

Compliance Technical Bulletin

2024 Year-End Review and Reminders

This year we rang in the fiftieth anniversary of the Employee Retirement Income Security Act (ERISA), the federal benefits law that provides the foundation for welfare and retirement plans sponsored by private employers. 2024 is also an election year, with the Biden administration issuing a number of proposed and final regulations to fulfill the remaining pieces of its agenda. The focus this year, however, has been litigation and how court decisions will shape benefit laws in the future after companion cases *Loper Bright Enterprises v. Raimondo* and *Relentless, Inc. v. Dep't of Commerce* (referred to as *Loper Bright* below) overturned the *Chevron* doctrine, which required courts to defer to agency interpretation for ambiguous regulations. Post-*Loper Bright*, we can now expect lawsuits on any future health and welfare regulations and guidance. Some benefit regulations have already been subject to *Loper Bright* challenges, and we expect additional challenges as noted below.

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Action steps are provided after each section to assist in preparation of compliance.

MENTAL HEALTH PARITY

This fall the Departments of Health and Human Services (HHS), Labor (DOL), and the Treasury (collectively, the Departments) issued the final regulations on the Mental Health Parity and Addiction Equity Act (MHPAEA). The regulations codify the non-quantitative treatment limitation (NQTL) comparative analysis requirement, outline the new process to determine parity for NQTLs, and add a new requirement to offer meaningful mental health and substance use disorder benefits in the same classifications in which medical or surgical benefits are offered.

The new NQTL tests include the design and application test, which prohibits plans from imposing an NQTL unless, as written or in operation, the processes, strategies, evidentiary standards, and other factors used to design and apply the NQTL to mental health and substance use disorder benefits are comparable to and are applied no more stringently than the NQTL on medical and/or surgical benefits. Beginning in 2026, plans will be prohibited from using discriminatory factors to design or apply an NQTL, and plans will be required to review relevant data (e.g., denied claims) to reveal whether there is a material difference in access to mental health and substance use disorder benefits as compared to medical or surgical benefits.

The plan must document the review in an NQTL comparative analysis with required content elements. When the plan discovers a material difference in how an NQTL impacts mental health or substance use disorder access as compared to access to medical or surgical benefits, the plan must document the steps taken to correct the difference. The comparative analysis must be provided, upon request from a Secretary of a federal enforcement agency (i.e., the DOL, HHS, or Treasury) or state, within 10 business days.

For ERISA plans, the plan's named fiduciary must certify that they engaged in a prudent process to engage any plan service providers involved in the preparation of the NQTL comparative analysis and should engage the vendor in discussions to understand the plan's MHPAEA compliance. Additionally, the analysis must be provided to participants in ERISA plans, upon written request, within 30 calendar days.

Insurers are primarily responsible for MHPAEA compliance and the NQTL comparative analysis on fully insured plans while self-insured plans should work with their third party administrators (TPAs), pharmacy benefit managers (PBMs), and a qualified service provider to prepare the analysis. This requirement is ongoing, such that a new analysis must be completed when there are changes to the plan's design that impact MHPAEA compliance.

Beginning in 2026, plans must provide "meaningful benefits" for mental health conditions or substance use disorders in all classifications of benefits that medical and/or surgical benefits are provided. Whether a mental health or substance use disorder benefit is "meaningful" is determined by comparing the benefits provided in the same classification of medical and/or surgical benefits. At a minimum, the plan must cover a "core treatment" in the classification, which is a standard treatment indicated by generally recognized independent standards of current medical practice.

It is possible that these rules will be overturned by Congress and reissued in the future after the Trump administration takes over in January. We also expect some provisions of the law to be subject to *Loper Bright* challenges that could impact effective dates.

Mental Health Parity Action Steps:

- Review Gallagher's [Mental Health Parity Toolkit](#).
- Discuss the MHPAEA compliance with your plan's insurer or TPA and PBM.
- Develop a plan to test parity and document an NQTL comparative analysis along with any necessary corrections.
- ERISA plans should also determine the named fiduciary to certify the prudent process taken to choose plan service providers to document the analysis and name a party responsible for responding to participant requests for the NQTL comparative analysis.
- Listen for news of litigation delays.

