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2025 Compliance & Benefits Update

February 2025

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Agenda

1. Fiduciary Duties
2. Transparency and Reporting Rules
3. Affordable Care Act
4. Other Benefits Updates
5. Shifting Regulatory Landscape

Fiduciary Duties

Plan Fiduciary Updates

- Fiduciary duties apply to both retirement plans and health and welfare plans – duties owed by plan fiduciaries to plan beneficiaries (participants)
- Proliferation of lawsuits against retirement plans since 2006
- New trend developing against health and welfare plans of large self-funded employers
- Fiduciaries have personal and co-fiduciary liability – benefits committees and HR executives are named defendants in lawsuits
- DOL's focus on cybersecurity highlights fiduciary concerns from different angles

Plan Fiduciary Updates

Johnson & Johnson

An employee who was diagnosed with cancer filed suit based on breach of plan fiduciary duties as J&J failed to manage PBM costs. The claimant says it is representing 130,000 J&J employees who have been asked to pay excessive fees for pharmacy benefits, especially for generic specialty medications, which are managed by Express Scripts.

Lewandowski v. J&J- On 1/24/25 NJ Court dismissed two of the three claims for lack of standing (no direct injury to participant or the plan). The court did not reject the premise of the claim.

Lockheed Martin

Class action suit initiative by Fairmark Partners *(NY law firm)*. Law firm is reaching out to employees and retirees to garner sufficient interest of participants to file a class action suit for mismanagement of plan assets that resulted in higher costs that are then transferred to plan participants.

Plan Fiduciary Updates

Wells Fargo Company

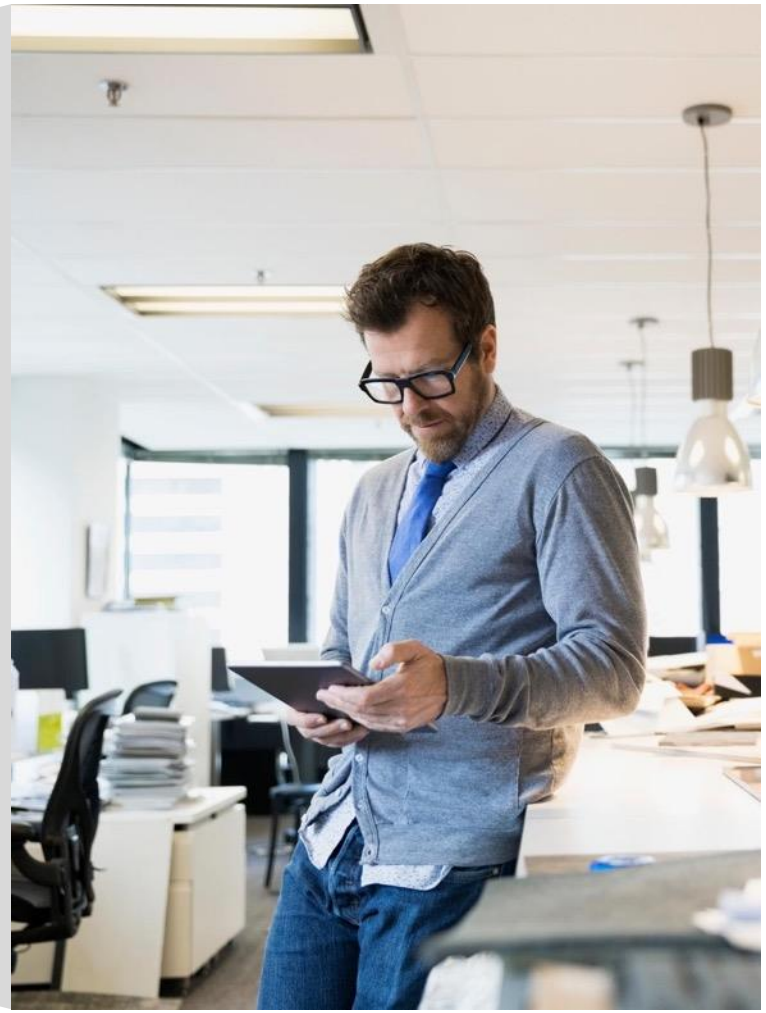
Lawsuit brought by employees and retirees of WFC. WFC was in breach of its fiduciary duties and engaged in self-dealing *(prohibited transaction under ERISA)* as the plan paid excessive fees for prescription drugs and PBM fees purchased through Express Scripts and its pharmacy Accreedo.

