Compliance Watch

January 2025 Roundup: Cyber Rules, Reporting Shifts & Regulatory Pauses

PROVANT

Hot Topics in Recent Alerts:

JANUARY 2025

HHS Proposed Cyber Updates to HIPAA Security Rule

Major updates to confront the barrage of cyber attacks on ePHI and ensure health plans and business associates are taking strong enough measures to protect ePHI and document everything.

President Trump's Executive Actions Affecting Employee Benefits

Froze recent regulations such as the final MHPAEA rule's 2026 requirements and the proposed HIPAA cyber rule above.

Other Hot Topics:

2025 Adjusted Penalty Amounts Released

The Department of Labor (DOL) issued the 2025 annual adjustments to penalties applicable to group health plan benefits. The 2025 amounts are effective for penalties assessed after January 15, 2025 for violations occurring after November 2, 2015.

Applies To:

- All employers with a fully insured, level-funded or self-funded group medical plan or an ICHRA.
- All employers with ERISA health or welfare plans subject to the jurisdiction of the DOL.

Go Deeper:

Following are the revised penalties for 2025 applicable to health benefit plans:

WHAT'S NEW

HIPAA Cyber Rule Proposed
HHS seeks stronger cybersecurity for ePHI and tighter documentation.

Executive Freeze on Benefit Rules
President Trump halts MHPAEA and HIPAA cyber regulations.

ACA Reporting & Penalty Changes
2025 brings new FPL safe harbor, filing rules, and penalties.

Gag Clause Attestation Clarified
New FAQs define employer responsibility for GCPCA submissions.

TAKEAWAY

Regulators push forward on cyber and ACA updates, but executive action delays some key benefit rulemaking for now.

	2024	2025
Form 5500 per day late	$2,670	$2,739
Form M-1 per day late	$1,942	$1,992
Summary of Benefits and Coverage (SBC) per failure	$1,406	$1,443
GINA Violations per person per day	$141	$145
Medicaid/CHIP Disclosures per person per day	$141	$145
DOL Information Request	$190 per day, up to $1,906 per request	$195 per day, up to $1,956 per request

Employers sponsoring group benefits need to be aware of potential penalties for various failures, and make necessary changes to avoid such penalties.

Federal Civil Penalties Inflation Adjustment Act Annual Adjustments for 2025:

https://www.federalregister.gov/d/2024-31602

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2025 Federal Poverty Level Increased Affecting FPL Affordability Safe Harbor

Updated guidelines set the 2025 FPL at $15,650 (up from $15,060 in 2024) for a person living in the mainland US, $17,990 in Hawaii and $19,550 in Alaska.

Applies To: Large employers with a fully insured, level-funded, or self-funded group medical plan or an ICHRA.

Go Deeper:
There are three affordability safe harbors an applicable large employer (ALE) can rely upon to determine whether coverage is "affordable" for an employee. The three safe harbors include:

1. Federal Poverty Level (FPL)
2. Rate of Pay
3. W-2

The FPL safe harbor is the easiest of the three to apply because the employer only has to do one calculation, which, in this case, does not depend on employees' actual wages.

The FPL safe harbor says the employer's lowest cost single plan providing minimum value (MV) is FPL affordable if the employee's portion does not exceed 9.02% (for 2025) of whatever FPL is in effect in any of the 6 months prior to the start of the plan year. Since the new year's FPL is published after January 1 but before February 1, the 2024 FPL must be used for calendar year plans but the new 2025 FPL can be used for all 2025 non-calendar year plans.

- **Calendar Year 2025 Plan:** 2024 FPL ($15,060, $17,310 HI, or $18,810 AK) × 9.02% ÷ 12 = $113.20/mo, or $130.11/mo in Hawaii, or $141.38/mo in Alaska
- **Non-Calendar Year 2025 Plan:** 2025 FPL ($15,650, $17,990 HI, or $19,550 AK) × 9.02% ÷ 12 = $117.63/mo, or $135.22/mo in Hawaii, or $146.95/mo in Alaska

For ALEs who like to know in advance that their coverage is affordable the entire year no matter what employees earn, asking employees to pay no more than the FPL targets above for the lowest-cost single MV plan is a fail-safe way to go.

For ALEs wanting to take advantage of simplified reporting under the "Qualifying Offer Method," one condition is that the offer must be mainland FPL affordable the entire calendar year, so the FPL thresholds for Hawaii and Alaska are too high to be "qualifying offers." As a reminder, a qualifying offer can be reported on the 1095-C using 1A in line 14 and leaving lines 15 and 16 blank those months, which means there is only one row of data to audit later instead of three rows to audit.

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ACA Reporting (6055 and 6056) Deadlines and New Relief for ALEs

The IRS issued final forms and instructions related to ACA reporting requirements (2024 Instructions for Forms 1095/1094-C and 1095/1094-B), which do not reflect new relief for ALEs.

Applies To:

- Applicable Large Employers (ALEs) with a fully insured, level-funded, or self-funded group medical plan or an ICHRA.
- Small employers with a level-funded group medical plan or an ICHRA.

