Because You're Different

2024 YEAR END LEGISLATIVE RECAP

Affordable Care Act

Employer Sponsored Plan Statistics

According to the U.S. Census Bureau[1] in 2023, 92% of the U.S. population (305.2 million people) were enrolled in health insurance, with employment-based health coverage accounting for 53.7% of that enrollment. Rising health care costs are nothing new, however predictions for 2025 are staggering. Industry trend reports predict a 9% increase on average for all U.S employer sponsored coverage in 2025. Within this figure, the highest projected rate of increase for all health benefit plan cost trends is for prescription drugs at 11.4%. This exceeds prior cost growth, which was closer to 6% in 2024, and slightly below 6% in 2023.

The 'Employer Mandate' Section 4980(H)

4980H(a): If Employer does not offer coverage to 95% of its full time employees, and one employee receives a subsidy to purchase insurance on the Health Exchange, the Employer is subject to a penalty equal to $2,900 x every full time employee (minus 30).

4980H(b): If employer offers coverage that is unaffordable (affordability measure for 2025 is 9.02%) or doesn't offer minimum value, and any employees qualify for a subsidy to purchase insurance on the Health Exchange, the employer is subject to a penalty equal to $4,350 x the number of full time employees that receive a subsidy to purchase insurance on the Health Exchange.

Infertility and Title VII

While the ACA requires large group plans to cover a myriad of services, fertility benefits are largely up to each states' insurance laws. Plaintiffs in several cases[2] since 2022 have challenged their employer health plans' infertility benefits on the grounds of 1557 and Title VII. In one case, Aetna settled with plaintiff, agreeing to change their clinical policy and definition for 'infertility' to align with the recent guidelines from the American Society for Reproductive Medicine[3] which are more inclusive.

GLP-1 Drugs and Section 1557

Anthem, Inc. has been sued by a group of plaintiffs under 1557, who allege that the health plan's exclusion of GLP-1 drugs for obesity discriminates on the basis of a disability. The complaint filed in Holland v Elevance Health Inc[4] points to coverage of these drugs for a diagnosis of diabetes, but not a diagnosis of obesity (which is a disability under court precedent), as discrimination.

[1] *Health Insurance Coverage in the United States: 2023, issued September, 2024*

[2] *Briskin v City of New York et al., No. 24 Civ. 3557 (S.D.N.Y.) , Goidel v Aetna (CASE NO 1:21-cv-07619-VSB-VF), Berton v Aetna (CASE N.: 4:23-cv-01849-HSG)*

[3] *Committee opinion published in 2023 to replace the definitions of infertility and recurrent pregnancy loss under the 2020 guidance*

[4] *Holland v. Elevance Health, Inc., No. 24-cv-00332 (D. Me. Sept. 20, 2024)*

HHS & CMS

New Final HIPAA Rule (Reproductive PHI)

HHS has issued a new final rule[5] which specifically prohibits the disclosure of PHI related to lawful reproductive health care, when the disclosure is for 'criminal or civil investigation or individual identification purposes'. Following the momentous Supreme Court ruling in Dobbs and subsequent state laws regulating abortion, HHS has stepped in to add a layer of protection for employees and employers alike.

The new rule applies to requests for PHI, when the health plan finds:

- The reproductive health care is lawful under the law of the state in which it is provided (ie. if a resident of one state traveled to another state to receive reproductive health care, such as an abortion, that is lawful in the state where such health care was provided)
- The reproductive health care is protected, required, or authorized by Federal law (such as use of contraceptives)
- The reproductive health care was provided by a person other than the entity that receives the request for PHI.

The Final Rule continues to permit health plans to use or disclose PHI for purposes otherwise permitted under the Privacy Rule. Additionally, providers are required to obtain an attestation from any party that requests access to the type of PHI described in the final rule.

Medicare Part D Reforms

The Inflation Reduction Act contained Medicare Part D reforms slated to take effect in 2025. Employers must inform employees annually, prior to the start of the Medicare open enrollment period beginning October 15, if their drug plans are 'creditable'. This determination depends on many factors and is the responsibility of the plan sponsor to confirm, however many carriers make this determination on behalf of their employer clients. Most relevant to creditable status determinations, the Part D annual out-of-pocket costs will be capped at $2,000 for people with Medicare Part D starting in 2025 (in 2024, the limit was $8,000). Under traditional Medicare rules, employees that postpone Medicare enrollment until they retire at an age older than 65 will face a monthly penalty if they do not maintain creditable coverage prior to Medicare Part D enrollment. This means that new Medicare cost limits have the potential to render some employer plans non-creditable, exposing employees to Part D penalties when they eventually enroll in Medicare. Benefits advisors will help clients ensure their plans still meet creditable status and provide proper action steps should that status change.