PRESCRIPTION DRUGS

Oklahoma PBM Regulation and ERISA Preemption

All 50 states have adopted some version of a law regulating PBM operations. While the laws directly impact PBM business practices, they can also have an impact on employer-sponsored plans. For ERISA plans, these laws have raised preemption questions, as ERISA preempts most state laws that attempt to regulate ERISA plans.

In 2020, the U.S. Supreme Court found that Arkansas' PBM law was not preempted by ERISA because the law merely increased the cost of doing business in the state. However, Oklahoma's PBM law goes further by limiting a PBM's (and therefore a plan's) ability to utilize mail order pharmacies and network pharmacy cost sharing reductions. The Pharmaceutical Care Management Association (a PBM trade association) sued Oklahoma in *PCMA v. Mulready* arguing that the law is preempted by ERISA to limit its applicability to its clients (and operations). Although the lower court found that Oklahoma's law was not preempted, the Tenth Circuit Court of Appeals disagreed. Late this year, Oklahoma Insurance Commissioner Mulready filed a writ of certiorari with the U.S. Supreme Court. The Court has yet to respond to the writ but recently requested the U.S. Solicitor General's position on the issue.

PCMA and other PBMs' use of the ERISA preemption clause to limit state law impacts has the potential to narrow preemption protections for ERISA plans which could result in more state regulation and cause more ERISA plans to comply with various state laws, not just those related to PBMs.

Prescription Drugs Carve-Outs Limited

New guidance from the Centers for Medicare and Medicaid Services (CMS) and the Departments clarified their stance that non-grandfathered group health plans must count prescription drug costs toward the plan's out-of-pocket maximum, which means that excluding certain types of drugs from the definition of essential health benefits (EHBs) is non-compliant unless the drug is a benefit mandate rather than on the state's benchmark plan. Beginning in 2025, individual and small fully insured plans, which must cover the full menu of EHBs, must count all covered drugs as EHBs unless the drug is mandated by the state versus part of the state's benchmark plan. The Departments noted that similar regulations would be issued for large fully insured or self-insured plans, which may choose which EHBs to cover. This change would primarily impact

plans that attempt to carve out prescription drugs that treat obesity and patient assistance programs that enable access specialty drugs that treat cancer, arthritis, psoriasis, and hemophilia.

To Count or Not to Count Drug Manufacturer Coupons

Drug manufacturer coupons are regularly used by consumers to lower their out-of-pocket costs at the pharmacy. Guidance from 2021 permitted plan sponsors the choice to count the value of those coupons toward the plan's out-of-pocket maximum. Most plans chose not to count the value of the coupons. As a result, consumer advocacy groups sued, and in 2023, a district court overturned the 2021 guidance and required the coupon's value to accrue toward the out-of-pocket maximum. The Departments announced that they would not enforce the rule and would appeal the decision. The government later dropped the appeal and noted that new regulations would be issued in the future, but we have yet to see that new guidance. This guidance is especially important for high deductible health plans (HDHPs), which cannot count the value of a coupon against the deductible without ruining participants' eligibility to contribute to health savings accounts (HSAs). We are hopeful that upcoming guidance will offer much needed insight.

Medicare Negotiations, Part D, and Creditable Coverage

The Inflation Reduction Act of 2022 (the Act) made substantial changes to Medicare Part D by negotiating high-cost drugs directly with the manufacturers to achieve cost savings for Medicare recipients. The law also capped Part D out-of-pocket costs to \$2,000, along with other cost saving features, beginning in 2025. Plan sponsors experienced an indirect effect from the Act, as it is expected that employer-sponsored group health plans will experience increased prescription drug costs to offset the lost profits from Medicare negotiations. Further, the improvement of Part D coverage caused plan sponsors to have lower cost sharing standards that qualify as creditable coverage, causing some high deductible, high out-of-pocket plans to become non-creditable. While employers are not required to offer creditable coverage, the loss of creditable status impacts Medicare-eligible employees who enroll late into Part D. Find out more about the Part D issue in [Creditable Coverage: A Closer Look](#).

