Compliance Watch

February 2025 Roundup: ACA Relief, Gender Guidance Reversal & IVF on the Horizon

PROVANT

Hot Topics:

FEBRUARY 2025

In addition to BCS Alerts provided earlier in February discussing executive orders and Arkansas Rule 128, here are other hot topics for employers to be aware of.

ACA Reporting (6055 and 6056) Deadlines

ACA reporting is coming due in March! The 2024 forms and instructions have been out for months. However, new relief previously available to small employers now extends to large employers, allowing them to only provide 1095 forms to individuals upon request starting March 3 as long as they post proper notice to their public website by March 3. All forms must be electronically submitted to the IRS by March 31.

Who this applies to:

- Applicable large employers (ALEs) responsible for 1094-C/1095-C forms whether they sponsor any type of medical plan or not
  - ALEs are typically those with 50+ full-time and equivalent employees, with employers in a controlled group or affiliated service group combining their employee counts
- Small employers who are not ALEs sponsoring level-funded, self-funded, or ICHRA plans, making them responsible for 1094-B/1095-B forms.

Go Deeper:

1095 Statements to Individuals:

1095-B or 1095-C statements must be provided to individuals 30 days after January 31, or March 3 this year. However, if the employer responsible for completing 1095 forms provides proper notice on their public website by March 3 and keeps it there through October 15, then the employer can provide the 1095 form to only those who request it. Guidance states all size employers can take advantage of this in an easy two-step approach.

WHAT'S NEW

ACA 1095 Relief Expanded
All employers can now furnish 1095 forms only upon request.

Gender-Affirming Care Guidance Rescinded
HHS withdraws 2022 guidance as new rules are expected.

RxDC & Medicare Deadlines Approaching
CMS Part D notice due March 3; RxDC due June 1.

IVF Coverage Policy Under Review
Executive order aims to reduce costs and expand access to IVF.

TAKEAWAY

ACA reporting flexibility has broadened, but employers face new deadlines, shifting guidance, and evolving benefit trends.

First, the main public webpage must provide a prominent link to “Tax Information.” A public webpage should be a website former employees can access and would be reasonably expected to visit to find employer contact information.

Then the secondary public webpage that link takes people to must also be accessible to former employees and must include the following content:

- “IMPORTANT HEALTH COVERAGE TAX DOCUMENTS” in all caps
- How a “responsible individual” may request a copy of “Form 1095-B, Health Coverage,” or
- How a “full-time employee” may request a copy of “Form 1095-C, Employer-Provided Health Insurance Offer and Coverage”
- With email address, mailing address, and telephone number

Requests must be honored within 30 days. Individuals can give consent to electronic delivery, and that individual's consent may be relied upon until revoked in writing.

©2025 The Provant Group, LLC. All rights reserved.

Electronic Filing to IRS

As a reminder, starting last year, all 1094/1095 forms must be **filed electronically for all employers** who file 10 or more of various types of information returns combined (i.e., after they add up all the W-2, 1099, 1095, and a few others listed here). This essentially means every employer with an ACA reporting obligation must e-file their forms to the IRS by March 31. An extension can be requested by submitting Form 8809 no later than March 31.

In addition, the penalty for failing to file electronically or for failing to submit accurate or complete forms is increasing to $330 per return or statement (up from $310). This is reduced to $130 if corrected by August 1, or $60 if corrected within 30 days of the original due date. These fees apply separately related to statements due to individuals by March 3 vs. returns due to the IRS by March 31.

Keep in mind that several states (CA, MA, NJ, RI, and D.C.) have additional state filing obligations.

Employers should consider the preparations of such filings, including any state filings, and work with their payroll provider or ACA reporting vendor to complete any applicable filings electronically by the above due dates.

©2025 The Provant Group, LLC. All rights reserved.

Medicare Part D Coverage Disclosures Due March 3rd for Calendar Year Plans

Any sized employer who sponsors a group health plan is required to notify the Center for Medicare and Medicaid Services (CMS) of the plan's Medicare Part D creditable coverage status, generally within 60 days of the plan's renewal and in other circumstances as outlined below.

Who this applies to:

All size employers with any group medical plan, including an ICHRA.

Go Deeper:

This must be done through an online form available on the CMS website. Hard copies are typically not allowed, unless the company has no internet access.

