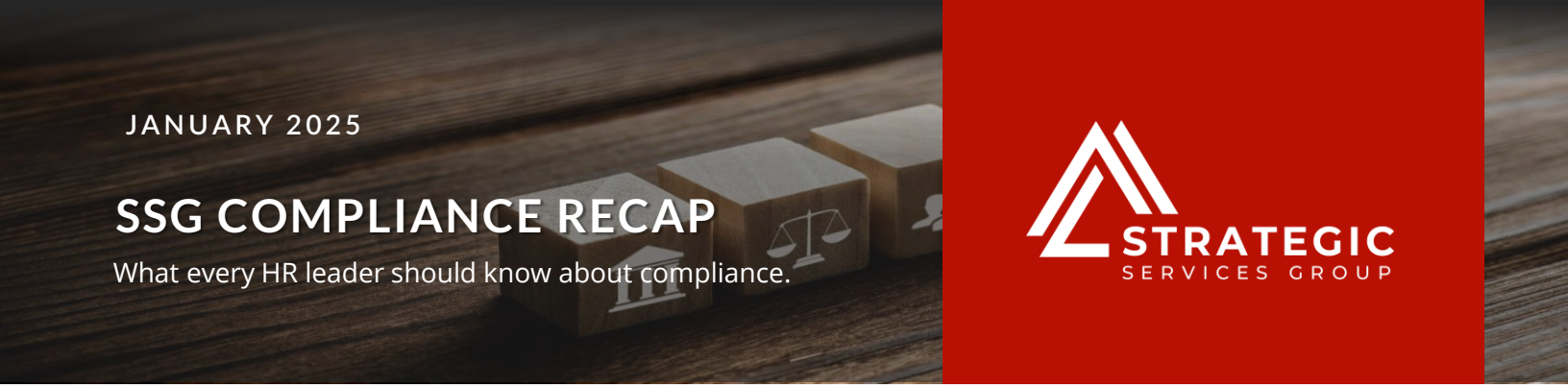

JANUARY 2025

SSG COMPLIANCE RECAP

What every HR leader should know about compliance.

STRATEGIC SERVICES GROUP

Court Dismisses ERISA Fiduciary Breach Claims Against Johnson & Johnson

On January 24, 2025, a New Jersey district court dismissed two ERISA fiduciary breach claims in Lewandowski v. Johnson & Johnson, et al. The plaintiff, representing a proposed class, alleged Johnson & Johnson (J&J) mismanaged its prescription drug plans by failing to prudently select and monitor its pharmacy benefit manager (PBM), leading to excessive drug costs. The court ruled the plaintiff lacked standing under Article III of the U.S. Constitution, a decision that underscores the difficulties plaintiffs face in establishing standing for similar claims.

Key Findings

- The plaintiff alleged that J&J's PBM selection and contract terms led to higher drug costs, increasing premiums and out-of-pocket expenses for participants.
- The court determined that the plaintiff failed to show an actual, concrete injury-in-fact, as required under Article III.
- Citing the Knudsen v. MetLife Group Inc. case, the court ruled that speculative claims about premium increases and plan costs did not establish standing.
- While the plaintiff argued that she overpaid for certain drugs, the court found this claim was not redressable since she had already reached her out-of-pocket maximum.
- The court dismissed the fiduciary breach claims but allowed the plaintiff to amend her complaint within 30 days to address deficiencies.
- The plaintiff's claim regarding J&J's failure to timely provide plan documents was allowed to proceed.

EMPLOYER CONSIDERATIONS

The ruling in Lewandowski is a significant victory for health plan sponsors and follows similar decisions that limit broad fiduciary breach claims based on ERISA. Courts have consistently held that plaintiffs must demonstrate a personal and concrete injury linked to fiduciary mismanagement. The decision reinforces that general allegations of excessive fees or plan mismanagement will not suffice.

However, the court left open the possibility that a participant who had not yet reached the plan's out-of-pocket maximum might establish standing in a similar case. This suggests that while the ruling is a positive development, ERISA fiduciary breach litigation may continue under different factual circumstances.