Prescription Drug Action Steps:

- Watch for the PBM litigation to reach the Supreme Court again next year.
- Individual and small group plans should reassess any prescription drug coverage to ensure the costs accrue toward the plan's out-of-pocket costs, unless not included in their benchmark plan.
- Large fully insured and self-insured plans should watch for new guidance on how to treat prescription drugs as an EHB and any potential exceptions.
- Stay tuned for updates on the drug manufacturer coupon issue.
- Communicate with employees and CMS about any changes to prescription drug creditable status.

PREVENTIVE CARE

***Braidwood* and the ACA Preventive Care Mandate**

The Patient Protection and Affordable Care Act (ACA) preventive care mandate is still a main topic of litigation in the 15th year since the law's passage. The preventive care mandate requires non-grandfathered group health plans to cover, without cost sharing, the items and services recommended by

three appointed entities – the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA). In 2022, in *Braidwood Mgmt. Inc. v Becerra*, a Texas court found that the USPSTF was not properly appointed, making all associated recommendations after enactment of ACA unlawful, and issued a nationwide injunction. The Fifth Circuit agreed and remanded to redetermine if ACIP and HRSA were properly appointed, but removed the nationwide injunction, applying the injunction only to the *Braidwood* plaintiffs. HHS Secretary Becerra filed an appeal to the U.S. Supreme Court that has yet to grant certiorari. Assuming the case is accepted by the Court, it's unlikely that the Trump administration will defend this lawsuit, making it possible for at least a portion of the preventive care mandate to be optional if the Supreme Court concurs with the Fifth Circuit.

Over the Counter Contraceptive Care in 2026

The Departments issued proposed regulations that, beginning in 2026, will require non-grandfathered group health plans to provide coverage, without cost sharing, for recommended preventive care contraceptive products available over the counter (OTC) without a prescription (e.g., emergency contraception, male condoms) purchased at in-network pharmacies. The Departments also requested comments on whether coverage without cost sharing should expand to a larger subset of preventive care products. If finalized, this would be the first time plans would be required to cover male contraceptives and OTC products without a prescription.

The Departments also proposed requiring a new approach to preventive care due to the perceived failure of plans to provide ACA-mandated contraceptive coverage. Under the new rule, plans would be required to cover every FDA-approved contraceptive drug or drug-led product without cost sharing unless the plan covers a therapeutic equivalent.

Just days before the Departments issued the proposed regulations, the IRS issued [Notice 2024-75](#), which expanded the list of preventive care items and products that HSA-compatible HDHPs may cover before satisfaction of the plan's minimum deductible to include male condoms and OTC oral contraceptives, and [Notice 2024-71](#), which categorizes male condoms as a medical expense under Section 213(d).

Preventive Care Action Steps:

- Stay tuned for a final decision on *Braidwood*, which is likely to be taken up by the Supreme Court.
- Discuss 2026 OTC contraception rules with your insurer or PBM.

IMPORTANT LITIGATION

***Loper Bright* and the *Chevron* Deference**

The *Loper Bright* decision was not focused on health and welfare benefits, but the decision has and will continue to impact past and future benefit regulations by eliminating *Chevron* deference, which required courts to defer to agency interpretation of guidance. The decision has already had an impact on the Section 1557 regulations and the No Surprises Act arbitration rules. The Texas Attorney General is also using it to try to dismantle the new HIPAA reproductive disclosure rule (discussed below) and the 2000 Privacy Rule.

This legal wrangling is bound to continue, as plaintiffs attempt to vacate or enjoin various pieces of guidance. Since the passage of the ACA, new administrations have gone back and forth on specific issues causing new regulations to be issued each time a new political party takes control. This will be a new wrinkle in the back and forth with one party initiating *Loper Bright* challenges against the other party's guidance.

Health Plan Fiduciary Litigation

When the *Lewandowski v. Johnson & Johnson (J&J)* case hit the media, there was a collective gasp from plan consultants and fiduciaries. Retirement plan fiduciary lawsuits are nothing new, but such lawsuits were uncommon in the welfare sphere where it is rare to have substantial assets like retirement plans do. Now we have our second fiduciary lawsuit pertaining to the selection of PBMs and formularies in *Navarro v. Wells Fargo*. Neither court has ruled on the merits of the cases yet.

