COMPLIANCE CHRONICLE

REGULATIONS | POLICIES | STANDARDS | REQUIREMENTS | LAWS

Navigating the ever-evolving landscape of compliance can be challenging and time-consuming. Warner Pacific is happy to share monthly updates to help your organization stay informed about new requirements and minimize compliance risks.

Let us handle the complexities, so you can focus on what matters most — your business.

ONE BIG BEAUTIFUL BILL, BIG CHANGES AHEAD

Key Health Policy Updates Under the One Big Beautiful Bill Act (OBBB)

The recently passed One Big Beautiful Bill Act (OBBB) introduces several significant updates affecting both group and individual health coverage. From permanent HSA flexibility for telemedicine and direct primary care arrangements to tighter ACA verification requirements and changes to premium tax credits, these provisions will impact plan design, eligibility, and compliance in the years ahead.

Below is a summary of the most relevant health and welfare updates for your review.

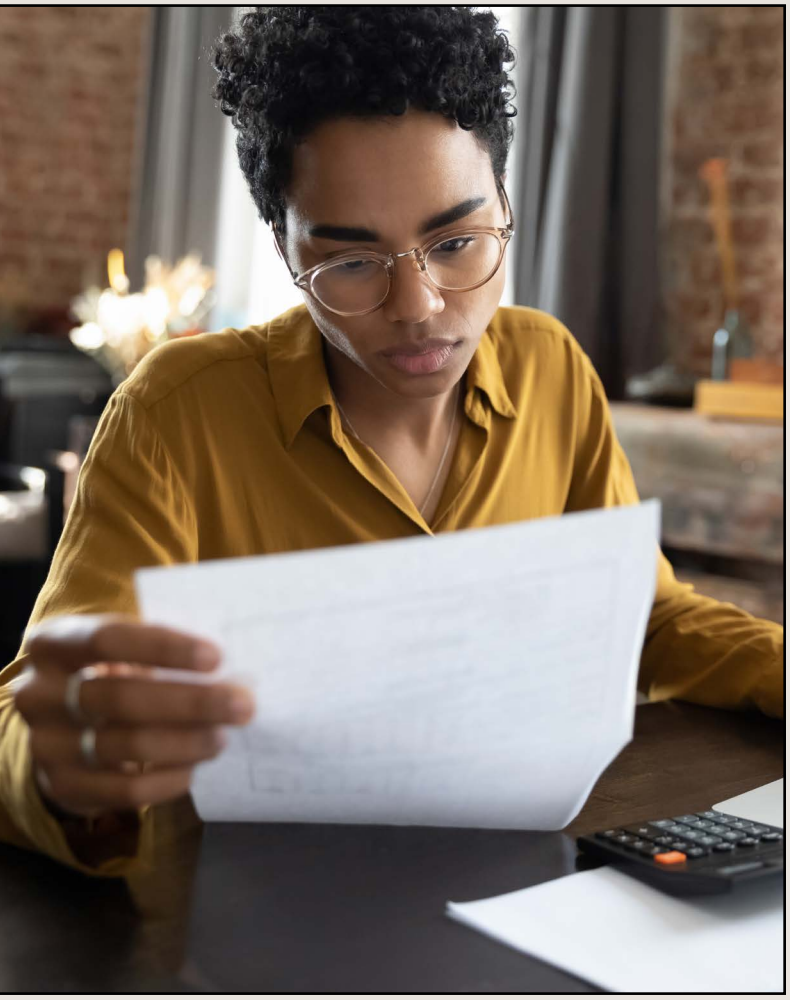
Healthcare: Group Market

Telemedicine & HSAs

- The CARES Act temporarily allowed pre-deductible telemedicine coverage for HSA-compatible plans.
- **OBBB makes this permanent**, effective for plan years beginning after **December 31, 2024.**
- This provision is **retroactive to January 2025.**

Direct Primary Care (DPC) & HSAs

- DPC arrangements previously disqualified individuals from HSA contributions.
- **OBBB allows DPC arrangements** for HSA holders.
- Monthly fee limits:
  - » $150 for individuals
  - » $300 for families
- Fees are considered **medical services,** not premiums — **HSA funds can be used.**
- Effective for months beginning on or after **December 31, 2025.**



Healthcare: Individual Market

Stricter ACA Pre-Enrollment Verification

- Tightened verification for income and immigration status before receiving premium tax credits.
- Key changes:
  - » **Full repayment** of excess tax credits (effective **January 1, 2026**).
  - » **No tax credits** for lawfully present aliens with income below 100% of poverty (effective **January 1, 2026**).
  - » **Pre-verification required** before credits are issued (effective **January 1, 2028**).
  - » Passive reenrollment prohibited (effective January 1, 2028).