Kraft Heinz v. Aetna

Kraft-Heinz is suing for failure to share medical claims data. Kraft-Heinz alleges Aetna ***illegally withheld information*** regarding actual payments to providers. Absent this data, Kraft-Heinz is unable to assess Aetna's handling of the Plans' funds thereby compromising Kraft-Heinz's ERISA fiduciary obligations

Fiduciary Best Practices

- Conduct due diligence when selecting new service providers – carriers, TPAs, PBMs, COBRA administrators, FSA vendors, brokers, etc.
  - Compare services, pricing and contract terms
  - Not required to use the lowest cost providers, but cost must still be reasonable – only way to know is to check the market
- Monitor existing service providers
  - Are services being delivered as promised?
  - Are only agreed upon fees being charged?



Fiduciary Best Practices – Benefits Committees

- Consider forming a benefits committee to assist with meeting fiduciary obligations – similar to retirement plan committees
- Often comprised of HR plus other core functions (finance, procurement, operations, etc.)
- Committees can monitor due diligence, act as the record keeper for processes and decision making, and help avoid potential conflicts
- HR / Benefits team must often educate and train committee members on programs and services sought
- Train committee members and all plan fiduciaries on obligations
- Purchase fiduciary liability coverage to protect fiduciaries – common for retirement plans
- Document meetings with minutes (minutes are a summary, not a transcript)

Transparency and Reporting

Transparency

- Transparency requirements originated from a 2019 executive order issued by President Trump
- Aimed at increasing transparency in healthcare
- Air ambulance reporting will be required eventually – waiting on final rules
- Cost comparison tools – available from carriers and TPAs but still in need of work
  - Can be challenging to use
  - May contain limited pricing info
  - User experience needs improvement before full utility is achieved
- Gag Clause Attestation – FAQ 69 requires elimination of limits on number of audits per year, number of records audited, where the records can be reviewed and who the results of the audits can be shared with.

Transparency

Requirement	Machine-Readable Files	RxDC Reporting	Gag Clause Attestations
What	Post machine-readable files containing costs of INN and OON claims on external website	Report certain data related to prescription drug spend and overall plan expenses	Attest that provider / network agreements do not contain gag clauses prohibiting sharing of certain information
Who	Can be completed by carrier / TPA / PBM on behalf of plan sponsor, or may require plan sponsor to directly complete		
When	Ongoing	June 1, 2025 and thereafter	December 31, 2025 and thereafter
How	Posted on employer's website or website of carrier / TPA	Completed via the CMS HIOS platform	

Transparency Bills

Lower Costs, More Transparency (LCMT) Act (H.R. 5378)

PBM Reform Act (S. 1339) approved by Senate Health, Education, Labor and Pensions

Modernizing and Ensuring PBM Accountability Act (S. 2973) approved by Senate Finance Committee

Site-based Invoicing and Transparency Enhancement (SITE) Act (S. 1869)

Health Care PRICE Transparency Act 2.0 (S. 3548)

Healthy Competition for Better Care Act (H.R. 3120/S. 1451): restricts anti-competitive contracting terms in health plan and provider contracts

Affordable Care Act

Affordable Care Act

- ACA is still the law of the land.
- Generally expected to remain in place, although President Trump did try to repeal it back in 2017.
- Likely to see changes, including certain changes made the last time President Trump held office.
- Statute of limitations for enforcement of ACA Section 4980H(a) and (b) is limited to 6 years. Employers will be granted 90 days to appeal a Letter 226-J.

2025 ACA Affordability

Affordability of Employee-only Coverage

Lowest cost plan that is **minimum value. Safe harbor is 8.39%** for 2024, the 2025 safe harbor is **9.02%**. Affordability is based on one of the three safe harbors:

1 Rate of Pay

(Hourly rate of pay x 130)
9.02% Maximum amount to charge for employee-only coverage will increase from 2024 to 2025.

- ***Example:*** An employee earning $16.50 an hour in 2024 cannot pay more than $179.96 per month if the plan is to be deemed affordable; however, in 2025, that employee earning $16.50/HR cannot pay more than $193.47 *(decrease in employer cost of $13.51 per month).*

2 Federal Poverty Level *(FPL)*

Calendar year plans and plans renewing before 7/1/25 must use **2024 FPL x 9.02% / 12** to assess affordability for 2025 *($15,060 x 9.02% / 12) =* ***$113.20***

- Non-calendar year plans renewing after 7/1 use the **2025 FPL X 9.02%/12** to assess affordability for 2025 ($15,650 X 9.02%/12) = $117.63.