The *J&J* case focuses on the selection of a PBM and the formulary prices for certain drugs being higher than the cash price without insurance. An employee sued, arguing that the selection of the PBM and formulary breached the benefit committee's fiduciary duty to engage in a prudent process in the selection of plan service providers and to pay reasonable administrative plan expenses. One of the potential issues with this case is that the plaintiff was not prescribed any of the drugs listed in the complaint. This should make it difficult for the plaintiff to prove an injury and establish standing to sue the plan's fiduciaries. However, the plaintiff recently amended her complaint to argue that her injury is the increased cost sharing and contributions; however, standing in benefit cases typically requires a denied benefit.

The *Wells Fargo* plaintiffs make a similar argument about the fiduciary's selection of the PBM and formulary, but a primary difference is that the plaintiffs in this case have been prescribed the drugs at issue, providing them a better path to standing.

Plan sponsors should ensure that fiduciaries understand their obligations to the plan and participants and how to mitigate risk of a similar lawsuit. For more, see the [ERISA Fiduciary Governance Toolkit](#).

Prescription Drug Rebates and Standing to Sue

The Third Circuit Court of Appeals affirmed the lower court's dismissal of a class action lawsuit against MetLife, as a plan sponsor, in *Knudsen v. MetLife*. The plaintiffs argued that MetLife violated its fiduciary duties by retaining the plan's drug rebates, which resulted in the plaintiffs paying higher cost sharing. While the Court dismissed the fiduciary breach claim, the opinion also potentially opens a broader path to establish standing.

The case confirms that rebates do not have to be shared directly with participants; however, it should be noted that ERISA plans are required to abide by their fiduciary obligations when dealing with rebates. However, it also appears the court is willing to consider a broader standing rule that could make it easier for participants to sue plans, including in the fiduciary cases noted above.

Tobacco Surcharges and Reasonable Alternatives

Another building stream of litigation targets HIPAA health contingent wellness plans, specifically those with tobacco surcharges. The plaintiffs argue that the plan sponsors did not effectively set up or communicate a

reasonable alternative standard that, if met, would require the plan to remove the surcharge on a prospective and retroactive basis. Plan sponsors with HIPAA health contingent wellness programs should ensure that the required notice announcing the availability of reasonable alternative standards appears in all materials that describe the wellness program, that an administrative process is set up to provide that information to participants, and when those alternative standards are met, remove surcharges appropriately. For more, see [New Trend in Litigation Targets Wellness Program Tobacco Surcharges](#).

Litigation Action Steps:

- Understand that current and future regulations are likely to have delayed effective dates due to *Loper Bright* challenges.
- Stay tuned for decisions in the two fiduciary breach cases and take steps to shore up your organization's fiduciary practices.
- Verify HIPAA health contingent programs meet the HIPAA wellness requirements.

OTHER DEVELOPMENTS

HIPAA Reproductive Disclosures

Covered entities may disclose protected health information (PHI) only in specific circumstances, one of which is when the disclosure is required by law. HHS issued new rules this year for disclosures relating to reproductive health care. Effective December 23, 2024, covered entities are prohibited from disclosing highly sensitive PHI for criminal, civil, or administration investigations in connection with seeking or assisting in obtaining reproductive health care where such health care is lawful. Moreover, covered entities must obtain a signed attestation from the entity requesting the PHI potentially related to reproductive health care that the use or disclosure is not for a prohibited purpose. HHS released the [model attestation](#) earlier this year. Plans should amend their HIPAA Privacy policies and add the new form. Plans (especially in the healthcare industry) should consider adding the new rule to annual training for their workforce members. The Texas Attorney General recently filed a lawsuit challenging this rule and the 2000 HIPAA Privacy Rule. Find out more in [HIPAA Final Rule Adds Protections for Reproductive Health Care Information](#).

New Language Taglines

The Departments issued new county-specific data in late 2023 that provides details by zip code on the major non-English languages spoken in those areas. Plan sponsors are required, for plan years beginning on or after January 1, 2025, to use this data to determine which of the nine different language taglines should be added to the plan's summary of benefits and coverage (SBC) and claims and appeal communications. You can find the county data and instructions in our Directions article, [New Language Requirements for Certain Services and Notices under the ACA](#).