Expiration of Enhanced ACA Tax Credit

- COVID-era enhancement (coverage cost >8% of income) **expires end of 2025.**
- Original ACA formula (100–400% FPL) resumes **January 1, 2026.**

HSA Eligibility for Bronze & Catastrophic Plans in the Marketplace

- These plans will now qualify as **HSA-compatible HDHPs** in the **individual market.**
- Effective for months beginning on or after **December 31, 2025.**
- Does **not apply to employer group coverage.**

Other Relevant Issues

Dependent Care FSAs

- Maximum increased from **$5,000 to $7,500.**
- Effective for plan years beginning after **December 31, 2025.**

Summary of Health and Welfare Provisions of OBBB

PROVISION	DETAILS	EFFECTIVE DATE
Telehealth Relief	Telehealth available at no cost-sharing on an HDHP will not impact HSA eligibility	Retroactive to December 31, 2024
Direct Primary Care	Certain DPC arrangements up to $150/$300 monthly are not HSA disqualifying coverage	Plan years after December 31, 2025
HSA Eligibility for Exchange Plans	Bronze and catastrophic Exchange plans in the individual market are HSA eligible	Plan years after December 31, 2025
Dependent Care FSA increases	Salary reductions increase from $5,000 to $7,500	Plan years after December 31, 2025
Student Loan Repayment	Employers may make student loan payments up to $5,250 annually tax-free	Remaining in place
Transportation Benefits	Salary reductions for bicycle commuting are no longer tax-free	Plan years after December 31, 2025
Premium Tax Credits Eligibility	NO PTCs will be available to individuals who enroll during a special enrollment event due to change in household income	Plan years after December 31, 2025
Premium Tax Credit Verification	Exchange enrollees will be subject to pre-enrollment verification to ensure they are eligible	January 1, 2027
Medicaid Eligibility	Certain individuals will be required to work 80 hours a month to maintain Medicaid eligibility	Phased in through 2028
PFML Credit	Permanently extends the PFML Tax Credit set to expire this year	Remaining in place
Employer provided childcare credit	Permanently extends the Employer provided child care tax credit from $150,000 to $500,000	After December 31, 2025

Medicare Spotlight

Medicare Part D Notices Are Due Before October 15, 2025

Each year, Medicare Part D requires group health plan sponsors to disclose to individuals who are eligible for Medicare Part D and to the Centers for Medicare and Medicaid Services (CMS) whether the health plan's prescription drug coverage is creditable.

Plan sponsors must provide the annual disclosure notice to Medicare-eligible individuals **before October 15, 2025** — the start date of the annual enrollment period for Medicare Part D. CMS has provided model disclosure notices for employers to use.

This notice is important because Medicare beneficiaries who are not covered by creditable prescription drug coverage and do not enroll in Medicare Part D when first eligible will likely pay higher premiums if they enroll at a later date. Although there are no specific penalties associated with this notice requirement, failing to provide the notice may be detrimental to employees.

Action Steps

Employers should confirm whether their health plans' prescription drug coverage is creditable or non-creditable and prepare to send their Medicare Part D disclosure notices before October 15, 2025. To make the process easier, employers often include Medicare Part D notices in open enrollment packets they send out prior to October 15.

Creditable Coverage

A group health plan's prescription drug coverage is considered creditable if its actuarial value equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general, this actuarial determination measures whether the expected amount of paid claims under the group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the Medicare Part D prescription drug benefit. For plans that have multiple benefit options (for example, PPO, HDHP and HMO), the creditable coverage test must be applied separately for each benefit option.

Model Notices

CMS has provided two model notices for employers to use:

- A Model Creditable Coverage Disclosure Notice for when the health plan's prescription drug coverage is creditable; and
- A Model Non-creditable Coverage Disclosure Notice for when the health plan's prescription drug coverage is not creditable.

These model notices are also available in Spanish on CMS' website.

Employers are not required to use the model notices from CMS. However, if the model language is not used, a plan sponsor's notices must include certain information, including a disclosure about whether the plan's coverage is creditable and explanations of the meaning of creditable coverage and why creditable coverage is important.

Medicare Spotlight

Notice Recipients

The creditable coverage disclosure notice must be provided to Medicare Part D-eligible individuals who are covered by, or who apply for, the health plan's prescription drug coverage. An individual is eligible for Medicare Part D if they:

- Are entitled to Medicare Part A or are enrolled in Medicare Part B; and
- Live in the service area of a Medicare Part D plan.