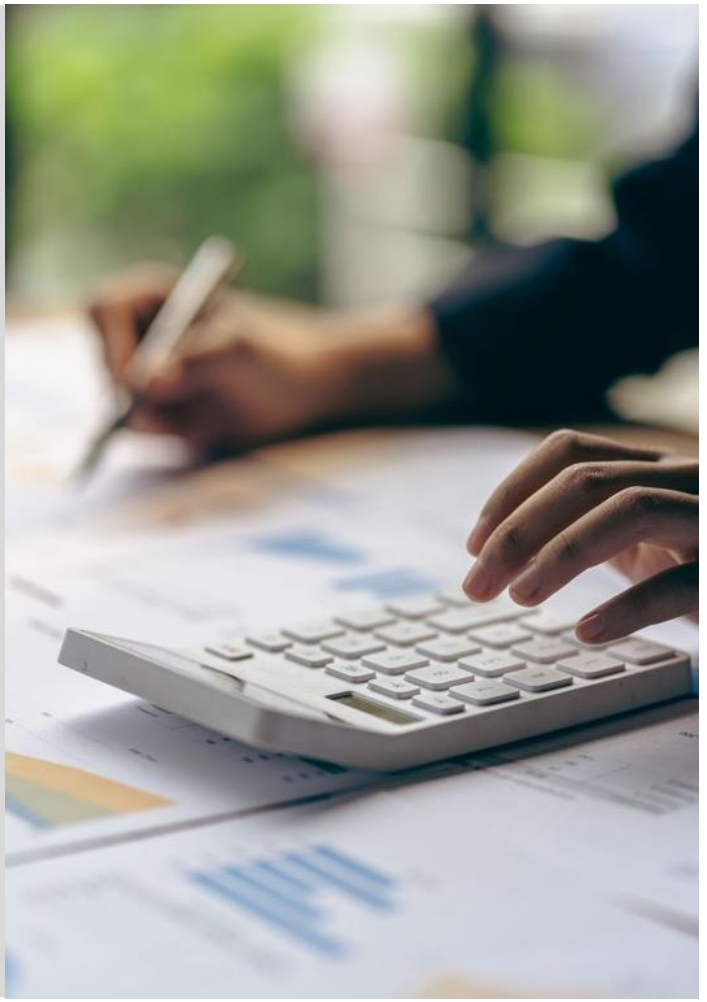
3 W-2 Safe Harbor

Use Box 1 of employee's W-2 earnings.
Must use projected 2025 income; amount cannot change throughout the year.

- Box 1 = gross earnings minus pre-tax deductions under a cafeteria plan and a 401(k) plan

ACA Affordability Reminders

- For employer mandate purposes, affordability is based only on the employee only tier of coverage
- Affordability is based on the lowest cost plan offered to the employee the employee is eligible to enroll in, not the employee's election
- Only one safe harbor needs to be satisfied and only one plan option needs to be affordable
- The Rate of Pay Safe Harbor is always based on 130 hours per month, regardless of how many hours the employee works
- The W-2 Safe Harbor is based on the employee's taxable income (Box 1 of Form W-2), not gross income or salary
- Lower rates for participating in a wellness program cannot be used for affordability unless the program is tied to tobacco use



ACA Reporting – Reminders for 2025

Remember: Self-insured medical plans, including MEC and ICHRA plans sponsored by employers of any size are required to comply with ACA reporting requirements. Self-insured and level-funded medical plans must comply with federal and state individual mandate reporting requirements.

Who is required to report?

Issuer of MEC: Self-insured medical plans including MEC, ICHRAs and level-funded plans sponsored by **employers of any size**. Must report the months an employee and covered dependents were enrolled in the group health plan. Insurance carriers will comply with the reporting requirements for insured medical plans.

Applicable Large Employer (ALE): An employer who employed on average 50 FT or FTE employees in the prior calendar year*(2023)*. Must report the offer of coverage made, the cost of coverage and if the FT employee elected or waived enrollment in coverage.

What forms are Covered Employers Required to use?

Self-insured *(including MEC and ICHRAs)* or level-funded employer with less than 50 FT and FTE employees: Must use Form 1094 and 1095-B to report the months employees and dependents were covered by a self-insured/level-funded group health plan.

Self-insured *(including MEC and ICHRAs)* or level-funded employer who is an ALE: Must use Forms 1094/1095-C must complete Parts I, II and III of the Form 1095-C. Part III it reports the months the employee and dependents, COBRA QB and retirees were enrolled in the group health plan.

Fully-insured employer who is an ALE: Must use Forms 1094/1095-C, must complete only Parts I and II of Form 1095-C.

ACA Reporting – Reminders for 2025

When are the returns due?

- Under the Paperwork Burden Reduction Act, starting in 2025 (for calendar year 2024 reporting) employers generally **only need to provide employees with a copy of Form 1095-C upon request. Returns may be distributed in electronic format with employee's consent.**
- **IRS Deadlines:**

File Forms 1095-B & -Cs with the IRS *(electronic)*:
March 31, 2025

File Forms 1095-B & -Cs with the IRS *(paper)*:
February 28, 2025, noting that if an **employer files 10 or more returns** *(any return W-2,1099, other) they will be required to e-file all returns.*

- **State deadlines vary depending on the state, refer to state chart for additional details.**
  - **CA and MA–** Forms must be distributed to employees / participants by **January 31, 2025**.
  - Self-insured / level-funded plans must comply with federal and state reporting requirements.