Fixed Indemnity Notice

A new notice is required, beginning in 2025, warning participants that fixed indemnity plans are not comprehensive medical coverage. The notice must be included on the front page of enrollment and re-enrollment materials (including websites). When the enrollment materials summarize multiple benefits, the notice may be placed in front of the fixed or hospital indemnity information. Employers subject to ERISA

that rely on the voluntary plan safe harbor to exempt their voluntary benefits from ERISA should discuss the notice with their voluntary benefits insurer. For more, see [Reminder: New Notice for Fixed Indemnity Plans](#).

Section 1557

HHS issued new final regulations (the third iteration) for Section 1557 this year. Section 1557 prohibits discrimination in healthcare by covered entities that receive federal financial assistance from HHS. Section 1557 generally only applies to health care organizations, including insurers and their TPAs, and targets the lack of assistance available in healthcare settings to individuals with disabilities, those in need of language assistance, and transgender individuals. The rules only apply to employer-sponsored health plans when the plan itself receives the federal financial assistance (e.g., employer group waiver plans or retiree drug subsidies). Not long after the rules were issued, attorneys general and providers challenged the rules as exceeding HHS' authority, and the courts agreed, with a nationwide injunction placed on enforcement of the prohibitions on discrimination on the basis of sex as it relates to gender identity. The courts declined to defer to HHS' interpretation invoking *Loper Bright*. For more, see [Section 1557 Suffers Challenges as Agency Deference Dissolves in Loper Bright's Wake](#).

Other Development Action Steps:

- Amend HIPAA policies before the end of the year to incorporate the new disclosure rule and form. This change will result in changes to the plan's notice of privacy practices, which must be disclosed within 60 days of a material change.
- Ensure you are using appropriate language taglines in your SBC and that your group health plan claims administrators are utilizing them in claims and appeal responses.
- Incorporate the fixed indemnity notice into enrollment materials. ERISA plan sponsors should evaluate whether to keep that information separate from the main menu of benefits.
- Healthcare industry employers should stay abreast of the litigation and next steps and continue to comply with the remaining provisions of Section 1557.

WHAT TO EXPECT AS THE YEAR CLOSES

We anticipate the following will be released in the last month of 2024 or early 2025.

- The COVID-era telemedicine rule that allows for free interactions for HDHP participants before satisfying the HDHP minimum deductible will end December 31, 2024 for calendar year plans, unless Congress acts. We hope to see something in the final spending bill.
- We are awaiting guidance on the prescription drug machine readable file technical requirements, identification cards, continuation of care, and network directories. The advanced explanation of benefits and good faith estimate requirements have not been issued. We expect proposed guidance in 2025.
- The No Surprises Act has been subject to ongoing litigation out of Texas from out-of-network providers and air ambulance services. This will continue along with new regulations to replace the ones nullified.
- A national PBM law may be near. The Lower Prices, More Transparency Act passed the House but has stalled since. It would require PBMs to comply with transparency requirements like plans and insurers.
- The Restore Protections for Dialysis Patients Act would prohibit plans from limiting coverage for outpatient dialysis treatments. Initially introduced in late 2023, we may see it in the final spending bill.

ANNUAL PLAN LIMITS

The following is a chart of commonly used health and welfare plan indexed dollar values for 2024. A more in-depth health and welfare chart is included in Gallagher's [Health and Welfare Plan Limits Chart](#) and annually adjusted retirement plan values may be referenced in the [Retirement Plan Limits Chart](#).

Annually Adjusted Figure		2025
Cost Sharing Limits		
HDHP Self-Only Minimum Deductible		\$1,650
HDHP Family Minimum Deductible		\$3,300
HDHP Self-Only Out-of-Pocket Maximum		\$8,300
HDHP Family Out-of-Pocket Maximum		\$16,600
ACA Self-Only Out-of-Pocket Maximum		\$9,200
ACA Family Out-of-Pocket Maximum		\$18,400
Account-Based Plan Limits		
HSA Self-Only Maximum		\$4,300
HSA Family Maximum		\$8,550
HSA Catch-Up (age 55 and over)		\$1,000
Health FSA Maximum Salary Reduction		\$3,300
Health FSA Carryover		\$660
Dependent Care FSA (DCAP)		\$5,000 (\$2,500 married/filing separately)
Employer Shared Responsibility Amounts		
ACA Employer Mandate Affordability Rate		9.02%
FPL Safe Harbor Monthly Limit (Calendar Year Plans)		\$113.20
ACA Employer Mandate Penalty	4980H(a) \$2,900	4980H(b) \$4,350
Transportation		
Mass Transit/Van Pooling		\$325/month
Parking		\$325/month

YEAR-END REMINDERS

This chart includes important considerations for plan sponsors for the next calendar year or plan year.