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[5] *Published in the Federal Register on April 26, 2024*

IRS

Notice 2024-75

On October 17, the IRS released an updated list of items considered 'preventive' and therefore permitted to be covered without deductible satisfaction, without disrupting HSA eligibility for HDHP plans under Section 223[6].

The following will be treated as preventive care for purposes of an HDHP:

- All types of breast cancer screening for individuals who have not been diagnosed with breast cancer
- Continuous glucose monitors for individuals diagnosed with diabetes, when the monitor both monitors and provides insulin
- Over-the-counter oral contraceptives (including emergency contraceptives) and male condoms

The guidance interprets items in the Inflation Reduction Act of 2022, and while issued in 2024, it is applicable to plan years beginning on or after January 1, 2023.

SCOTUS

Loper Bright Enterprises v Raimondo

In the landmark decision[7] published by the Supreme Court on June 28, a long standing principal known as "Chevron Deference' was explicitly overruled. Justice Roberts delivered the majority decision, noting "we have sometimes required courts to defer to "permissible" agency interpretations of the statutes those agencies administer— even when a reviewing court reads the statute differently." For employers, this decision implicates numerous IRS, DOL and HHS guidance on which employers have relied for decades in the administration of their employee health plans.

"The Administrative Procedure Act requires courts to exercise their independent judgment in deciding whether an agency has acted within its statutory authority, and courts may not defer to an agency interpretation of the law simply because a statute is ambiguous; Chevron is overruled. Pp." 7–35.

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[6] *Preventive Care for Purposes of Qualifying as a High Deductible Health Plan under Section 223, Notice 2023-75*

[7] *22-451 Loper Bright Enterprises v. Raimondo (06/28/2024) (603 U. S. ____ (2024))*

No Surprise Act

In August, the 5th Circuit Court of Appeals upheld the lower court's holding in Texas Medical Assoc. v HHS[8], which essentially creates an environment where health plans may end up paying larger fees to health service providers.

Many health care providers have challenged the regulations implementing the No Surprise Act, arguing that the independent dispute resolution process, and the guidelines' reference to 'qualifying payment amounts' (QPA) are beyond the language (and scope) of the statute itself. Plaintiffs argued that the Departments are "...tilting the arbitration process in insurers' favor and resulting in unacceptably low payments to providers".

Unless the Departments announce intentions to reform the dispute resolution and qualifying payment rules, the uncertainty will continue. In the meantime, plan sponsors (especially those with self insured health plans) may see higher costs associated with claims submitted to arbitration under the No Surprise Act.

Mental Health Parity

Employers will recall the amendments to existing Mental Health Parity and Addiction Equity Act (MHPAEA) made by the 2021 Consolidated Appropriations Act. Notably, these updates require all plans to perform and maintain a comparative analysis for all non-numerical (non-quantitative) treatment limitations (NQTLs) applicable to mental health benefits. The Final Rules codifying many of the proposed changes were issued on September 9, and many take effect on January 1, 2025.

Among the myriad provisions contained in the Final Rules, several will be of particular significance to employers. While fully insured health plans will generally rely on their carriers for substantive compliance, there are still several aspects that will fall to these employers. As with many compliance tasks, self-funded employers will need to collaborate with their ASO providers and benefits consultants on these requirements. Key changes include:

- Elimination of any hurdles to mental health services
- Requirement for comparative analysis of non-quantitative treatment limits (NQTLs)
- Prohibition on plans and issuers using discriminatory information, evidence, sources, or standards that systematically limit access to MH/SUD benefits as compared to medical/surgical benefits when designing NQTLs

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[8] *Texas Medical Assoc. V HHS Case No. 6:22-cv-450-JDK*

CALIFORNIA

CA SDI 2025

Under CA Short Term Disability (SDI), income replacement rates will increase in 2025. With the elimination of the taxable wage cap, employees whose wages place them at or below 70% of the state average weekly wage will receive 90% of their wages for claims initiated in 2025.