State Individual Mandate Reporting Deadlines

Insurance carriers, self-funded *and* level-funded medical plans *(ICHRAs, level-funded and MEC plans)* covering residents in 2024 – REPORTED in 2025

California

- 1095 C/B mailed to employees by **January 31, 2025**
- 1095 C/B filed with State of CA Franchise Tax Board by **May 31,2025 (extension granted by CA FTB)**
- File the State Healthcare MEC on paper if under 250 files; otherwise, must file electronically
- Mandated distribution deadline is not automatically extended to mirror the federal deadline.
- Report health insurance information | FTB.ca.gov

Massachusetts

- Distribute Form MA 1099-HC annually to employees enrolled in their health plan no later than January 31, 2025
- Complete HIRD Form for Six (6) or more employees and submit each year on December 15th of the reporting year
- Will be required to file on MassTaxConnect (MTC) portal

New Jersey

- 1095 C/B to be distributed to employees by **March 3, 2025**
- File NJ-1095 form by **March 31, 2025**, with the New Jersey Division of Taxation Payroll Taxes and Wage Withholding Login (state.nj.us).
- Insured plans should not file Form 1095-C if Part III of the form 1095-C is blank. Employers should file NJ-1095 form instead if their medical insurance carrier will not be filing Forms 1095-B on their behalf with the NJ Division of Taxation.

Rhode Island

- Forms 1095-C/B must be distributed to covered participants by **March 3, 2025**
- Forms 1095 C/B must be filed with the RI Division on Taxation by March 31, 2025.

Washington D.C.

- Employers that have a Washington D.C. residence and have 50 or more employees
- Forms 1095-C/B must be distributed to covered participants as outlined by IRS, including any extensions
- 1095 C/B must be filed with the Office of Tax and Revenue no later than 30 days after the deadline established by the IRS to file returns, including extensions.
- Electronically-submitted only to the D.C Office of Tax and Revenue (OTR) at MyTaxDC

ACA Reporting – Penalties

For filings due in 2025 $330 for each return or statement to which a failure relates, per calendar year. This applies separately to:

- Each failure to send the statement to the employee; *and*
- Each failure to send the statement to the IRS.

Penalty amounts are reduced if failures are corrected by the following dates:

Thirty-Day Rule

If a failure is corrected within **30 days** after the required filing date *(or the deadline for furnishing individual statements)*, the penalty is reduced to **$60 per return or statement,** and the calendar-year **maximum penalty is capped at $664,500**.

August 1 Rule

If a failure is corrected after the 30-day rule described above but **on or before August 1**, the **penalty is reduced to $130** per return or statement, and the calendar-year **maximum penalty is capped at $1,933,500.**

August 1st or later

If the returns are amended **after August 1, the penalty is $330** per return capped at **$3,987,000**.

Intentional disregard of ACA filing requirements

Employer is subject to a penalty of at least **$660 per form**—with no maximum.

Penalties Through the Years

		2020	2021	2022	2023	2024	2025
4980H(a) Penalty	**Annual Amount**	$2,570.00	$2,700.00	$2,750.00	$2,880.00	**$2,970.00**	**$2,900.00**
	Monthly Amount	$214.17	$225.00	$229.17	$240.00	**$247.50**	**$241.66**
	MEC Offer % of FT	95%	95%	95%	95%	**95%**	**95%**
	FT Headcount Reduction	30	30	30	30	**30**	**30**
4980H(b) Penalty	**Annual Amount**	$3,860.00	$4,060.00	$4,120.00	$4,320.00	**$4,460.00**	**$4,350.00**
	Monthly Amount	$321.67	$338.33	$343.33	$360.00	**$371.67**	**$362.50**
	Affordability Safe Harbor %	9.78%	9.83%	9.61%	9.12%	**8.39%**	**9.02%**
	FPL Annual Amount *(individual)*	$12,760.00	$12,880.00	$13,590.00	$14,580.00	**$15,060**	**$15,650**
		Current Enforcement	**2021**	**2022**	**2023**	**2024**	**2025**

ACA Enforcement

IRS enforcing employer mandate for 2022. Employer will have 90 days rather than 30 days to appeal a Letter 226-J.

Since 2022, the IRS has been increasing the focus/priority of ACA Penalty Enforcement – may change with new administration.

The reason: As of June 2020, the IRS had assessed $264 million in ACA mandate & reporting penalties (since 2015) and “only” collected $66 million.

IRS is relying on W-2 Form filings to determine if an employer is an ALE and should have filed Forms 1094/1095-C.

Forms 1094/1095-C are used to enforce the Employer Shared Responsibility Mandate of the ACA, IRC Sections 4980H(a) and(b).

Increased enforcement = Increased government revenue.

