BENEFITS LEADER

Your Guide to Health & Welfare Compliance

2024

QUARTER 1

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UPDATE ON PENALTIES AND ENFORCEMENT

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Each year in mid-January, the Department of Labor adjusts ERISA penalty amounts to account for inflation. This year's increases are modest, amounting to approximately 3%. The quick-reference chart below summarizes selected penalty amounts that may be imposed against plan sponsors for various federal law violations, including the recently adjusted ERISA penalties and others. The adjusted amounts apply to ERISA violations that occured after November 2, 2015, if penalties are assessed after January 15, 2024, and before January 16, 2025. A fact sheet detailing the most recent adjustments can be found on the DOL website: https://bit.ly/EBSA2024Penalties.

QUICK-REFERENCE FOR WELFARE PLAN PENALTIES

PLAN DOCUMENTS & SPDS	Most violations - $100 to $110/day per affected participant Failure to provide SPD or SMM when requested by DOL - **$190** per day, up to **$1,906** maximum per violation
REQUIRED NOTICES	SBC - **$1,406** per willful failure to provide to participants CHIPRA - **$141**/day for failure to provide notice COBRA - $100 to $110/day per affected person
GINA	**$141**/day per affected person
FORM 5500 REPORTING	Up to **$2,670**/day per plan for failure to file $110/day per affected person for failure to distribute SAR
MEDICARE SECONDARY PAYER (MSP) RULES	**$11,162** per violation

*Note: Figures in **bold** are subject to annual adjustment*

Below are the current inflation-adjusted penalty amounts for failure to file forms 1094 and 1095 with the IRS and failure to provide form 1095 to applicable employees. Both penalties increase to $630 per form if failure is due to "intentional disregard" (criminal penalties may also apply). Please note figures in **bold** are subject to annual adjustment.

FAILURE TO FURNISH

$60 per form if provided up to 30 days late

$120 per form if provided from 31 days late through August 1

$310 per form if not provided by August 1

FAILURE TO FILE

$60 per form if filed up to 30 days late

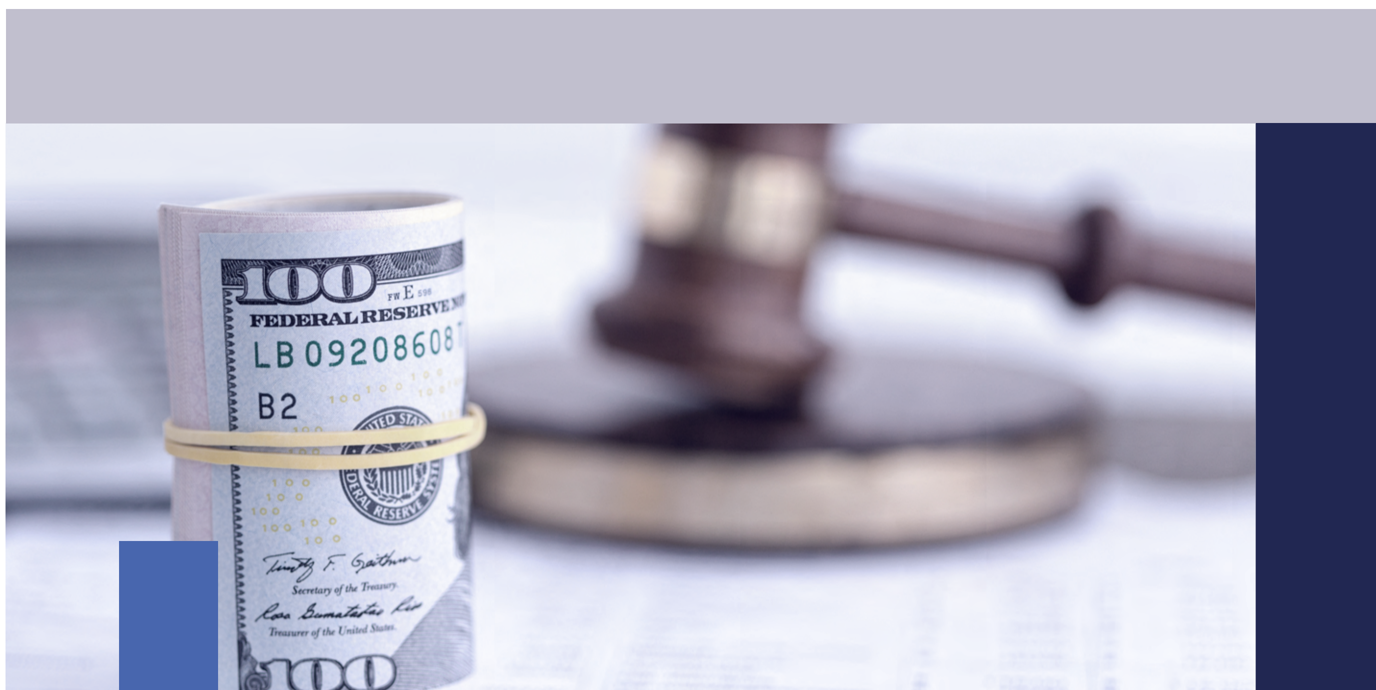
$120 per form if filed from 31 days late through August 1