CA PFL 2025

Beginning January 1, 2025, employers will no longer be able to require PTO exhaustion for the first two weeks of PFL leave, before PFL benefits payments begin[9]. PTO use is still permitted under the new rules, but it can no longer be a requirement.

NEW YORK

New York PFL for 2025

Employers located anywhere in the U.S. with even one employee physically working in New York are subject to NY PFL. The 2025 State Average Weekly Wage (SAWW) is $1,757.19. The PFL maximum weekly benefit for claims initiated in 2025 is 67% of the applicable SAWW, which equals $1,177.32;

The employee withholding rate in 2025 is 0.388% of an employee's gross wages per pay period, up to a maximum annual contribution of $354.53 (which is an increase from the 2024 rate of 0.373% and a maximum annual contribution of $333.25)

Paid Prenatal Leave

Beginning January 1, pregnant employees physically working in New York will be entitled to 20 hours of paid leave for all prenatal care (defined very broadly). This is in addition to existing paid time off, paid sick leave, and PFL entitlements. Time off can be taken in one hour increments, and must be available on January 1 without accrual requirements. The leave will be paid by employers, and is not an insured benefit related to existing PFL policies.

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[9] *Assembly Bill 2123*

2024 Versus 2025 Plan/ Out of Pocket/ FSA Limits

Plan Type	2024 Limit	2025 Limit
HDHP minimum deductible amount	$1,600 / $3,200	$1,650 / $3,300
HDHP Maximum OOP Limit (determined by IRS)	$8,050 / $16,100	$8,300 / $16,600
NON-HDHP Maximum OOP Limits (determined by HHS per ACA)	$9,450 / $18,900	$9,450 / $18,900
HSA Maximum Contribution Amount	$4,150 /$8,300	$4,300 /$8,550
Catch–up contributions (those age 55+)	$1,000	$1,000
FSA Maximum Contribution/Rollover	$3,200 / $640	$3,300 / $660
Dependent Care (DCA)	$5,000	$5,000
Qualified Transportation Benefit	$315 transportation / $315 parking	$325 transportation / $325 parking
Employer Mandate 4980H(a)	$2,970	$2,900
Employer Mandate 4980H(b)	$4,460	$4,350
Affordability Percentage	8.39%	9.02%
PCORI Fee	$3.22	$3.38 * (projected)

State Paid Leave

State/Law	Effective Date of Paid Leave	Maximum Number of Weeks Available
California SDI and PFL	2004	SDI- 52 weeks PFL- 8 weeks in a 12-month period
Colorado PFML	2024	12 weeks (*16 weeks if the leave relates to health condition related to pregnancy or childbirth complications)
Connecticut PFML	2022	12 weeks
Delaware	2026 (EE contributions begin 1/1/25)	12 weeks
Maryland	2026	12 weeks
Massachusetts	2021	26 weeks to care for covered service member; 20 weeks for medical leave; 12 weeks for family/bonding leave
Maine	May 2026 (EE contributions begin 1/1/25)	12 weeks
Minnesota	2026	12 weeks
Michigan	February 21, 2025	*Earned Sick Time Act (ESTA) replaces Paid Medical Leave Act (PMLA); employees get 72 hours paid sick leave per year
New Jersey TDI and FLI	2009	TDI- 26 weeks or the period necessary for benefits to equal 1/3 of total wages in base year, whichever is less; FLI- 12 consecutive weeks or 56 intermittent days during a 12-month period beginning with the first date of the claim
New York DBL and PFL	2017	DBL- 26 weeks within 52-week period PFL- 12 weeks
Oregon PFML	2023	12 weeks (16 weeks if combining PFML with unpaid leave under OFLA)
Rhode Island TDI and TCI	2014	TDI- 30 weeks in any benefit year TCI-4 weeks in any benefit year
Washington PFML	2017	12 weeks for employees' own medical condition/family care; 14 weeks for pregnancy related condition; 16 weeks combined medical leave for employees own condition and family care; 18 weeks combined leave for employees own medical condition if due to pregnancy incapacitation and family care
Washington DC PFML	2020	*12 weeks for child bonding, to care for family member, medical leave; 2 weeks for pre-natal leave *as of Oct 2022)