Other Benefits Updates

Mental Health Parity

ERISA Industry Committee (ERIC) filed a complaint against HHS on 1/17/25 to suspend the enforcement of the new MHPAEA regulations.

- **Final MHPAEA Rules released (September 9, 2024)**
- **Effective Date:** Plans renewing on or after January 1, 2025. For some provisions, the effective date will be the first plan year beginning on or after January 1, 2026, the provisions effective in 2026 are:
  - Implementing the meaningful benefits standard,
  - Prohibition on discriminatory factors and evidentiary standards,
  - Required use of outcomes data, and
  - Comparative analysis requirements
- **New rules effective for plan years beginning or after January 1, 2025 provide:**
  - Elimination of State and local government health plans' ability to opt out of compliance with MHPAEA
  - MHPAEA protects plan participants, beneficiaries, and enrollees from facing greater restrictions on access to MH/SUD benefits as compared to medical/surgical benefits.
  - Reinforce that health plans and issuers cannot use NQTLs applicable to MH/SUD benefits that are more restrictive than the predominant NQTLs applied to substantially all medical / surgical benefits in the same classification. Examples of NQTLs include prior authorization requirements and other medical management techniques, standards related to network composition, and methodologies to determine out-of-network reimbursement rates.

Mental Health Parity

- **New Rules (continued):**
  - Require plans and issuers to collect and evaluate data and take reasonable action, as necessary, to address material differences in access to MH/SUD benefits as compared to medical/surgical benefits that result from application of NQTLs, where the relevant data suggest that the NQTL contributes to material differences in access.
  - Codify that health plans and issuers conduct comparative analyses to measure the impact of NQTLs. This includes evaluating standards related to network composition, out-of-network reimbursement rates, and medical management and prior authorization NQTLs.
  - Prohibit plans and issuers from using discriminatory information, evidence, sources, or standards that systematically disfavor or are specifically designed to disfavor access to MH/SUD benefits as compared to medical/surgical benefits when designing NQTLs.
- **Next Steps**
  - Review with carriers and TPAs impact to 2025 plan renewals
  - For plans governed by ERISA, the plan fiduciary must certify that a thorough process was followed in selecting a qualified service provider to conduct and document the comparative analyses of NQTLs. The fiduciary must also verify that the service provider's performance and documentation of these analyses are continuously monitored.
  - Determine if a third-party vendor will have to be retained to conduct the NQTL analysis; or if using the TPA or insurance carrier will satisfy the new certification requirements.
  - Review plan design and exclusions to ensure parity in access to care as it pertains to MH and SUD

Preventive Care Updates

5th Circuit Court of Appeals issued decision on June 21, 2024, addressing the constitutionality of the recommendations issued by the USPTF since March 23, 2010.

- 5th Circuit Court ruled that only the plaintiffs were granted relief dismissing the national injunction issued by the lower court. The Court's decision requires that all other employers continue to cover and pay for preventive care services at no cost.
- Only the plaintiffs are exempt from paying for PrEP *(for individuals who are high risk for HIV)* from their group health plans, as it violates their rights under the Freedom of Religion Act.
- SCOTUS to hear arguments on this case and to render a final decision in June 2025.

ACA FAQ 68 – Requires plans to cover oral and injectable formulations for pre-exposure prophylaxis (PrEP)-

- Coding instructions for preventive items
- Clarifies breast reconstruction requirements under Women's Health and Cancer Rights Act

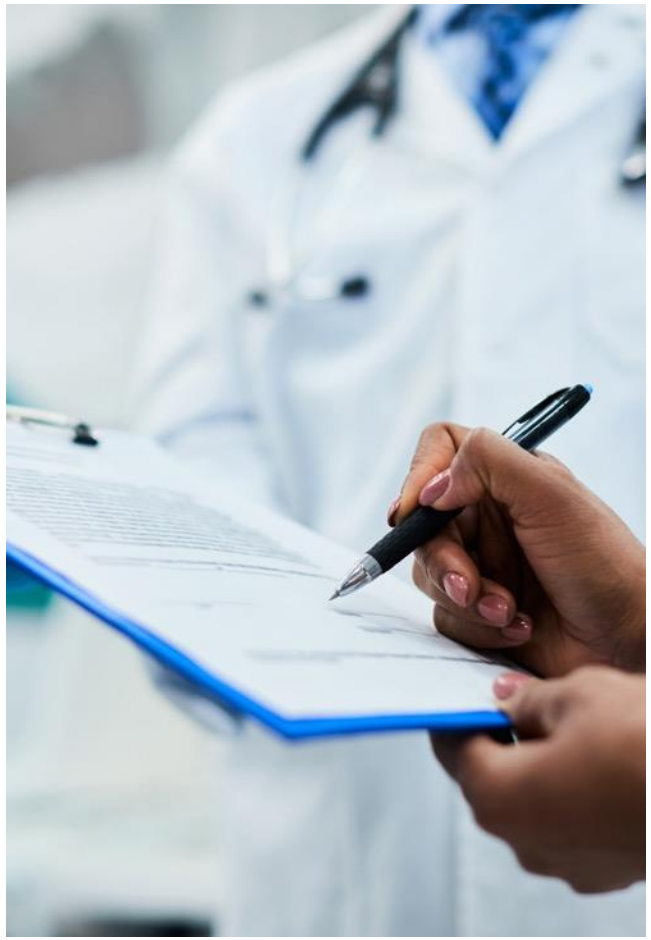
HHS rescinds coverage of OTC contraceptives