The form is relatively straightforward. The only two questions that require a little work are as follows:

- Estimate how many Medicare-eligible individuals are covered at the start of the plan year, including active employees, retirees, disabled individuals or anyone on COBRA. However, if the employer sponsors a retiree drug subsidy (RDS), any RDS participants should be excluded. If the employer has no employee or spouse enrolled who is age 65+ and is unsure how many might be eligible for Medicare due to disability or ESRD, then zero can be entered.
- The last date a Part D creditability notice was sent to employees.

While this disclosure is typically due within 60 days of the plan's renewal, CMS must be notified earlier (within 30 days) after the group's prescription drug plan's creditability changes or the plan terminates.

Lastly, there is no specific penalty for failure to complete the Disclosure to CMS Form, but ERISA plan fiduciaries will want to ensure operating in compliance with all laws and this is an easy five-minute submission.

©2025 The Provant Group, LLC. All rights reserved.

Next Round of RxDC Submissions Due by Sunday, June 1, 2025

Section 204 of Consolidated Appropriations Act (CAA) requires group health plans and issuers to report detailed prescription drug data, but also requires information related to healthcare spending. The next round of reports for data during the "reference year" 2024 must be submitted directly to CMS by Sunday, June 1, 2025.

Who this applies to:

All size employers sponsoring a group medical plan and prescription drug benefit that is not an ICHRA

Go Deeper:

In order to comply with this requirement, employers must rely heavily on their claims administrators because these service providers possess the required data.

Any gaps in submissions should be addressed by either the employer submitting themselves in the government's HIOS system or engaging with a third-party vendor to assist with coordinating submissions.

Typically, the claims administrator or carrier will facilitate the full reporting but will ask the employer for key information needed two to three months before the June 1 annual deadline.

- They primarily need to know how much the employer paid vs. how much participants paid (including COBRA participants) for the previous calendar year's medical/Rx coverage (even if the plan does not operate on a calendar year).
- If self-funded, the premium "equivalent" for this will be actual fixed costs plus actual claims (choose either incurred claims or paid claims for the calendar year, and stick with that choice every year), less stop loss rebates and pharmacy rebates retained by the plan.

Employer plan sponsors, especially self-funded health plan sponsors, should continue to take necessary steps in order to prepare for the June 1 deadline. Helpful information can be found on CMS's RxDC webpage.

©2025 The Provant Group, LLC. All rights reserved.

Federal Updates:

CHIP Model Notice Updated

The DOL has updated the CHIP model notice as of Jan 31, 2025.

Who this applies to:

All size employers sponsoring any type of medical plan which employees contribute to.

Go Deeper:

An employer is subject to the CHIP annual notice requirement if its group health plan covers participants who reside in a state that provides a premium assistance subsidy, regardless of the employer's location.

A model notice is available in English and Spanish. The notice is updated January 31 and July 31 each year to reflect changes in the phone, email, and website information when states make changes.

Employers sponsoring a group health plan should provide the CHIP notice with other health plan eligibility materials, such as with new hire and annual open enrollment materials or with the summary plan description (SPD).

HHS OCR Rescinds March 2, 2022, Gender Affirming Care Guidance

On February 20, 2025, the Department of Health and Human Services (HHS) Office for Civil Rights (OCR) issued a rescission of the "HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy" issued March 2, 2022. This rescission is effective immediately.

Who this applies to:

Employers of any size sponsoring a medical plan

©2025 The Provant Group, LLC. All rights reserved.

Go Deeper:

The 2022 guidance had stated:

- Restrictions on gender-affirming care "likely violates Section 1557"
- Gender dysphoria might qualify as a disability, so restrictions on gender dysphoria treatment "may…violate Section 504 and Title II of the ADA"
- Disclosure of protected health information (PHI) about gender affirming care is subject to additional restrictions

These provisions are immediately rescinded, largely due to legal challenges that have prevailed and the new administration wanting to move forward with new guidance to be issued in the near future. Executive orders and this rescission have indicated intent to issue rules clarifying §1557 does not consider restrictions on gender dysphoria treatment to be discrimination on the basis of sex, that gender dysphoria is not a disability, and that HIPAA law allows the disclosure of PHI without the individual's express authorization when such disclosure is required by another law and complies with that law's requirements.

However, this notice does not discuss the application of Title VII civil rights protections, and the 11th Circuit did determine last year in Lange v. Houston County, Georgia, that a health plan restricting gender dysphoria treatment was discriminating on the basis of sex.