$310 per form if not filed by August 1

Below are the current inflation-adjusted penalties for HIPAA Privacy and Security rule violations (Note: Figures in **bold** are subject to annual adjustment).

TIER 1	TIER 2	TIER 3	TIER 4
CIVIL PENALTIES	CIVIL PENALTIES	CIVIL PENALTIES	CIVIL PENALTIES
Lack of Knowledge ***$137 - $68,928*** *per violation*	Reasonable Cause ***$1,379 - $68,928*** *per violation*	Willful Neglect (corrected within 30 days) ***$13,785 - $68,928*** *per violation*	Willful Neglect (not corrected within 30 days) ***$68,928 - $2,067,813*** *per violation*
CRIMINAL PENALTIES	CRIMINAL PENALTIES	CRIMINAL PENALTIES	
Reasonable Cause or No Knowledge of Violation *Up to 1 year imprisonment*	**PHI Obtained Under False Pretenses** *Up to 5 years imprisonment*	**PHI Obtained for Personal Gain or with Malicious Intent** *Up to 10 years imprisonment*	

Note: There is a **$2,067,813** calendar-year cap for multiple violations of the same provision. Monetary penalties may also apply under criminal penalties.



HELPFUL RESOURCES & LINKS

1. DOL/EBSA Fact Sheets & Enforcement Statistics
2. EBSA Enforcement Manual
3. HHS "Wall of Shame" for HIPAA Violations

JOHNSON & JOHNSON CLASS ACTION: WHAT BROKERS NEED TO KNOW

A Class Action Complaint was filed against Johnson & Johnson on February 5, 2024, in the United States District Court for New Jersey. This legal action brings to light issues concerning the company's management of its Welfare Plan, specifically related to its pharmacy benefits. For brokers navigating the complexities of healthcare plans and fiduciary responsibilities, it's important to understand the nuances of this complaint.

BREACH OF FIDUCIARY DUTY

At the heart of the complaint is an allegation of a breach of fiduciary duty by Johnson & Johnson in managing their pharmacy benefit. The complaint asserts that Johnson & Johnson failed in their duty of prudence, a requirement under 29 U.S.C. §1104(a)(1)(B), which requires fiduciaries of group health plans to act with "care, skill, prudence, and diligence under circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims." Specifically, the complaint suggests that Johnson & Johnson neglected to adequately monitor their Pharmacy Benefit Manager (PBM), Express Scripts (owned by Cigna Corp since 2018).

TRADITIONAL PHARMACY BENEFIT MANAGERS (PBMS)

The complaint alleges that traditional PBMS make their money in four ways:

1. Negotiated rates with pharmacies for prescription drugs.
2. Contracted rates with group health plans, often known as the "spread" when referring to the Average Wholesale Price.
3. Direct dispensing of medication through their own prescription order services.
4. Receipt of rebates from drug manufacturers for inclusion on their formulary.

ALLEGATIONS AND CONCERNS

This case appeared similar to many COBRA class actions, with a Qualifying Beneficiary going to an attorney for HR issues such as termination due to discrimination not specific to an individual who was on FMLA and issue with reasonable accommodation, and lawyer now claiming she is a "whistleblower" in this class action. This case revolves around a generic medication she was taking, Teriflunomide (brand name Aubagio), to treat multiple sclerosis. Without insurance, it is available at Walgreens for $40.55, ShopRite for $41.05, and Walmart for $76.41. However, the contract between Johnson & Johnson and Express Scripts shockingly indicated a reimbursement amount of $10,239.69, far exceeding the retail prices of the medication, suggesting a significant discrepancy.