- January 15, 2025- HHS rescinds requirement for non-grandfathered plans to cover OTC contraceptives.

New HIPAA Privacy Regulations – Reproductive Health Rights

TX v. HHS - Complaint requesting dismissal of new HIPAA reproductive rights. Pending Court decision.

- On April 22, 2024, HHS issued updated HIPAA regulations implementing new protections and restrictions on when information may be disclosed to a third party about individuals who provided or sought potentially related to health reproductive services (including abortion, but well beyond only abortion related services).
  - These updates were enacted mostly in response to SCOTUS overturning *Roe v. Wade*, thereby granting the states the authority to regulate abortions.
- Implements protections against disclosing information to third parties related to reproductive services if the services are performed in a state where it is lawful.
- Establishes the use of an attestation prior to disclosing reproductive health information to a third party.
- Requires distribution of a new HIPAA Privacy Notice to covered participants no later than February 16, 2026.
- Extends HIPAA civil and criminal penalties for the violation of these new reproductive health care rights.



New HIPAA Privacy Regulations – Reproductive Health Rights

Regulated Parties

All HIPAA Covered entities and their business associates.

- **Group health plans:** all self-insured, all level funded, and fully-insured that access PHI.
- Rules will apply mostly to medical plans, pharmacy plans, health FSAs, and HRAs as these plans may reimburse or pay for health reproductive services.

Effective dates

- **June 26, 2024:** Amended rules officially go into effect
- **December 23, 2024:** HIPAA-covered group health plans become subject to the new rules and must:
  - Update HIPAA Policies and Procedures documents to account for the new protections granted to individuals seeking reproductive health services.
  - Implement new attestation requirements
  - Update HIPAA Business Associate Agreements to include new protections and use of attestations
  - Train staff on updated internal procedures to align with the new rules
- **February 16, 2026:** Update and distribute new HIPAA Privacy Notices that include the new protections around disclosing information regarding reproductive healthcare.

New Confidentiality of Substance Use Disorder Records

Effective Date: February 16, 2026

Patient Consent

- Allows a single consent for all future uses and disclosures for treatment, payment, and health care operations.
- Allows covered entities and business associates that receive records under this consent to redisclose the records in accordance with the HIPAA regulations.

Other Uses and Disclosures

- Permits disclosure of records without patient consent to public health authorities, provided that the records disclosed are de-identified according to the standards established in the HIPAA Privacy Rule.
- Restricts the use of records and testimony in civil, criminal, administrative, and legislative proceedings against patients, absent patient consent or a court order.

Penalties

- Aligns Part 2 penalties with HIPAA by replacing criminal penalties currently in Part 2 with civil and criminal enforcement authority that applies to HIPAA violations.

Shifting Regulatory Landscape

Election

- Full sweep by the Republican Party
- Most anticipated some type of split results
- Clears the way for big potential changes, however any significant changes will take time
- Different factions within the Republican party still have different priorities so there is not necessarily a cohesive agenda
- Don't forget about centrists such as Senators Collins and Murkowski who voted to keep the ACA in place in 2017
- Will the filibuster remain?
- Immediate priority, extending the Tax Cuts and Jobs Act before key provisions expire on December 31, 2025.

Telehealth and Medicare Part D

Telehealth and HDHP (HSAs)

