BENEFITS COMPLIANCE NEWS TO KNOW.

HIPAA Special Enrollment Q&A

Let's consider a question & answer regarding HIPAA's special enrollment rules where an employee drops coverage only to later request it.

Question: "One of our employees enrolled in our company's group health plan when first eligible, but later dropped the coverage after obtaining other group health coverage through her spouse's new employer. The spouse's employment has terminated, and both are losing their coverage. Does the loss of that coverage trigger special enrollment rights under our plan?"

Continue reading on page 4 for legal analysis & guidance.

PATRIOT GROWTH INSURANCE SERVICES COMPLIANCE BENEFITS WATCH

2nd Wednesday monthly at 1 pm EST

August 14 – Federal FMLA
September 11 - Cafeteria Plans & Nondiscrimination Testing
October 9th – HIPAA Privacy Rule

Click here to join!

Upcoming Deadlines

- ✓ **July 31** – PCORI Fee due for self-funded plans. Complete IRS Form 720
- ✓ **July 31** - File Form 5500 or Form 5558 for an extension via eFAST2
- ✓ **September 30** – Summary Annual Report (SAR) due to participants for 1/1 plans only
- ✓ **December 31** – Gag Clause Attestation due via CMS

Access the 2024 Benefits Compliance Checklist or ask your Patriot Advisor.

The Rundown

- Need to Know: Three Factors to Determine if a Bona Fide Association is an ERISA Employer
- Resource: DOL's FMLA PowerPoint Presentation Slides
- Resource: Medicare Secondary Payer Chart & California Carriers
- IRS: DRAFT IRS 2024 Form 8941 - Small Employer Health Premium Credit
- IRS: Form 720 – PCORI Fee & Instructions for Form 720 (Rev. June 2024)
- IRS: Sample Educational Assistance Program Form 5993 – TEMPLATE
- Blog: IRS FAQs on Educational Assistance Programs Highlight an Opportunity to Provide Student Loan Assistance
- Blog: ACA Employer Mandate and Reporting FAQs
- Blog: Why Group Medical Stop-Loss Captives and Level-Funded Plans Don't Mix
- Blog: Healthcare claims audits for self-insured plan sponsors
- Blog: Federal Trade Commission's Interim Report Documents Harmful Impact of Pharmacy Benefit Managers on Independent Pharmacies
- Federal Trade Commission: Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies
- HHS: Resources to Support HIPAA Final Reproductive Privacy Rule Updates
- CMS: Updated Submission Instructions & User Manual for the Gag Clause Prohibition Compliance Attestation (GCPCA).
- CMS: HHS Announces Cost Savings for 64 Prescription Drugs Thanks to the Medicare Rebate Program Established by the Biden-Harris Administration's Lower Cost Prescription Drug Law | CMS
- News: Fifth Circuit Reverses Nationwide Injunction in ACA Litigation Over PrEP, HPV, and Contraceptives

In a Nutshell: What is the *Chevron* Deference?

Q: We've heard noise about *Loper Bright Enterprises v. Raimondo (S. Ct. 2024)* (summary here), and that employee benefits law will be impacted. What is the *Chevron* Deference?

A: *"Chevron U.S.A. Inc. v. Natural Resources Defense Council* (S. Ct 1984) ("Chevron"), is the 40-year-old Supreme Court case establishing a two-step process for a federal court to undertake when reviewing a regulation (or sub-regulatory guidance) issued by a federal agency with subject matter expertise over the applicable issue(s):

- ✓ First, the court must determine whether Congress has directly spoken to the precise question at issue.
- ✓ If, *and only if*, congressional intent is clear, the inquiry is over. But if the statute is silent or ambiguous, the court must proceed to step two of the *Chevron* ruling.
- ✓ It must defer to the agency's interpretation [of the statute] if it is "based on a permissible construction of the statute."

– per Adam Cantor, Partner, Ford Harrison

Summer Webinar Schedule

PATRIOT GROWTH INSURANCE SERVICES COMPLIANCE BENEFITS WATCH

August 14 – Federal Family & Medical Leave Basics & 1 PM EST (60 min.)

Another FMLA basics webinar? Yes. Since States are enhancing the federal "floor" by offering various versions of paid & unpaid protected leave, let's review the process. Join Patriot's Benefits Compliance Counsel, Olivia Ash, for a one-hour webinar to outline the FMLA process. This month Olivia welcomes a guest Leave of Absence expert to reveal how federal leave interacts with state leave (or not), including a quick glance at current & upcoming leave laws.

Q&A: HIPAA Special Enrollment

Continued from page 1

Answer: HIPAA requires a group health plan to provide special enrollment opportunities to certain employees and dependents who—

- ✓ lose eligibility for other group health coverage or health insurance coverage;
- ✓ lose eligibility for Medicaid or a state Children's Health Insurance Program (CHIP), or become eligible for a state premium assistance subsidy under Medicaid/CHIP; or
- ✓ acquire a new spouse or dependent by marriage, birth, adoption, or placement for adoption.