Allegations also include filling prescriptions through their own mail-order pharmacy, which is more expensive than potentially filling at a pharmacy. However, the participant is deceived because the co-payments are different. Additionally, the complaint raises concerns about the lack of transparency regarding rebates received by PBMs from drug manufacturers, which are often not shared with the group health plans.

IMPLICATIONS FOR BROKERS

Brokers, who play a pivotal role in connecting employers with healthcare benefits, are not exempt from scrutiny in this case. Allegations of receiving "kickbacks" from PBMs raise concerns about conflicts of interest. Brokers could get $1.00 to $5.00 per RX filled, and allegations say one broker took $6.50 and had it sent to a P.O. Box in a different state. These instances further underscore the need for transparency and ethical conduct in the brokerage industry. AON, a prominent broker, is mentioned explicitly in the complaint.

PASS-THROUGH PBMS

An alternative model, known as Pass-Through PBMs, is highlighted as a potential solution to mitigate costs. Unlike traditional PBMs, Pass-Through PBMs charge the actual cost of prescriptions filled at pharmacies and a service charge. Companies like DuPont have embraced this model, leading to cost reductions for their plans.

GET STARTED ON THE MEDCOM BRIDGE!

Our Bridge platform is a streamlined communication platform, one part hub for secure compliance documents and marketing materials.

What you get with the Medcom Bridge:

- Real-time updates & 24/7 access to all Medcom compliance services
- Compliance checklist
- Place orders, get quotes, & generate proposals
- Tracking & communication tools to stay updated on all current compliance projects
- Book appointments with a Compliance Account Manager
- Secure document vault
- Auto-renew feature for annual services
- Run personalized reports
- ...and more!

We also recently added our consumer-driven health plan implementation process to the Bridge. Plus quickly and seamlessly request proposals for our COBRA services.

Contact us at bridge@medcombenefits.com to schedule a Bridge demo with your team and get your personalized log-in.

DOCUMENTATION AND REMEDIES SOUGHT

The complaint meticulously documents industry practices and precedents, aiming to hold Johnson & Johnson accountable for alleged breaches of fiduciary duty. Remedies sought include enjoining against further ERISA violations (also failed to provide plan documents upon request), making amends for plan losses from breach of fiduciary duties, awarding actual damages, and removing fiduciaries involved in the alleged misconduct.

CONCLUSION

The Class Action Complaint against Johnson & Johnson serves as a wake-up call for brokers and stakeholders in the healthcare industry. It highlights the importance of fiduciary responsibility, transparency, and ethical conduct in managing welfare plans. As the legal process unfolds, the healthcare landscape may undergo significant transformations, prompting brokers to adapt to new standards and practices. In summary, it remains imperative for brokers to stay informed and uphold the highest standards of integrity in serving their clients and plan participants alike.

MEMORANDUM OF LAW: COBRA RETIREES

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Senior Legal Counsel

Question Presented

When an employer offers retiree benefits and the retiree refuses the benefits offered under the retiree plan when first eligible, is the employer also obligated to offer COBRA under the Group Health Plan under which the employee had been covered up to the date of retirement?

Answer

Yes, unless there is no interruption in benefits for the retiree, and the retiree is not required to take any affirmative action for benefits to continue.

Facts

Employer offers group health care coverage to employees. Upon retirement, an employee has the option to elect or waive retiree coverage. The employee cost for the retiree coverage is more than the employee would pay for the group health plan prior to retirement. The employee must sign an election/waiver form, which also outlines the increased cost.

LEGAL ANALYSIS

The Department of Labor (DOL) provides a good explanation of what needs to be done under The Consolidated Omnibus Budget Reconciliation Act (COBRA). The DOL states that "COBRA requires employers with 20 or more employees who offer group health coverage, to offer continuation coverage to covered employees, former employees, spouses, former spouses, and dependent children when group health coverage would otherwise be lost due to certain specific events known as qualifying events." Qualifying events include the death of a covered employee, termination, or reduction in the hours of a covered employee's employment for reasons other than gross misconduct, a covered employee becoming entitled to Medicare, divorce or legal separation of a covered employee and spouse, and a child's loss of dependent status (and therefore coverage) under the plan. COBRA sets rules for how and when continuation coverage must be offered and provided, how employees and their families may elect continuation coverage, and what circumstances justify terminating continuation coverage.

