the qualifying event for purposes of starting the clock.
  - But then the maximum COBRA coverage period must also not commence until that same date..
- Consequence of delayed notice:
  - Qualified Beneficiary's election window is 60 days from when the election notice is furnished—possible insurer and stop loss issues if election notice is late.
  - Discretionary penalties of $110/day

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Top COBRA Mistakes—Failure to Provide Notice of Unavailability

- Notice of Unavailability must be furnished:
  - If the plan administrator determines it will not offer COBRA after receiving a notice of qualifying event from a covered employee or Qualified Beneficiary;
  - If the plan administrator decides it will not continue COBRA past the original maximum coverage period after receiving a notice of second qualifying event; or
  - The plan administrator determines that COBRA coverage will not continue past the original coverage period after receiving a notice of the SSA's disability determination.
- Must be furnished to the person who was expecting to receive coverage not to the person who provided the notice.
  - For example, an employee notifies the Plan Administrator of a legal separation, but the plan provides COBRA for divorce but not legal separation. The Notice of Unavailability goes to the spouse, not the employee who provided the notice.

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Top COBRA Mistakes—Failure to Document Delivery of Election Notice

- Most courts hold that the plan administrator bears the burden of proving proper method of delivery of an election notice.
- Election notices must be furnished in a manner "reasonably calculated to ensure actual receipt of the material," but proof of receipt is not required.
- Recommended method of proof:
  - Mail by first class with:
    - a post office certificate of mailing; or
    - Documented with business records that satisfy court evidentiary requirements

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Top COBRA Mistakes—Offering COBRA when not Required

- Qualified beneficiaries include covered employees and their covered spouses and covered dependents.
  - Domestic Partners are not qualified beneficiaries under COBRA
  - Is the covered child of a domestic partner a qualified beneficiary?
- Medicare entitlement
  - Medicare entitlement is a qualifying event (for spouses and children) only if coverage is lost due to Medicare entitlement, which is unlikely (but not impossible) in a plan for active employees due to Medicare Secondary Payer rules.
  - Employee's voluntary disenrollment from plan due to Medicare entitlement is not a qualifying event for the spouse and covered dependent children.

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Top COBRA Mistakes—Addressing Shortfalls Improperly

- A special rule applies when a COBRA premium payment "is not significantly less than the amount the plan requires to be paid for a period of coverage."
- a premium payment shortfall is insignificant if it is less than or equal to the lesser of (a) $50; or (b) 10% of the COBRA premium required by the plan.
- Such shortfall payments will be deemed satisfactory under COBRA unless the plan notifies the QB of the amount of the deficiency and grants a reasonable period of time for payment.
- Significant shortfalls may be the basis for immediate termination of COBRA coverage after the grace period.

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Top COBRA Mistakes—Severance Agreements

- Need to coordinate COBRA and severance in both the plan document and terms of severance agreement.
- Watch out for discrimination in favor of highly compensated individuals.
- Possible 409A issues.
- Any agreement for COBRA to run concurrent with severance extension (or deferred) must require proper COBRA election procedures.
- Alternate coverage may create a new group health plan.
- COBRA waivers are effective if done properly but must be revocable.
- Does insurer or stop loss allow for the arrangement?

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