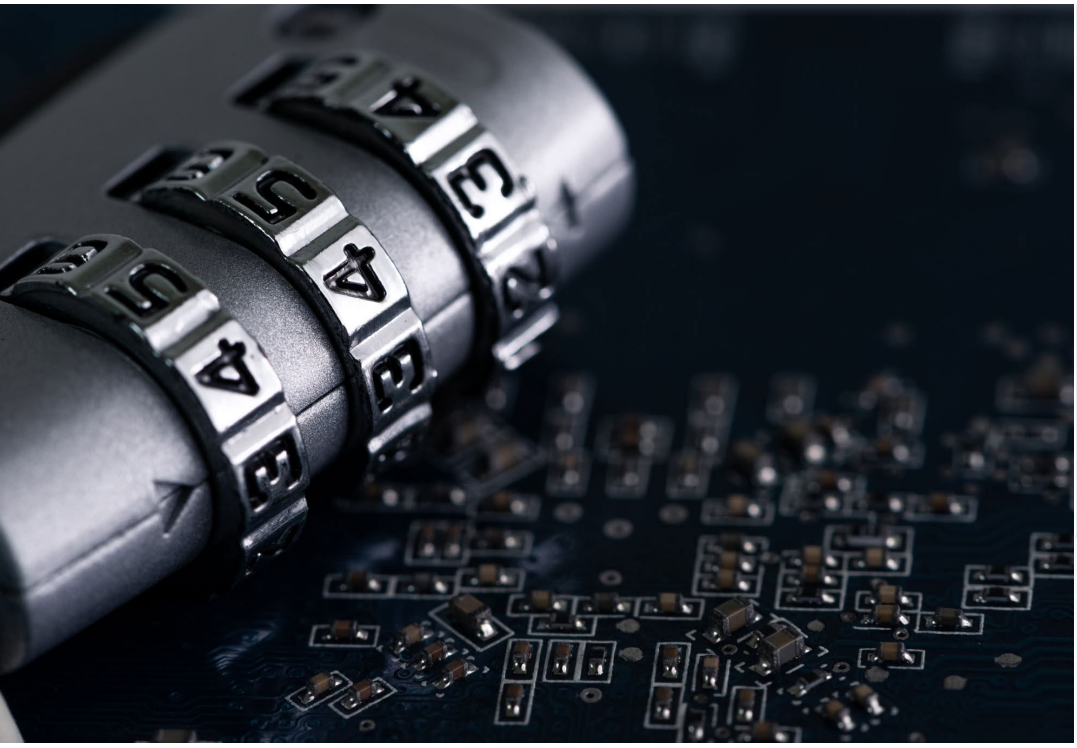
Compliance *News to Know*



Recent Cyberattack Urges OCR Open Letter

On March 13th the Office of Civil Rights (OCR), the enforcement arm of the Department of Health & Human Services (HHS), released a letter to address a cybersecurity incident impacting a unit of UnitedHealthcare Group. The incident is disrupting worldwide healthcare and billing information operations. In 2023, 79% of reported breaches were due to hacking, the largest affecting 134 million+ persons.

The OCR enforces HIPPA's Privacy, Security, and Breach Notification Rules, including requirements for HIPAA Covered Entities (CEs) regarding security of electronic Protected Health Information (ePHI). A requirement is the necessity of CEs to establish procedures in the event of a suspected or actual breach of ePHI. Unfortunately, many CEs simply don't have a process in place or have aging and weak security solutions.

According to the letter, OCR is opening an investigation of the incident and reminding business associates of CEs about their role in protecting ePHI, including securing BAAs. The letter offers links to several resources.

PATRIOT GROWTH INSURANCE SERVICES COMPLIANCE BENEFITS WATCH

2nd Wednesday each month at 1 pm EST

April 10 – ERISA Plan Docs. 101
May 8 – ERISA Plan Docs. 201

Register Here!

Upcoming Deadlines

- ✓ **April 1** - Electronic filing deadline – 1094/1095 Series
- ✓ **June 1** – RxDC Report due File online via CMS Reporting Instructions
- ✓ **July 31** – PCORI Fee due for self-funded plans. Complete IRS Form 720
- ✓ **July 31** - File Form 5500 or Form 5558 for an extension via eFAST2

Access the 2024 Benefits Compliance Checklist or ask your Patriot Advisor!

April 10th Benefits Watch Webinar

Register here for ERISA Plan Docs. 101 at 1 pm Est.

Can you describe the characteristics of, and explain the differences between, a SPD, SMM, SBC, SAR, and WRAP Docs.? What is the foundation document required under ERISA for group health plans? In the first of two webinars covering ERISA plan documents, Patriot's Benefits Compliance Counsel, Olivia Ash, will define and describe essential plan documents, and outline the six required elements of an ERISA plan document, and why it's essential to create and maintain it. Then, in ERISA Plan Docs. 201 on May 8th, Liv will dive into details and outline specific reporting requirements for ERISA-required documents.

Patriot Agency Staff Reminder: each Thursday after a compliance newsletter release, join Benefits Counsel Liv for a live Zoom call to discuss compliance. Bring your regulatory questions or listen for a deeper dive into newsletter content & current events. Contact Liv for questions.