Amendments	
Plan Documents	Plan documentation should be amended for 2025 changes to be effective at the beginning of the plan or calendar year and those changes should be communicated to employees. Employers subject to ERISA that materially reduce coverage (e.g., increase in copay) must disclose a summary of material reduction (SMR) within 60 days of the decision to amend the plan.
Cafeteria Plans	Adopt formal plan amendments by plan year end if plan sponsor allowed midyear election changes permitting employees to drop medical coverage for family members when that family member is eligible for an open or special enrollment into Marketplace coverage.
Reporting	
Gag Clause Prohibition Compliance Attestation	Group health plan sponsors, insurers, and TPAs are required to attest to compliance with the prohibition on gag clauses. The submission for the 2024 reporting year is due by December 31, 2024.
Creditable Coverage Disclosure to CMS	Plan sponsors that provide prescription drug coverage must disclose the plan's creditable coverage status annually to CMS. Plan sponsors disclose this information on the CMS HIOS platform within 60 days of the first day of the plan year. The disclosure is also required within 30 days after a midyear change in the plan's creditable status or upon plan termination.
Section 6055 and 6056 Reporting	Employers subject to the Employer Mandate and self-insured employers must report offers of coverage to the IRS on Forms 1095-B or 1095-C.
RxDC Reports	Insurers, TPAs, and group health plans must submit the RxDC report for the 2024 calendar year by June 1, 2025. Plan sponsors that change insurers, TPAs, or PBMs should confirm the former service providers will report on behalf of the plan and provide proof of submission. In the absence of their agreement, plan sponsors must report on their own behalf.
PCORI Fee	For plan years ending on or after October 1, 2023 and before October 1, 2024, the fee is \$3.22/covered life. As of the date of publication, the IRS has not yet issued the fee applicable for plan years ending on or after October 1, 2024 and before October 1, 2025.
Administrative	
Group Term Life Imputed Income	Determine the amount of imputed income for employer-provided group term life insurance exceeding \$50,000 and the value of all employer-provided dependent life insurance amounts if valued over \$2,000.

Health Coverage Imputed Income	Verify and update records to calculate imputed income for coverage of any non-federal tax dependents covered by the employer's medical plan, including non-tax dependent domestic partners or civil union partners, or older children. Calculate imputed income for highly compensated individuals or key employees that result from nondiscrimination testing failures.
Transparency	With plan changes, plan sponsors should confirm needed updates to comply with the transparency requirements. Confirm the plan's insurers or TPAs are prepared to issue plan ID cards, will update the network directory, provide continuation of care disclosures, host the plan's price comparison tool, post the plan's machine-readable files, and administer surprise billing processes.
Nondiscrimination	Perform year-end nondiscrimination tests for the 2023 plan year on cafeteria plans, health FSAs, self-insured medical plans, dependent care FSAs (DCAPs), and group term life insurance. Notify highly compensated individuals and/or key employees of any additional taxable income to correct a testing failure. Once 2025 enrollment data is available, consider performing preliminary tests and, if needed, notify highly compensated participants and/or key employees of a potential failure and need to modify their 2025 elections to pass year-end testing.
HIPAA Business Associate Agreements	Verify all business associate agreements are in place and up to date for newly appointed and established health plan service providers.
Vacation/PTO	Calendar year plans should determine the number of days to cash out before year-end.
Plan Design	
Annual Limits	Update non-grandfathered group health plan ACA out-of-pocket maximums, HDHP deductibles and out-of-pocket maximums, health FSA limits, and HSA maximum contributions in plan materials and communicate to participants in a timely manner.
ACA Employer Mandate	The 2025 ACA affordability percentage is 9.02%. Review the employee required contribution for the lowest-cost, minimum value, employee-only option and evaluate the potential for penalties for failure to offer affordable coverage using an IRS affordability safe harbor.
Grandfathered Plans	Plans losing grandfathered status must comply with the ACA market reforms (e.g., preventive care, expanded claim process). Additionally, plans must begin complying with the transparency requirements, as described above.
Preventive Care	Plans must provide coverage for newly recommended items or services with no cost sharing on the first day of the plan year that begins one year after the item or service was added to the list. Non-grandfathered group health plans should verify new preventive care services are provided without cost sharing