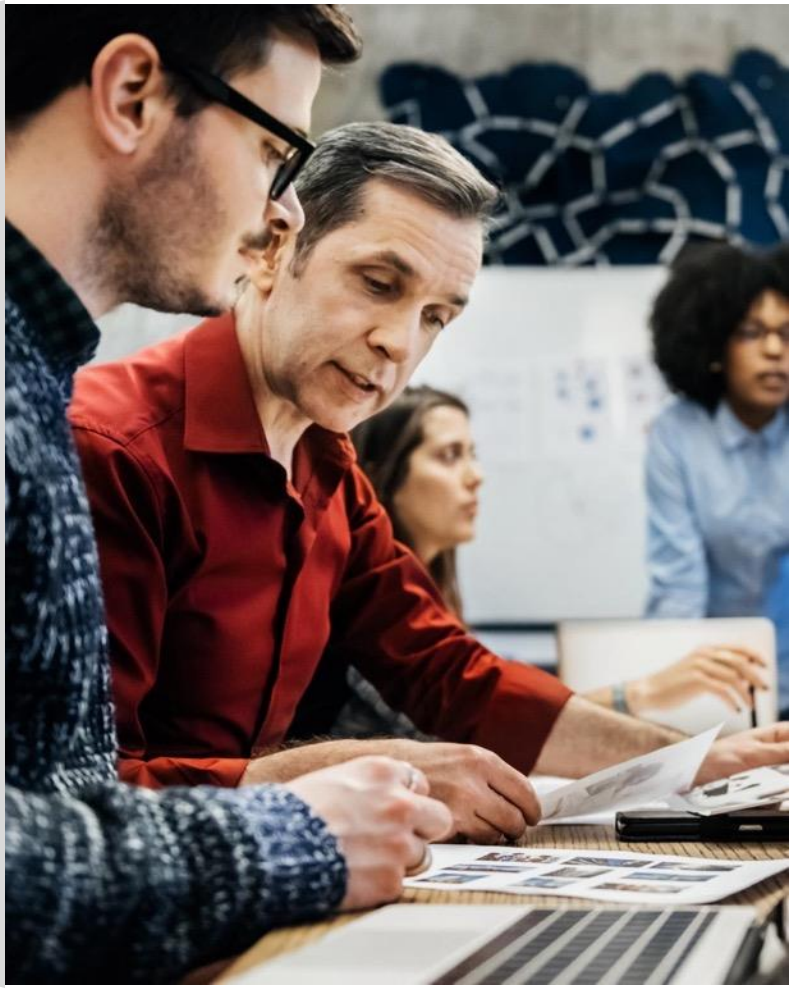
- Since 2020, high deductible health plans have been allowed to cover telehealth without cost sharing
- Concession sunset on December 31, 2024 for all plan years. HDHP must charge fair market value for telehealth services as of January 1, 2025.
- Support exists to extend concession, but it is not an immediate priority for Congress to issue an extension

Medicare Part D

- CMS released draft proposal of modifications to the Medicare Part D simplified determination for CY 2026.
- New simplified determination would require a plan to satisfy the following requirements:
  - Provide reasonable coverage for brand name and generic prescription drugs and biological products;
  - Provide reasonable access to retail pharmacies; and
  - Is designed to pay on average at least 72 percent of participants' prescription drug expenses.
- Alternatively plans can use the actuarial determination.

The Future of ACA Subsidies

- American Rescue Plan Act ("ARPA") enabled more individuals to qualify for subsidies on the exchanges, and increased subsidy amounts
- Extended through 2025 under the Inflation Reduction Act
- Statutory sunsetting accomplishes two Republican goals
  - Weakens the ACA by making exchanges less affordable for many people
  - Savings can be used to pay for extending the Tax Cuts and Jobs Act