Employers should:

- Review ERISA fiduciary governance: Ensure that PBM contracts and prescription drug pricing structures are thoroughly evaluated and documented.
- Monitor legal developments: This case sets a precedent, but similar claims may evolve.
- Ensure compliance with ERISA document requests: The court's decision to allow the plaintiff's document request claim to proceed highlights the importance of timely responses.

While the Lewandowski ruling provides some relief to employers, it serves as a reminder that proper plan governance and documentation remain critical to minimizing litigation risks.

IN THIS ISSUE

Stay one step ahead with an easy-to-understand summary of these legislation highlights.

IRS Issues Tax Guidance On State Paid Family And Medical Leave Programs

On January 15, 2025, the Internal Revenue Service (IRS) released **Revenue Ruling 2025-4** (providing guidance on the taxation and reporting of contributions and benefits under state paid family and medical leave (SPFML) programs.

Key Highlights

Employer and Employee Contributions

- Employee-required SPFML contributions paid by an employer are considered taxable income for federal tax purposes and must be reported on the employee's Form W-2 (Boxes 1, 3, and 5).
- Employer-mandated contributions are treated as state taxes, not taxable to employees, and require no federal reporting by employers.

Taxation of SPFML Benefits

Family Leave Benefits:

- Fully taxable as federal gross income.
- Not considered wages for Social Security and Medicare taxes.
- The state administering the benefits must report payments to the IRS and provide employees with Form 1099.

Medical Leave Benefits:

- Generally taxable unless related to an employee's own serious health condition.
- The taxable portion depends on the employer's premium contribution percentage. For example, if an employer pays 40% of the premium, then 40% of the benefits received are subject to taxation.

Transition Period and Employer Compliance

The IRS has designated 2025 as a transition period for states and employers to implement the necessary reporting and compliance systems. Full enforcement of RR 2025-4 will begin in 2026, making it imperative for employers to update payroll and tax reporting procedures before the transition period ends.

Interaction Between State PFML and FMLA

The U.S. Department of Labor (DOL) clarified how state PFML programs interact with the Family and Medical Leave Act (FMLA). The opinion letter from the Wage and Hour Division (WHD) outlined the following key rules:

1. No mandatory use of paid leave: Employers cannot require employees to use accrued paid leave (e.g., vacation or sick time) while receiving state PFML benefits.
2. Voluntary "top-off" agreements: Employees and employers can agree to use accrued leave to supplement state-paid benefits and bring total pay to 100%.
3. FMLA designation: Employers must classify leave under a state program as FMLA leave if it meets FMLA qualifications.
4. State-specific leave: If state PFML covers situations not recognized by FMLA (e.g., caring for a grandparent), that leave does not count against FMLA entitlement.

EMPLOYER CONSIDERATIONS

To remain compliant with these regulations, employers should:

- Review RR 2025-4 with tax and legal professionals.
- Update payroll systems to properly classify and report employee contributions and benefits.
- Educate employees on their rights and responsibilities under both FMLA and state PFML programs.
- Ensure FMLA compliance by correctly designating leave and preventing policy conflicts.

HHS Updates 2025 Federal Poverty Levels and ACA Affordability Impact

The Department of Health and Human Services (HHS) has updated the federal poverty level (FPL) guidelines effective January 15, 2025. The 2025 FPL is set at $15,650 for a mainland U.S. individual (up from $15,060 in 2024), $19,550 for Alaska (up from $18,810), and $17,990 for Hawaii (up from $17,310). These updates influence affordability calculations under the Affordable Care Act (ACA) for employer shared responsibility (ESR) assessments.

ACA Impact on Employers

Premium Tax Credits

Individuals earning between 100% and 400% of the FPL may qualify for premium tax credits for public exchange coverage. Receipt of these credits by ACA full-time employees can trigger ESR penalties for employers.

Affordability Safe Harbor Testing

Employers may use the FPL as one of the ACA's affordability safe harbors to determine whether their lowest-cost, self-only minimum essential coverage (MEC) meets affordability criteria. The ACA benchmark affordability percentage for 2025 is 9.02%, up from 8.39% in 2024.