The Department of Labor also emphasizes that "health coverage is one of the most important benefits that employers can provide for their employees. Employers that sponsor group health plans enable their employees and their families to take care of their essential medical needs, ensuring that they can devote their energies to productive work. Because of the critical importance of good health, employer-sponsored group health plans benefit employees, employers, and society as a whole." In fact, the Affordable Care Act now mandates that applicable large employers with fifty or more full-time employees (including full-time equivalents) must offer minimum essential coverage to their full-time employees which also meets a minimum actuarial value and is affordable. Failure to offer such coverage can lead to sizable penalties.

The question arose as to whether COBRA must be offered when a retiree who is entitled to continuation of health care benefits under a retiree plan waives the retiree coverage. Since there is no specific mention in the COBRA laws that addresses this exact scenario, we must turn our focus to the Courts and how they have interpreted COBRA when it comes to retirees. In the seminal case of Mansfield v. Chicago Park Dist. Group Plan, 997 F. Supp.1053, U.S. Dist. Lexis 3590, (1998), the United States District Court for the Northern District of Illinois, Eastern Division

concluded that COBRA must also be offered to retirees. In this case, the Chicago Park Dist. Group Plan (Park) argued that Mansfield did not have a qualifying event as he could have continued to elect coverage under the Park's retiree benefit plan. More specifically, Park argued that Mansfield lost coverage only because he voluntarily canceled the benefits. Id. at 1056. Mansfield argued that retirement was a qualifying event and that Park should have provided a COBRA notice "whether the retiree has some option under the retiree plan or not." See id.

The Court, recognizing that this was a case of first impression, first looked at the congressional intent of COBRA. The Court concluded that the congressional intent was clear and that "Congress enacted COBRA primarily to 'provide continued access to affordable private health insurance for many Americans.'" Id. at 1058 quoting H.R. Rep. No 99-241, at 44. The Court then concluded that "in light of this statutory scheme and legislative intent, it follows logically that if a retiring employee automatically continues to receive the same medical coverage he or she has had before retirement no qualifying event occurs." See id. The Court then went on to say that "a qualifying event would take place if the employer required the retiring employee to take some affirmative step to obtain continued health care coverage." See id.