Employers wanting to impose restrictions on gender dysphoria treatment may want to discuss with counsel while waiting for updated laws or regulations.

©2025 The Provant Group, LLC. All rights reserved.

Executive Order to Expand Access to In Vitro Fertilization

On February 18, 2025, President Trump issued executive order 14216 directing the Assistant to the President for Domestic Policy to provide policy recommendations on improving access to IVF and "aggressively reducing out-of-pocket and health plan costs for IVF treatment."

Who this applies to:

Employers of any size sponsoring a medical plan

Go Deeper:

While the executive order does not facilitate any changes yet, employers may want to consider budgeting for potential future IVF coverage rules. Nothing is known yet about the direction this could take, but some possibilities might include:

- A possible coverage mandate
  - Approximately one quarter of plans offer coverage and often limit to one or two rounds of IVF
  - California recently passed a law mandating large group fully insured plans must cover three rounds of IVF, and fully insured small group carriers must offer IVF coverage for employers who want it, for plan years on/after July 1, 2025
- Diagnosis and treatment of IVF possibly being deemed an essential health benefit (EHB), which would mean:
  - An annual or lifetime dollar limit could not apply
  - In-network cost-sharing would be subject to the in-network out-of-pocket limit
- There may also be considerations for expanding what is reimbursable under flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), and health savings accounts (HSAs). We will be watching for further guidance.

©2025 The Provant Group, LLC. All rights reserved.

Question of the Month:

What is a controlled group for determining Applicable Large Employer (ALE) status?

Many benefits-related regulations apply the controlled group test, including for the applicable large employer determination, MEWA status, COBRA rules and other areas beyond benefits.

As discussed at the start of this newsletter, an applicable large employer (ALE) for a calendar year is an employer who employed (along with members of its controlled group or affiliated service group) an average of at least 50 full-time employees (plus full-time-equivalent employees) on business days during the preceding calendar year.

A controlled group means that all entities who are treated as a single employer under Code § 414(b), (c), (m), or (o) are also treated as a single applicable large employer under the ACA's employer mandate and must be counted together. Note that the employer mandate regulations do not incorporate the separate line of business (SLOB) rules applicable to Code 414(r).

These cross-referenced subsections of Code §414 include all members of—

- a controlled group of corporations (Code §414(b));
- a group of trades or businesses under common control (Code §414(c));
- an affiliated service group (Code §414(m)); and
- certain other arrangements described in regulations (Code §414(o)).

If there is sufficient common ownership, all groups must be treated as a single employer to determine whether or not an employer is actually an ALE when employee counts are combined. If so, 1094-C/1095-C requirements would apply for each of the "ALE members."

Under the parent/subsidiary test (which is the most common) two or more employers would be treated as a single employer if there is a chain of corporations connected through one common parent, the common parent owns at least an 80% interest in one or more of any other corporations in the chain, and at least 80% of each other corporation in the chain is owned by one or more of the other corporations in the chain. For purposes of this test, the 80% ownership interest extends to voting power of stock or to total value of stock.

©2025 The Provant Group, LLC. All rights reserved.

Under the brother/sister test, two or more corporations are in the same brother/sister group if they are controlled (both actual control and effective control) by the same five or fewer persons (or estates or trusts). Control means that those five or fewer individuals own stock possessing 80% or more of the total combined voting power of all classes of stock entitled to vote of each corporation AND more than 50% of the total combined voting power of all classes of stock entitled to vote of each corporation, taking into account the stock ownership of each owner only to the extent that the level of ownership interest is identical with respect to each corporation.

Thus, the brother/sister-controlled group should be of concern where five or fewer shareholders (1) own at least 80% of each corporation and (2) own more than 50% of all corporations, taking into account identical ownership interests with respect to each corporation.

Note that the more subjective affiliated service group rules may also apply with lower percentages.

An employer's **CPA or legal counsel, not their benefits consultant/advisor**, will need to review the Code §414(b), (c), (m), or (o) rules to determine if there is or isn't a controlled group between the companies. And if there is a controlled group, that group is considered a single employer for determining whether or not you are an applicable large employer (ALE) under the ACA.

The IRS provides a high-level educational resource regarding controlled group and affiliated service group rules here: https://www.irs.gov/pub/irs-tege/epchd704.pdf

©2025 The Provant Group, LLC. All rights reserved.