LILLIS MCKIBBEN BONGIOVANNI & CO.
305 WEST 6TH STREET
ERIE, PENNSYLVANIA 16507
(814) 452-4085
http://www.lmbcoerie.com

Compliance Recap | February 2025

March 5, 2025

The federal government in 2025 is experiencing significant internal restructuring, workforce reductions, and communication restrictions across various departments. The results from the Departments of Labor and Health and Human Services investigations into Mental Health Parity and Addiction Equity Act (MHPAEA) enforcement have been shared. The IRS has eased regulations surrounding ACA reporting, Centers for Medicare & Medicaid Services (CMS) online disclosures come due, and President Trump signs an executive order on price transparency.

Results of Agency Enforcement of MHPAEA Investigations

The U.S. Departments of Labor (DOL) and Health and Human Services (HHS) recently released their latest enforcement findings on the Mental Health Parity and Addiction Equity Act (MHPAEA), covering investigations completed during the 2023-2024 fiscal year. Their report sheds light on key areas of noncompliance and emphasizes the government's ongoing commitment to ensuring mental health and substance use disorder benefits are on equal footing with medical and surgical coverage.

Scope of Enforcement

MHPAEA investigations are often complex and lengthy, particularly when large service providers are involved. Over the past year, the DOL and HHS reviewed 56 plans, identifying 33 violations. These infractions were split between financial/quantitative treatment limitations (such as copays and deductibles) and nonquantitative treatment limitations (such as prior authorization policies and benefit exclusions).

Key Findings

The violations included:

Quantitative Treatment Limitation Violations

- Applying 30% coinsurance for outpatient mental health and substance use disorder services but failing to apply the same requirement to substantially all medical or surgical benefits.

- Visit limits on other autism spectrum disorders (ASD) related services.
- Impermissible higher copays for mental health and substance use disorder office visits, when compared to medical/surgical office visits.
- Failure to conduct an analysis of the predominant copay that applied to substantially all medical/surgical benefits (a requirement for the QTLs).
- Imposing a higher specialist copy on all mental health and substance use disorder outpatient services when the lower, regular office visit copay should have applied.

Non-quantitative Treatment Limit Violations

- Excluding applied behavior analysis (ABA) therapy, which is used to treat ASD.
- A blanket precertification requirement to all mental health and substance use disorder services, with no similar requirement for medical/surgical services.
- Requiring that drugs to treat mental health conditions must be prescribed by a psychiatrist or neurologist or else be subject to 50% coinsurance, with no similar requirement for drugs used to treat medical/surgical conditions.
- Imposing a six-month limit on ABA prior authorizations (thus requiring a new authorization every six months) when there was no such limitation for medical/surgical benefits.
- Excluding methadone treatment for opioid use disorder when there was no comparable exclusion for a medical/surgical medication treatment.
- Imposing factors that were not comparable for determining whether to cover a drug to treat mental health and substance use disorders versus those to treat medical/surgical conditions and applying those factors more stringently to the mental health/substance use disorder treatments.

Employer Considerations

The report highlights that DOL investigations can be triggered by complaints from individuals, including mental health providers. When violations are found, the Departments often require insurers or third-party administrators to correct the issue across their entire portfolio of plans—not just the one under review.

For employers, this serves as a strong reminder to proactively assess their health plans for compliance with MHPAEA standards. Partnering with providers to address any potential disparities can help ensure fair coverage and avoid regulatory scrutiny.

IRS Introduces Alternative Reporting Method for Health Coverage Statements

On February 24, 2025, the Internal Revenue Service (IRS) released guidance on an alternative method for providing health insurance coverage statements under the Affordable Care Act. This update allows insurers and applicable large employers (ALEs)—those with 50 or more full-time employees—to meet reporting obligations by making statements available online rather than distributing them automatically to individuals.

Traditionally, organizations that provide minimum essential coverage must report coverage details to the IRS and furnish statements to individuals. However, following amendments under the Paperwork Burden Reduction Act, entities now have the option to post a clear and easily accessible notice on their websites, informing individuals that they may request a copy of their statement.

Key requirements:

- The notice must be posted by the original furnishing deadline, including any automatic 30-day extension, and must remain accessible until October 15 of the following year.
- If an individual requests a statement, the reporting entity must provide it within 30 days or by January 31 of the following year, whichever is later.

Employer Considerations

- For statements covering the 2024 calendar year, the required online notice must be posted by March 3, 2025.
- Electronic delivery is permitted for minimum essential coverage providers and for ALEs.
- The alternative furnishing method applies regardless of whether the individual shared responsibility payment (penalty for lacking coverage) under IRC 5000A is zero.
- The method is valid for statements required under both IRC 6055 and IRC 6056.
- Forms 1095-B and 1095-C, used for reporting health coverage, can be provided using this alternative approach.

This streamlined reporting option, effective for statements related to tax years after 2023, aims to reduce administrative burdens while ensuring individuals can access their health coverage information as needed. Employers and insurers should review their compliance strategies to align with these updated requirements.

Medicare Part D Disclosure for Plan Sponsors

Employers offering prescription drug coverage through a group health plan must meet annual disclosure requirements for Medicare Part D. For calendar year plans, this includes submitting a disclosure to the Centers for Medicare & Medicaid Services (CMS) by March 1 each year. CMS has provided instructions for completing the online disclosure.

Failing to meet this deadline can result in compliance risks, such as:

- Loss of eligibility for the Medicare retiree drug subsidy
- Potential ERISA fiduciary responsibility claims
- Late enrollment penalties for Medicare-eligible employees

When completing the disclosure, employers will need to provide:

- Company name and EIN
- Address and contact information
- Coverage type and number of prescription drug options
- Plan year details and end date
- Number of Medicare Part D-eligible individuals
- Date of annual notice distribution

If there are changes to a plan's prescription drug coverage or if coverage is terminated, a new disclosure must be submitted to CMS within 30 days of the change.

Employer Considerations

- Check with insurance carriers or third-party administrators (TPAs) to verify if your prescription drug plan is creditable or non-creditable.
- Complete the required online disclosure form within 60 days of the plan year's end (by March 1, 2025, for calendar-year plans).
- Ensure Medicare-eligible employees receive their annual notice by October 14 for calendar-year plans.

Enhanced Healthcare Price Transparency

On February 25, 2025, President Trump signed an executive order aimed at bolstering healthcare price transparency. This directive mandates that federal agencies enforce a 2019 order requiring hospitals and insurers to disclose actual healthcare costs. The Departments of Treasury, Labor, and Health and Human Services have 90 days to establish a framework ensuring compliance. Hospitals must display pricing for 300 services and provide comprehensive rate lists, while health plans are required to post their negotiated rates and out-of-network payments.

Question of the Month

Q. If a client has a spousal surcharge, would that be considered pre-tax or post-tax?

A. Typically, a spousal surcharge is just treated as an additional premium that employees have to pay for family coverage. This premium would be eligible to be paid pre-tax, just like the other premiums, under the company's cafeteria plan.