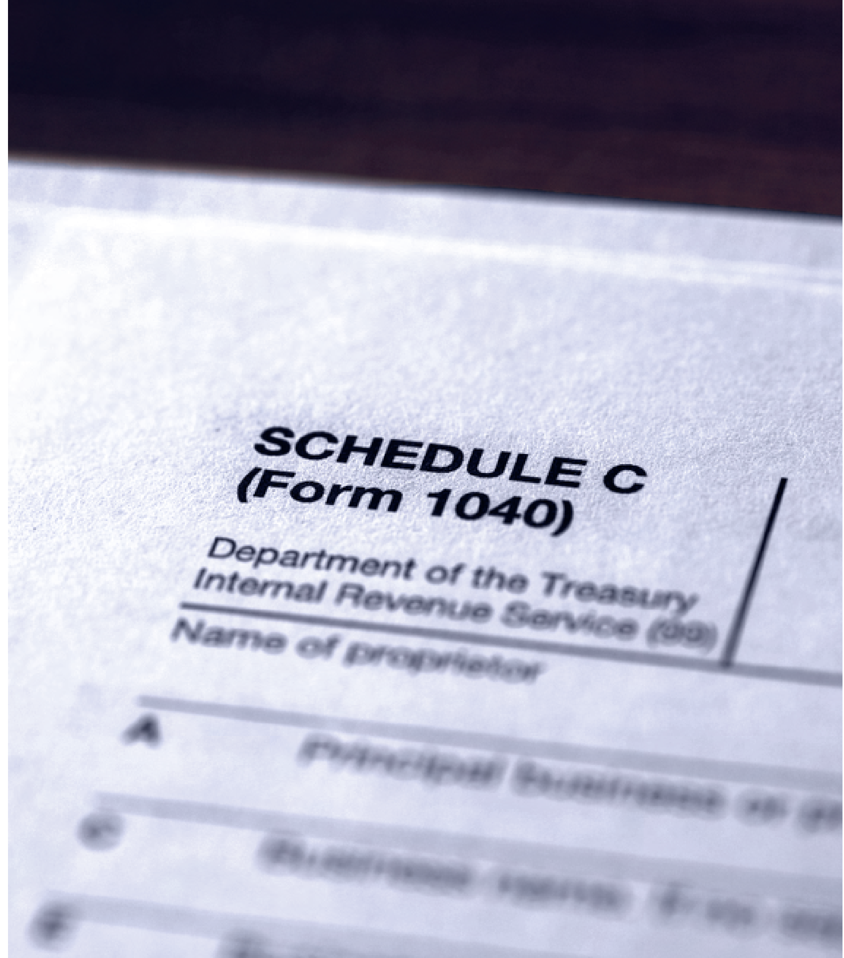
CONCLUSION

Therefore, the employer must provide a COBRA notice to retirees who lose health benefits even if they are offered retiree benefits and given an option to elect. Unless the health coverage is continuous and requires no action on the part of the employee, a COBRA notice should be given. With fines of up to $110.00 per day for late notices, employers should be mindful that any affirmative action on the part of a retiree to choose or decline retiree benefits would trigger a qualifying event and COBRA should be offered.

FORM 5500 REPORTING: SCHEDULE A VS. SCHEDULE C

Meagan Hendrix, Managing Senior Advisor, Health and Welfare Compliance

When filing Form 5500 for employee benefit plans, it's important to understand the differences between Schedule A and Schedule C. These schedules gather different types of information about insurance and service providers, giving insights into how the plan is managed and if it follows the rules.



SCHEDULE A: INSURANCE DETAILS

Schedule A is where you list all the insurance information for the benefit plan, covering things like group health, life, and disability insurance. You'll share important information like how much you pay for premiums, the terms of your policies, and any commissions paid to insurance agents. Schedule A helps you see clearly what insurance the plan has and how money is spent with insurance companies.

SCHEDULE C: SERVICE PROVIDERS

Schedule C is about the people and companies that provide services for the plan. It details service providers who received over $5,000 during the year. This includes consultants, investment managers, lawyers, and accountants. By listing who got paid and how much, Schedule C helps you understand who's working for the plan and how they're paid. It also helps spot potential conflicts of interest and ensures everyone knows about the fees involved.

USING SCHEDULE A AND SCHEDULE C

Both Schedule A and Schedule C are essential for Form 5500 reporting, but they focus on different things. Plan administrators must fill them out carefully to show exactly what insurance the plan has and who's providing the services. This transparency helps everyone involved trust that the plan is managed well and follows the rules, which is crucial for the people who benefit from the plan.

In short, knowing the differences between Schedule A and Schedule C is key for anyone involved in managing employee benefit plans. These schedules give important details that help make good decisions and follow the rules. As regulations change, it's important to keep up with Form 5500 requirements and understand how Schedule A and Schedule C fit into the big picture.

UPCOMING DEADLINES

APRIL 1

1094-B, 1095- B, 1094-C, AND 1095-C FORMS DUE

- ALEs and Employers with self-funded plans must report offer and coverage information to the IRS as required under §§6055 and 6056. *Note: When reporting for the 2023 calendar year, employers with 10+ forms must report electronically (previously, employers filing <250 forms could file by mail).*

APRIL 15

LAST DAY FOR 2023 HSA CONTRIBUTIONS/CORRECTIONS

- Employers and individuals have until the tax filing deadline to make HSA contributions and corrections for a given calendar year.

JUNE 1

RXDC REPORTING

- Due date for reporting data for the 2023 calendar year.

JULY 28

LAST DAY TO ISSUE SMM FOR THE PRIOR PLAN YEAR (CALENDAR YEAR PLANS*)

- ERISA requires that a Summary of Material Modification (SMM) be issued any time there is a change in a plan provision that is "material" (but not a reduction) or any time there is a change in a plan provision that is required to be in the Summary Plan Description (SPD). The due date is 210 after the end of the plan year to which the change applies. *Note: For a material reduction, an SMM is required within 60 days of the adoption of the change.*

JULY 31

PCORI FEE AND 5500 FILING DEADLINE (FOR CALENDAR YEAR PLANS*)

- Patient-Centered Outcomes Research Institute (PCORI) fee is due for policy or plan years that ended in 2023.
- Employers must file 5500s for plans with at least 100 participants (i.e., employees) at the start of the plan year. In addition, employers with plans that have fewer than 100 participants must file a 5500 if the plan is "funded" (i.e., the plan's assets are segregated from the general assets of the plan sponsor through a trust).

CONSUMER DRIVEN HEALTH PLANS

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GOVERNMENT HEALTHCARE PROGRAMS

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