Employers with calendar-year plans must use the 2024 FPL for 2025 affordability testing, while non-calendar-year plans beginning in 2025 may apply the updated 2025 FPL.

2025 Affordability Safe Harbor Contribution Limits

	Non-calendar-year Plans beginning in 2025	2025 Calendar-year Plans (2024 FPL)
Mainland U.S.	$117.64	$113.20
Alaska	$146.95	$141.39
Hawaii	$135.22	$130.11

EMPLOYER CONSIDERATIONS

Employers should review their health plan contributions and compliance strategies to avoid penalties under ESR rules.

While the updated FPL levels provide important affordability benchmarks, the timing of their release may impact employer decisions. Employers should integrate these updates into ACA compliance efforts, especially for affordability testing and safe harbor applications for 2026.

Prepare To File Medicare Part D Disclosure to CMS

Group health plans that provide prescription drug coverage to Medicare Part D eligible individuals are reminded to disclose to the Centers for Medicare & Medicaid Services (CMS) whether that coverage is creditable or not creditable. Employers must submit this information electronically on the **Disclosure to CMS Form** through the CMS website. See the **CMS instruction guide** with screen shots for completing the form online.

FAQs Clarify Gag Clause Prohibitions and No Surprises Act Compliance

The Departments of Labor, Health and Human Services, and Treasury have released their 69th set of FAQs, providing clarifications on the Gag Clause Prohibition and the No Surprises Act. These updates impact employer-sponsored group health plans, particularly regarding transparency requirements and compliance obligations.

Gag Clause Prohibition Overview

- Under the Consolidated Appropriations Act, 2021 (CAA), group health plans and insurers cannot enter into contracts that restrict access to critical healthcare cost and quality information. Specifically, plans and carriers cannot:
- Prevent participants, sponsors, or referring providers from accessing provider-specific cost or quality data.
- Restrict electronic access to de-identified claims and encounter data upon request.
- Limit the sharing of such data with business associates, in compliance with privacy regulations

Key Clarifications from the FAQs

- Downstream Contract Restrictions: If a plan's third-party administrator (TPA) has contracts with provider networks, those contracts cannot contain gag clauses that restrict data access.
- Provider Discretion on Data Sharing: Plans cannot have agreements that condition data disclosure on provider or network entity approval.
- Electronic Data Access: Restrictions on the frequency, scope, or purpose of accessing de-identified claims data are considered prohibited gag clauses.
- Compliance Reporting: If a plan identifies a prohibited gag clause in an agreement it cannot modify, it must report the noncompliance in its annual attestation, detailing efforts to rectify the issue.

No Surprises Act Updates

The FAQs also address ongoing litigation regarding the No Surprises Act, particularly regarding the calculation of Qualifying Payment Amounts (QPAs):

- Plans and insurers must use a good-faith, reasonable interpretation of the QPA rules while litigation continues.
- Disclosure requirements regarding QPAs for out-of-network services remain in effect.
- The agencies will exercise enforcement discretion for plans that continue using pre-2025 methodologies for QPA calculations until August 1, 2025.

EMPLOYER ACTION ITEMS

- Review contracts with TPAs and provider networks to ensure compliance with gag clause prohibitions.
- Ensure full data access to provider cost, quality, and claims data as required.
- Submit the annual gag clause attestation by December 31, even if noncompliance exists.
- Monitor QPA developments and adjust payment dispute processes accordingly.

IRS Publication 969 Outlines Compliance for Tax-favored Health Plans

The IRS has released the newest version of **Publication 969**, "Health Savings Accounts and Other Tax-Favored Health Plans" outlining the rules and requirements surrounding health savings accounts (HSAs), health flexible spending arrangements (FSAs), health reimbursement arrangements (HRAs), and Archer medical savings accounts (MSAs). This reference document describes the administration and compliance requirements of these accounts.

Employer Reporting Requirements for Forms 1094-C And 1095-C

Employers with 50 or more full-time employees (including full-time equivalents) in the prior year must use Forms 1094-C and 1095-C to comply with IRS reporting requirements under Internal Revenue Code sections 6055 and 6056. These forms provide information on health coverage offerings and employee enrollment.