The Rundown

- Employers: Pregnant Workers' Fairness Act – guidance for compliance at EEOC's website.
- Are employees classified correctly? Effective March 11: DOL's return to the 6 Factor Test to determine employees vs. independent contractors. Access the DOL's website for FAQs
- NIST: Updated Cybersecurity Resource Guide
- External Article: Asking Service Providers to Verify Timely Filings on Behalf of Plans
- External Article: COBRA & Severance Contracts

IRS Alert: Beware of companies that qualify nutrition & wellness expenses as medical care for FSAs, HSAs, HRAs, & MSAs

IRS REMINDER: *Personal expenses for general health & wellness are not considered medical expenses under the tax law.*

Background: According to the IRS' March 6th article, some companies are misrepresenting circumstances wherein food & wellness expenses may be reimbursed under consumer-driven health plans (CDHPs). Doctor notes based merely on self-reported health data are not enough to be considered medical expenses. Generally, such personal expenses must be related to a targeted diagnosis-specific activity or treatment for reimbursement under CDHPs.

Visit the IRS website to read an example of a diabetic patient responding to a marketing ad about healthy foods.

Access Publication 969 to review tax treatment of HSAs & other tax-favored health plans.

Access the IRS' FAQs about medical expenses related to nutrition, wellness, & general health.

Does HIPAA Require both a Risk Analysis & Risk Management Plan?

For HIPAA CEs, the short answer is…Yes. A HIPAA CE is a health care provider, health care clearinghouse, or a health plan.

Under the HIPAA Security Rule, CEs must have both a risk analysis and risk management plan in place. The analysis is required to identify potential risks and vulnerabilities to ePHI. Such an analysis must be enterprise-wide, documented, and maintained.

A risk management plan is an outcome of the risk analysis. This is created to identify ePHI safeguards necessary to reduce identified risks. Plans must be specific regarding implementation of safeguards. Ideally, a CE should perform a risk analysis annually, & when the business undergoes a change in personnel, operations, or physical location.

The OCR enforces HIPAA compliance. They often penalize CEs for not conducting a (or using a one-size-fits-all) risk analysis & creating a risk management plan.

Visit HHS to learn about HIPAA risk management.

National Paid FMLA?

In the 2025 U.S. budget, President Biden proposed national paid family medical leave. According to page 25 of the budget, approximately 94 % of American's lowest-paid workers lack access to paid family leave through employers. The proposition includes funding via the Social Security Administration for 12 weeks of paid leave to eligible workers.

2025 Fiscal Year U.S. Budget

Disclosure documents for ERISA Welfare Plans - Basics

By Olivia Ash, Esq., MS

2024 is the 50-year anniversary of the Employee Retirement Income Security Act (ERISA). In upcoming newsletters, we'll review core employer requirements under ERISA for welfare plans. Data courtesy of the Reporting & Disclosure Guide for Employee Benefits Plans, at the DOL's website. The chart below outlines the 5 basic documents for retirement & welfare benefits plans: Plan Documents, SPD, SMM, SAR, and EOBs.

Basic Disclosure Requirements for Retirement & Welfare Benefit Plans			
Document	**Type of Data**	**Target Audience**	**Timing Requirements**
Plan Documents	The plan administrator must provide copies of certain documents upon written request and must have copies available for examination. These include the latest updated SPD, the latest Form 5500, the trust agreement, and other documents that dictate how the plan is established or operated.	• Participant • Beneficiaries Also see 29 CFR § 2520.104a-8 regarding the Department's authority to request documents.	Within 30 days after a written request. Plan administrators must make copies available at principal office of the plan administrator and certain other locations as specified in 29 CFR § 2520.104b-1(b).
Summary Plan Description (SPD)	The SPD is the primary way to inform participants and beneficiaries about their plan and how it operates. It must be written for an average participant and be comprehensive enough to inform people of their benefits, rights, and obligations under the plan. Must accurately reflect the plan's contents and may not contain outdated information from more than 120 days before its initial disclosure.	Participants & Beneficiaries receiving benefits	To participants: within 90 days of becoming covered by the plan. To beneficiaries: within 90 days after first receiving benefits. A plan has 120 days after becoming subject to ERISA to distribute the SPD. Otherwise, once every 5 years for amended plans. Once every 10 years for all other plans.

Summary of Material Modification (SMM)	The SMM describes modifications to a plan and changes to the information that is required to be in the SPD. The distribution of an updated SPD satisfies this requirement.	Participants & Beneficiaries receiving benefits	Within 210 days after the end of the plan year in which the change is adopted.
Summary Annual Report (SAR)	The SAR is a narrative summary of the Form 5500.	Participants & Beneficiaries receiving benefits. The SAR is not required for defined benefit pension plans to which Title IV applies and that instead provide the annual funding notice.	Within 9 months after the end of the plan year, or 2 months after the due date for filing Form 5500 (with an approved extension).
Notification of Benefit Determination (Claims Notices or "Explanation of Benefits")	This notification provides information regarding benefit claim determinations. Adverse benefit determinations must include the required disclosures (for example, the specific reason(s) for the denial of a claim, a reference to the specific plan provisions on which the benefit determination is based, and a description of the plan's appeal procedures).	Claimants, including: • Participants • Beneficiaries • Authorized claims representatives.	Requirements vary depending on the type of plan and the type of benefit claim involved.