Go Deeper:

According to the instructions, 1095/1094-C and B forms must be filed electronically for all employers who file 10 or more of various types of information returns, including W-2s, 1099s, 1098s and 1095-B or C.

In addition, the penalty for failure to file electronically is increased to $330 per return (up from $310), not to exceed $3,987,000 (up from $3,783,000), for employers who have more than 10 returns.

Thus, most employers need to prepare to file electronically and can no longer file via paper (threshold was 250 but is now 10 total returns).

Deadlines for filing ACA reports with the IRS are as follows:

- Paper filings are due to the IRS by Friday, February 28, 2025.
- Electronic filings are due as of Monday, March 31, 2025.
- 1095-C and B statements must be furnished to individuals by Monday, March 3, 2025, reflecting a permanent automatic extension 30 days after January 31.

Filers can apply for an extension with the IRS by submitting Form 8809 prior to the filing due date.

For non-ALEs with a level-funded group medical plan or an ICHRA, 1095-B forms are not required to be distributed to individuals if the employer posts a notice on their public website with specific instructions how to request the form and then provides the form within 30 days of request. However, employers must still populate these forms and file them with the IRS. Note, ALEs now qualify for this same relief with respect to 1095-C forms.

Keep in mind that several states (CA, MA, NJ, RI, D.C.) have additional state filing obligations with their own deadlines and requirements to distribute forms to individuals.

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ACA FAQs Part 69 Address the No Surprises Act and the Gag Clause Prohibition Compliance Attestation (GCPCA)

Regulators have a long list of FAQs addressing numerous aspects of the Affordable Care Act (ACA) and related legislation like the Consolidated Appropriations Act of 2021 (CAA-21). FAQ Part 69 provides clarifying guidance on two major CAA-21 provisions: five new Q&As for the No Surprises Act and four new Q&As for the Gag Clause Prohibition and Compliance Attestation (GCPCA).

Applies To: All employers with a fully insured, level-funded, or self-funded group medical plan (but not ICHRAs)

Go Deeper:

The five new Q&As addressing the No Surprises Act provide guidance to insurance carriers and third-party administrators (TPAs) on various aspects of making calculations, providing disclosures, opening a negotiation period and requesting an independent dispute resolution. IRS Notice 2025-12 also provides indexing to use in calculating 2025 Qualifying Payment Amounts (QPA) under the No Surprises Act. Most employers have their carrier or TPA handle all aspects of the No Surprises Act and will therefore be relying on them to comply with the updated guidance.

However, the GCPCA has a more symbiotic relationship between the employer and carrier/TPA, so employers may want to read through those Q&As which:

- Address how downstream agreements between the carrier/TPA and a provider or network cannot impose prohibited gag clauses.
- Provide additional examples of prohibited gag clauses.
- Require the entity responsible for submitting the annual GCPCA to submit the attestation even if there is a known prohibited gag clause. It should be notated in a special text box labeled “Additional Information” in step 3.
    - Insurance carriers are responsible for the GCPCA with respect to fully insured health plans.
    - Employers are responsible for the level-funded/self-funded medical plans they sponsor. To the extent an employer enters into a written agreement for the carrier/TPA to submit the attestation on their behalf and they are aware of a prohibited gag clause, the employer must verify the carrier/TPA includes information about the prohibited gag clause in the submitted attestation.

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Regulators Withdraw Proposed Rule on Enhancing Preventive Care Mandates

In late October 2024, regulators proposed to require health plans to expand mandatory contraceptive coverage and to ensure an exceptions process for any preventive care mandate which a person's attending provider deems necessary to cover differently than the plan approves. This rule is effectively withdrawn.

Applies To: All employers with a fully insured, level-funded, or self-funded group medical plan (but not ICHRAs).

Go Deeper:

The proposed rule would have required four things:

1. Plans "that utilize reasonable medical management techniques with respect to any recommended preventive services [would have] to provide an easily accessible, transparent, and sufficiently expedient exceptions process that allows an individual to receive coverage without cost sharing for the preventive service according to the frequency, method, treatment, or setting that is medically necessary for them, as determined by the individual's attending provider."
2. "Cover certain recommended over-the-counter contraceptive items without requiring a prescription and without imposing cost-sharing requirements."
3. "Cover certain recommended contraceptive items that are drugs and drug-led combination products without imposing cost-sharing requirements, unless a therapeutic equivalent of the drug or drug-led combination product is covered without cost sharing."
4. "Provide a disclosure pertaining to coverage and cost-sharing requirements for recommended over-the-counter contraceptive items in plans' and issuers' Transparency in Coverage internet-based self-service tools or, if requested by the individual, on paper."

Regulators have announced they are withdrawing the proposed rule at this time.

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Reminders:

Medicare Part D Coverage Disclosures Due January 31 or February 28 for Calendar Year Plans

Any sized employer who sponsors a group health plan is required to notify CMS of the plan's Medicare Part D creditable coverage status.