Purpose of Forms 1094-C and 1095-C

- Form 1094-C: Serves as a summary document for each applicable large employer (ALE) member and is used to transmit Forms 1095-C to the IRS.
- Form 1095-C: Reports details about each full-time employee's health coverage to both the IRS and the employee. It also helps determine if an ALE member owes an employer shared responsibility payment under section 4980H and whether an employee qualifies for premium tax credits.
- ALE Members providing self-insured health plans also use Form 1095-C to report minimum essential coverage details to the IRS and employees.

Who Must File?

- Applicable large employers (ALEs): Entities with at least 50 full-time employees (including equivalents) in the prior year.
- Aggregated ALE groups: If multiple employers are under common control and collectively meet the 50-employee threshold, each entity within the group is an ALE member and must file separately.
- Filing requirements: ALE members must submit at least one Form 1094-C (including an Authoritative Transmittal, if filing multiple forms) and a Form 1095-C for each full-time employee.
- Employers must also provide employees with a copy of their Form 1095-C.

Filing Deadlines

- Paper Filing: February 28 of the year following the reporting year.
- Electronic Filing: March 31 of the year following the reporting year.
- If the due date falls on a weekend or legal holiday, it moves to the next business day.

2025 ADJUSTMENTS TO DOL PENALTIES

Employers who fail to comply with Department of Labor (DOL) regulations—including those governing employee benefits, wage and hour laws, occupational safety and health, and workers' compensation—will face steeper penalties in 2025 due to inflation-related adjustments. The revised penalty structure applies to violations occurring after November 2, 2015, with penalties assessed on or after January 15, 2025.

Although the DOL seldom imposes the maximum penalty and frequently waives fines for infractions caused by reasonable circumstances, the risk of substantial penalties serves as a key enforcement mechanism and deterrent for noncompliance.

Continued

2025 ADJUSTMENTS TO DOL PENALTIES

	Maximum Penalty (unless otherwise indicated)	
Type of Plan Failure	**2025 (after Jan. 15)**	**2024 (after Jan. 15)**
Failure to file Form 5500	$2,739/day late	$2,670/day late
Failure to file a multiple employer welfare arrangement (MEWA) annual report (Form M-1)	$1,992/day late	$1,942/day late
Failure to provide plan documents to DOL within 30 days after request	$195/day late, capped at $1,956/request	$190/day late, capped at $1,906/request
Failure to inform an employee about Children's Health Insurance Program (CHIP) coverage opportunities (each employee is a separate violation)	$145/day late	$141/day late
Failure to timely provide to any state information about coverage coordination with Medicaid or CHIP (each participant or beneficiary is a separate violation)	$145/day late	$141/day late
Failure to meet genetic information restrictions (on discriminating in eligibility, coverage or premiums; requesting or requiring genetic tests; collecting genetic information; etc.)	$145/day of noncompliance	$141/day of noncompliance
Minimum penalty for de minimis failure not corrected before notice from DOL	$3,642	$3,550
Minimum penalty for non-de minimis failure not corrected before notice from DOL	$21,864	$21,310
Cap on penalties for unintentional failures	$728,764	$710,310
Failure to provide summary of benefits and coverage (SBC) with uniform glossary	$1,443 per failure	$1,406 per failure

Question of the Month

Q: An employer group is changing its lookback method for Family and Medical Leave Act (FMLA) eligibility. Are they required to give employees 60 days' notice of this change, and is there sample language that must be used for the notice?

A: If an employer changes methods for determining FMLA eligibility, the employer must give all employees at least 60 days' advance notice of the proposed change. During this 60-day transition period, employees get the benefit of the eligibility method that provides the greatest benefit to the employee. For more information, see the **Department of Labor FAQ** on the issue. There is no template notice at this time. The employer can simply explain the change and provide contact information for employee questions.

Answers to the Question of the Week are provided by Kutak Rock LLP. Kutak Rock provides general compliance guidance through the UBA Compliance Help Desk, which does not constitute legal advice or create an attorney-client relationship. Please consult your legal advisor for specific legal advice.