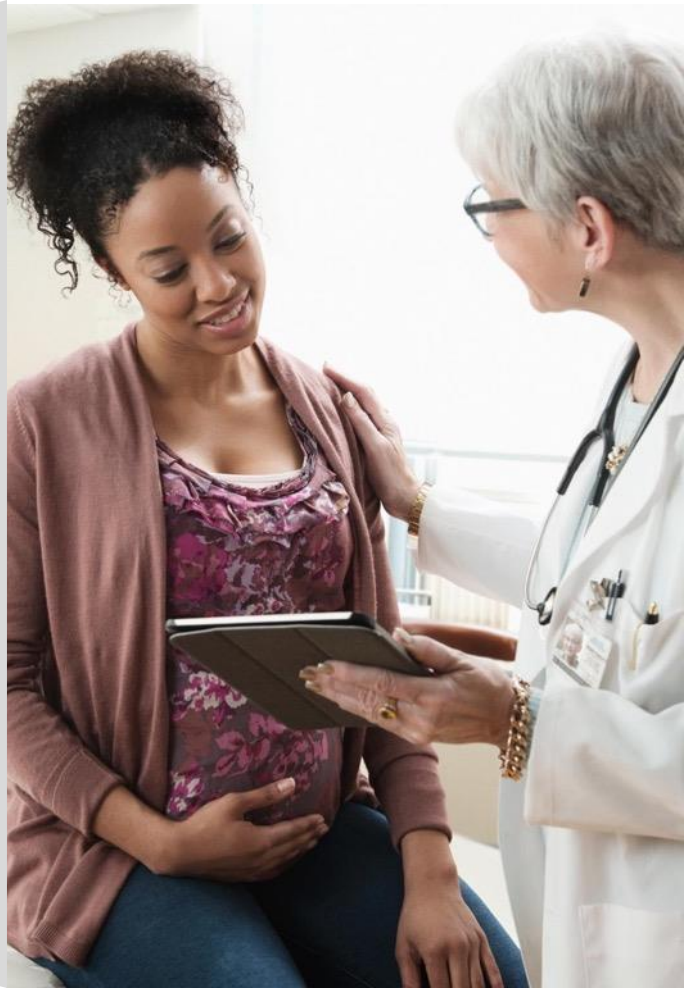


Tax Exclusion of Employer Provided Benefits

- IRC §104 and 105 of the Internal Revenue Code allow amounts received through health insurance for injuries or sickness and attributable to employer contributions are not taxed to the employee and can be deducted by the employer
- Support within the House of Representatives to cap, or even potentially eliminate, these exclusions for employers
- Could be used to pay for extending the Tax Cuts and Jobs Act
- Expands the tax base and could result in significant tax increases for employers
- Will the expanded tax base be offset by corresponding rate cuts?
- Will this impact enrollment in employer plans?

Reproductive Rights

- Since the Dobbs decision, many states have taken steps to significantly restrict access to abortion within those states
- Many other states have taken the opposite approach and sought to enshrine abortion access in their state constitutions
- As a candidate, President Trump indicated his support for leaving this decision up to individual states
- Fully-insured plans subject to state insurance laws, which may differ from state access to abortion laws
- Self-insured plans governed by ERISA, but state laws still determine access to abortion



Loper Bright, Corner Post and the Future of Agency Guidance

1984

Chevron Doctrine - if a federal agency is acting within its authority when interpreting ambiguous language in a federal statute, a court should defer to the agency's *interpretation of that statute*.

2024

Loper Bright overturns Chevron - the judiciary, not the executive branch (through its appointees), is responsible for interpreting ambiguous legislation.

2024

Corner Post effectively extends statute of limitations for alleging harm under the Administrative Procedures Act ("APA") – the clock starts ticking when the plaintiff alleges harm, allowing newly created entities to challenge existing rules

Potentially opens the door to more challenges to administrative guidance, which adds to uncertainty

Q&A

Thank you

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APPENDIX

Fixed Indemnity Notice

President Trump issued an EO rescinding President Biden's EO 14009 mandating the distribution of a fixed indemnity notice.

Fixed indemnity and hospital indemnity plans in the group market must also provide a notice to consumers highlighting the difference between fixed indemnity benefits and MEC – for plans renewing or sold on or after January 1, 2025. The rules described below have been struck down by a court, but appeals could be forthcoming.

Who must supply the Notice?

- The notice provisions beginning on or after **January 1, 2025** (at renewal or sold thereafter)
- Notice language provided by the Agencies is fixed (i.e., should not be altered or removed)
- Required for all fixed indemnity-type plans (hospital indemnity, critical illness, accident insurance and cancer plans), unless specifically exempted
- Common Exemptions: Stand-alone dental and vision; legal; disability; long-term care (but note that LTC policies have their own separate notice requirement); automobile; and travel policies.

Where does the Notice go?

- Notice must be 'prominently displayed' and in 14-point font in marketing, application, and enrollment (and reenrollment) materials in the individual and group markets
- This means front page of paper benefit guides and HRIS/BenAdmin systems (for electronic enrollment)

Section 1557 – Suspended

- HHS released on April 26, 2024, final regulations on ACA Section 1557, that were scheduled to become effective on July 5th, 2024.
- **General Provisions:** Reinstates language notice requirements; prohibits discrimination based on sex (extends protections for members of the LGBTQ+ community);mandates staff undergo training on the new protections; reaffirms entities subject to ACA 1557 mandates *(any entity that receives directly or indirectly federal funds from HHS)*; offer of telehealth services in a non-discriminatory manner and provides for a religious exemption for entities claiming protections under the RFA, must file for exemption with OCR.
- Covered Entities - Health programs and activities that receive federal funds from Medicare, Medicaid and National Institutes of Health *(Departments of HHS).*
- Language Assistance Notice must still be distributed by Covered entities no later than July 5, 2025.
- Executive Orders may further add further complexities.

Carriers and TPAs that receive Medicare and / or Medicaid funds	Health care providers that receive Medicare, Medicaid or HHS funds	Group plans receiving RDS payments	Subcontractors of Covered Entities

New DOL Penalty Limits

Violation	2024	2025
Failure to file Forms 5500	$2,670 per day	$2,739 per day
Failure to file an M-1 Form	$1,942 per day	$1,992 per day
Failure to provide to the DOL documentation	$190 per day, up to $1,906 per request	$195 per day, up to $1,956 per request
Failure to distribute CHIP Notice	$141 per day	$145 per day
Violation of GINA provisions	$141 per day	$145 per day
Failure to provide SBCs	$1,406 per day	$1,443 per day