Applies To: All employers with a fully insured, level-funded, or self-funded group medical plan or an ICHRA

Go Deeper:

Disclosure 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, but the employer needs to determine whether the prescription drug plan covers any Medicare-eligible individuals at the start of the plan year, including active employees, retirees, disabled individuals or anyone on COBRA. However, if the employer sponsors a Medicare retiree drug subsidy, participants of that plan should be excluded.

Employers may not be able to give an exact number of Part D eligible individuals, but should instead estimate the number of covered Part D eligible individuals described above.

The disclosure to CMS must be submitted annually within 60 days from the start of the plan year, or within 30 days if creditable status has changed for one or more plan options (or if all prescription drug plans have terminated). Thus, for plans that begin on January 1, the deadline to submit the CMS disclosure is either February 28, 2025, or January 31, 2025.

Lastly, there is no specific penalty for failure to complete the disclosure to CMS, but this filing requirement is one of the easiest and on average takes less than five minutes.

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W-2 Aggregate Cost of Coverage

If an employer filed more than 250 W-2 forms during the prior year, the aggregate cost of coverage must be included in box 12 of each employees' W-2.

Applies To: Large employers with a fully-insured, level-funded, or self-funded group medical plan (but not an ICHRA), who filed more than 250 Forms W-2 the prior year.

Go Deeper:

Specifically, the requirement to report is based on how many W-2 forms were filed under each EIN for the previous calendar year.

For example, if an employer filed more than 250 2023 W-2s under one EIN in early 2024, then they must report the aggregate cost of coverage for 2024 on 2024 W-2 forms issued in early 2025. In contrast, if the company has separate EINs and each EIN filed less than 250 W-2s in 2024, this requirement would not apply.

The total cost of coverage includes both the employee and employer contributions of the employer-sponsored group health coverage. This would also include any prescription drug coverage or dental or vision coverage that is combined with medical coverage.

The total cost of coverage does not include any standalone dental or vision plans, group life or disability coverage, individual worksite products, health FSA elections, HRA benefits, HSA contributions nor long-term care. However, in some cases, an EAP, indemnity plan, on-site clinic or wellness benefit may need to be included in the reportable amount.

Note this information reported on the W-2 is informational only and does not affect taxable income or any other amount reported in other boxes on employees' W-2s. However, if an employer fails to report this information or includes incorrect amounts, then amended W-2 forms must be filed with the IRS.

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Question of the Month:

If an employee discovered an election mistake shortly after our new plan year began, should we allow them to fix their mistake?

Employers should hold pretty firmly to communicating that all election decisions at hire and during annual open enrollment **are final** so employees must review their election confirmation statements for accuracy before all deadlines close. Ensuring clear, firm instructions and deadlines with easy-to-understand enrollment systems and easy to review benefit confirmation statements should mitigate the possibility of mistakes. It can also help ensure all enrollment terminology is clear. For example, if people are confused by the name "dependent care FSA" then consider calling it a "daycare FSA" to make it very clear it is not a separate health FSA for your dependents' health care expenses (we see this specific confusion MANY times a year EVERY year). Approach terminology from the perspective of a very young employee new to insurance or an employee for whom English is not their strongest language.

Once the new plan year begins, cafeteria plan pre-tax rules dictate that elections are locked for the plan year, and the only way to make a change during the plan year is to experience a qualifying event. However, there is informal guidance allowing for exceptions when a **clear and convincing mistake is documented**. So, in the event someone does not discover an error until the new plan year has begun, the employer (if interested in hearing and considering the employees reasoning) can do some due diligence to discover all the facts and circumstances behind the mistake to identify what happened and whether anything can be improved upon to prevent it from happening to others. Some considerations include:

- Was the enrollment system glitchy or not easy for the average person to follow?
- Was there a language, disability or technology barrier to using the enrollment system?
- How many times has this employee used this enrollment system in the past without error?
- Is there a log of them entering the system to make their elections?
- Is there evidence their benefit election confirmation statement went to spam rather than their inbox?
- Is there evidence the employee has always enrolled a certain way and the current setup is a deviation from the norm without explanation (e.g., they have always covered their whole family but now only the employee has coverage and there is no reason explaining why that would have changed)?
- Is there evidence supporting the employee never would have elected what they did (e.g., they would not have elected the daycare FSA because their spouse does not work or attend school full-time, or their children are not in daycare and will not go to summer day camp or are all over age 13, or the employee does not even have children)?

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If the employer can sufficiently document a clear and convincing mistake, they can unwind the mistake as if it never happened. However, this needs to be done as early in the plan year as possible. To that end, it may be worthwhile to remind employees to check their first paycheck deductions of the new plan year and their benefit elections with carrier or TPAs/vendor websites for accuracy to ensure things are addressed early, not months later when someone first goes to the doctor. The further away from the start of the plan year the error is discovered, the more difficult it will be to justify an exception to correct someone's mistake.

Of course, the employer can always hold firm to what they communicated during open enrollment: employees must verify benefits confirmation statements for accuracy before open enrollment closes, as no changes are allowed beyond the open enrollment. Just be sure enrollment systems, terminology and confirmation statements are clear as possible so there cannot be misunderstandings or mistakes by the average person when you want to hold firm to those deadlines.

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