in the plan. The following are the new recommended preventive services, for plan years beginning on or after:

- October 31, 2023: child anxiety and depression screenings
- May 31, 2024: latent tuberculosis screenings for adults
- June 30, 2024: adult anxiety and depression screenings
- August 31, 2024: expanded coverage for PrEP and folic acid supplements through pregnancy
- September 30, 2024: hypertensive screenings for pregnant persons

Mental Health Parity	Review and complete, in coordination with the plan's insurer or TPA and PBM, an NQTL comparative analysis on the plan's mental health and substance use disorder benefits. Retain a copy for recordkeeping purposes and be prepared to disclose upon request.
Wellness	Review program incentives, notices, and processes to ensure compliance with applicable regulations. With the continuing lack of EEOC guidance, employers should review their programs to determine what, if any, incentives will be included in the wellness program.

Participant Notices

Certificates of Creditable Coverage	Provides Medicare-eligible employees information about whether the prescription drug plan is creditable (or non-creditable). Plan sponsors must provide annually before October 15 and when a plan design change causes a change to the plan's creditable status midyear. If a plan's creditable status changed due to the 2025 Medicare Part D design, plans should communicate that change.
CHIP Notice	Discloses information about premium assistance available through the Children's Health Insurance Program (CHIP) and Medicaid. Plan sponsors must provide the notice annually.
Patient Protection Notice	Describes a participant's right to designate a primary care provider, or a pediatrician or OB/GYN as a primary care provider, if the plan requires or allows it.
Non-Federal Governmental Plan HIPAA Opt-Out Notice	Informs participants and CMS of the plan's opt-out of the Women's Health and Cancer Rights Act, Newborns and Mothers Health Protection Act, and/or Michelle's Law.
HIPAA Notice of Privacy Practices	Summarizes the plan's privacy and security policies to protect participant's PHI. Plans must disclose a notice of availability every third year; however, most provide it annually. If amendments to a plan's HIPAA policies result in a change to the Notice, the plan must re-disclose the full Notice within 60 days.
Summaries of Benefits and Coverage (SBCs)	Discloses a plan's primary financial provisions (e.g., copays, deductibles). Plan sponsors must disclose SBCs at open enrollment using the appropriate

	template and with updated plan information. Plan sponsors must also disclose at initial and special enrollment and upon request. New language taglines may need to be added this year dependent on employee zip codes.
Women's Health and Cancer Rights Act	Describes the plan's compliance with the law. Plan sponsors must comply with the law and disclose the notice annually by December 31.
Surprise Billing Notice	Describes the restrictions on balance billing for protected services and the rights and responsibilities of plan participants. Plan sponsors must post the notice on the plan's (or employer's) website.
Fixed Indemnity Notice	Informs participants that this coverage is not comprehensive. Model notice should be on the front page of enrollment materials or in front of the fixed or hospital indemnity information.

ADDITIONAL RESOURCES

Gallagher has the information and materials to help you comply with federal laws and regulations affecting employer-sponsored health and welfare plans. [Gallagher's website](#) contains Toolkits covering Mental Health Parity, Transparency, Surprise Billing, Section 6055 and 6056 Reporting, Employer Shared Responsibility Payments, and more. The Toolkits include summary articles, FAQs, charts, timelines, and webinars. We also make our Alerts, Back to Basics webinars, Practically Speaking video series, and Directions newsletters available publicly online.

Gallagher, through its benefits and human resource compliance experts and consultants, will continue to monitor legislative, regulatory, and judicial changes that may impact your health and welfare benefits and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher representative with any questions that you may have.

The intent of this analysis is to provide general information regarding the provisions of current federal laws and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.