For the first special enrollment trigger to apply, an employee or dependent of an employee must be eligible for coverage but not currently enrolled, and the employee or dependent must have had other health coverage when enrollment was offered and declined.

- ✓ *"Dependent"* is any individual who is or may become eligible for coverage under the terms of the group health plan because of the relationship to the employee, as defined under the eligibility provisions of each group health plan.

A special enrollment right arises when the other coverage is lost because of a loss of eligibility, cessation of employer contributions, or exhaustion of COBRA coverage.

- ✓ *"Loss of eligibility"* includes a loss resulting from termination of employment—and employees are not required to elect COBRA coverage to retain their special enrollment right.

Special enrollment rights are available to eligible employees, dependents of eligible employees, and dependents of COBRA qualified beneficiaries. (An employer may require its employees to state in writing at the time coverage was declined, and that the reason for declining coverage was the existence of other health coverage.)

It seems that special enrollment rights would apply in this circumstance.

Analysis: The requirements for special enrollment are that the employee was previously offered and declined coverage at a time when other health coverage was in place. Even though dropping coverage after enrollment is not directly addressed in the regulations, it should not matter whether the employee had coverage and then dropped it or never enrolled for coverage because, in either case, the reason was the existence of other coverage.

Source: *Thompson Reuters EBIA Staff Analysis, 2024, edited for concision.*

Fiduciary Corner

Plan Sponsor Question of the Week:

If we recently distributed ERISA welfare plan SPDs to participants, must another copy be provided to a participant who requests one?

Answer: "Yes. Nothing in ERISA eliminates the obligation to provide a requested SPD just because it was previously provided in the normal course. Failing to provide a copy exposes your company to substantial civil penalties."

- ✓ **Automatic SPD Distribution.** The SPD for an ERISA welfare plan must be furnished automatically & without charge within 90 days after a participant's plan coverage commences, and at specified intervals depending on whether material changes have been made to the plan.

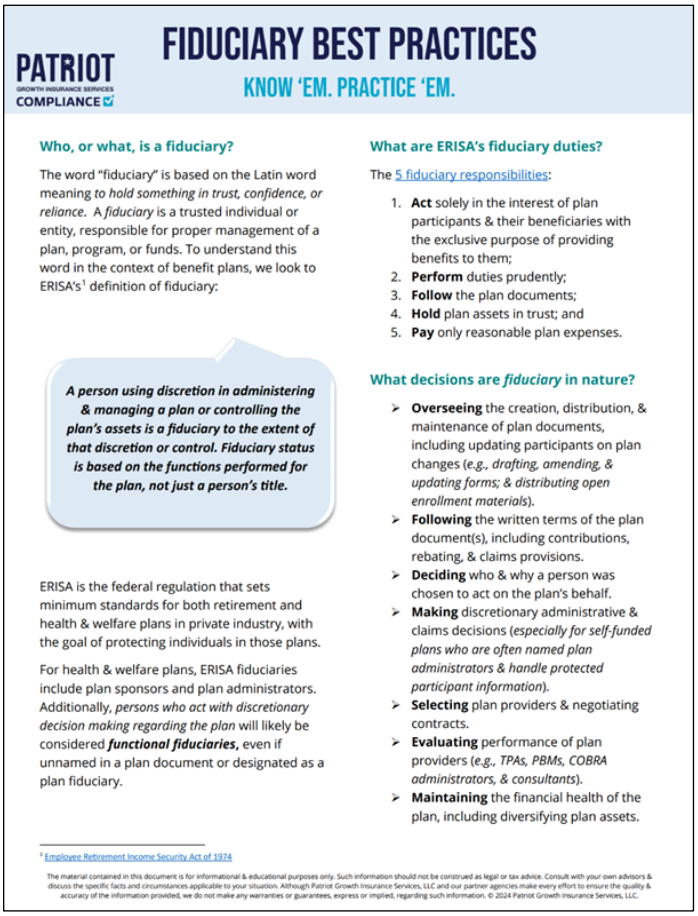
- ✓ **Participant/Beneficiary Document Requests.** A plan administrator must provide copies of certain documents, including the latest SPD (and any SMM), when a participant or beneficiary makes a written request.

Bottom line: "To comply with ERISA and avoid potential penalties . . . furnish the requested SPD to the participant even if it was just distributed to all participants."

~ Courtesy of Thompson Reuters Staff, 2024

Blog: $32,000 ERISA Penalty for Failure to Provide Plan Docs.

Patriot Advisors: *click on the upper right image* to access our 2-page handout: Fiduciary Best Practices, & chat with clients; or *click the bottom right image* for a resource reviewing Indemnity Plans, including those Patriot does not support.



PATRIOT GROWTH INSURANCE SERVICES COMPLIANCE

FIDUCIARY BEST PRACTICES

KNOW 'EM. PRACTICE 'EM.

Who, or what, is a fiduciary?

The word "fiduciary" is based on the Latin word meaning *to hold something in trust, confidence, or reliance.* A *fiduciary* is a trusted individual or entity, responsible for proper management of a plan, program, or funds. To understand this word in the context of benefit plans, we look to ERISA's[1] definition of fiduciary:

A person using discretion in administering & managing a plan or controlling the plan's assets is a fiduciary to the extent of that discretion or control. Fiduciary status is based on the functions performed for the plan, not just a person's title.

ERISA is the federal regulation that sets minimum standards for both retirement and health & welfare plans in private industry, with the goal of protecting individuals in those plans.

For health & welfare plans, ERISA fiduciaries include plan sponsors and plan administrators. Additionally, *persons who act with discretionary decision making regarding the plan* will likely be considered ***functional fiduciaries,*** even if unnamed in a plan document or designated as a plan fiduciary.

What are ERISA's fiduciary duties?

The 5 fiduciary responsibilities:

1. **Act** solely in the interest of plan participants & their beneficiaries with the exclusive purpose of providing benefits to them;
2. **Perform** duties prudently;
3. **Follow** the plan documents;
4. **Hold** plan assets in trust; and
5. **Pay** only reasonable plan expenses.

What decisions are *fiduciary* in nature?

- **Overseeing** the creation, distribution, & maintenance of plan documents, including updating participants on plan changes (*e.g., drafting, amending, & updating forms; & distributing open enrollment materials*).
- **Following** the written terms of the plan document(s), including contributions, rebating, & claims provisions.
- **Deciding** who & why a person was chosen to act on the plan's behalf.
- **Making** discretionary administrative & claims decisions (*especially for self-funded plans who are often named plan administrators & handle protected participant information*).
- **Selecting** plan providers & negotiating contracts.
- **Evaluating** performance of plan providers (*e.g., TPAs, PBMs, COBRA administrators, & consultants*).
- **Maintaining** the financial health of the plan, including diversifying plan assets.

[1] Employee Retirement Income Security Act of 1974

PATRIOT GROWTH INSURANCE SERVICES COMPLIANCE

INDEMNITY PLANS

WHAT ARE THEY?

At their core, indemnity plans[1] provide fixed, cash payments upon the occurrence of a health-related event & exist outside the Affordable Care Act's (ACA) regulations. In recent years, arrangements claiming to provide tax benefits via a monthly "wellness payment/benefit" have sprouted. These "plans" have prompted questions & analyses of whether such arrangements are "too good to be true" or whether they run afoul of tax law. Review indemnity policy types & other plans below: read on for assistance in analyzing market products.

Indemnity Health Plan - a type of health plan where the insurance company pays a pre-determined percentage of the reasonable & customary charges for a given service & the insured pays the rest.

Fixed Indemnity Plan – a type of medical insurance that pays a pre-determined amount (*e.g., fixed, cash payment*) on a per-period or per-incident (health-related) basis, regardless of total charges incurred. Includes hospital indemnity plans.

Fixed Indemnity Excepted Benefits Coverage is exempt from federal consumer protections & requirements for comprehensive health insurance. Coverage is designed to provide a source of income replacement, rather than full medical coverage. As of March 2024, a new rule requires consumer notice in the group market clarifying that coverage is not comprehensive.

Short-Term Limited-Duration Insurance (STLDI) is a type of health insurance designed to fill a temporary gap in coverage when an individual is transitioning from one source of coverage to another. It is not *individual health coverage* under the ACA. In March 2024, federal departments amended the definition of STLDI to reduce the initial contract term & require updated notice provisions.

Self-Insured Medical Reimbursement Plan (SIMRP), or Section 105 plan, is a plan which reimburses employees for medical expenses not provided by either an accident & health insurance policy, or a prepaid healthcare plan regulated under federal or state law. It is a direct reimbursement plan: the employer pays employees for medical care expenses.

Wellness Indemnity Policy – a type of arrangement where the insured receives a fixed monthly "wellness payment." These types of plans propose tax savings. However, there is debate whether this monthly "payment" is truly tax exempt or whether it's considered "double-dipping." Read on for details. *See also: IRS Memo on Tax Treatment*

[1] Hospital indemnity or other fixed indemnity insurance provides fixed, cash payments upon the occurrence of a health-related event. Benefits are paid regardless of the amount of expenses a consumer incurs. Fixed indemnity insurance has traditionally been used as a form of income replacement, and it is not a substitute for comprehensive coverage. Source: Short-Term, Limited-Duration Insurance Fact Sheet July 2023 CMS