In general, an individual becomes entitled to Medicare Part A when they actually has Part A coverage, and not simply when they are first eligible. Medicare Part D-eligible individuals may include active employees, disabled employees, COBRA participants and retirees, as well as their covered spouses and dependents.

As a practical matter, group health plan sponsors often provide the creditable coverage disclosure notices to **all plan participants.**

Timing of Notices

At a minimum, creditable coverage disclosure notices must be provided at the following times:

1. Prior to the Medicare Part D annual coordinated election period — beginning October 15 through December 7 of each year
2. Prior to an individual's initial enrollment period for Part D
3. Prior to the effective date of coverage for any Medicare-eligible individual who joins the plan
4. Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable Upon a beneficiary's request

If the creditable coverage disclosure notice is provided to all plan participants annually before October 15 of each year, items (1) and (2) above will be satisfied. "Prior to," as used above, means the individual must have been provided with the notice within the past 12 months. In addition to providing the notice each year before October 15, plan sponsors should consider including the notice in plan enrollment materials for new hires.

Method of Delivering Notices

Plan sponsors have flexibility in how they must provide their creditable coverage disclosure notices. The disclosure notices can be provided separately, or if certain conditions are met, they can be provided with other plan participant materials, like annual open enrollment materials. The notices can also be sent electronically in some instances.

As a general rule, a single disclosure notice may be provided to the covered Medicare beneficiary and all of his or her Medicare Part D-eligible dependents covered under the same plan. However, if it is known that any spouse or dependent who is eligible for Medicare Part D lives at a different address than where the participant materials were mailed, a separate notice must be provided to the Medicare-eligible spouse or dependent residing at a different address.

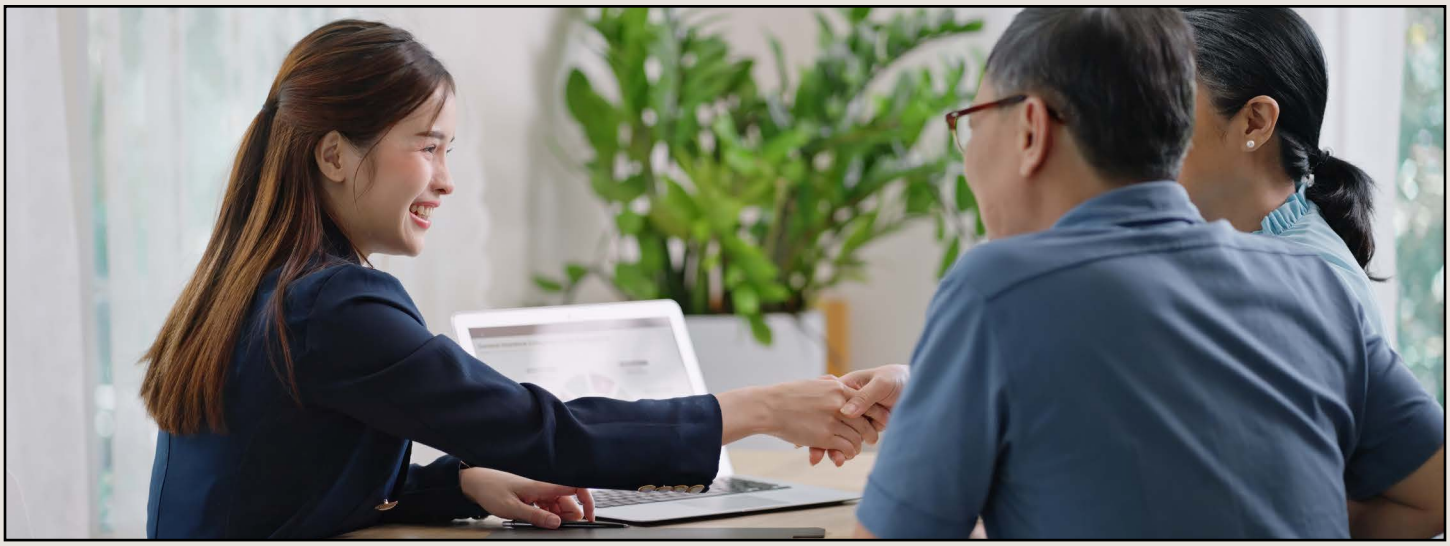
Electronic Delivery

Creditable coverage disclosure notices may be sent electronically under certain circumstances. CMS has issued guidance indicating that health plan sponsors may use the electronic disclosure standards under Department of Labor (DOL) regulations in order to send the creditable coverage disclosure notices electronically. According to CMS, these regulations allow a plan sponsor to provide a creditable coverage disclosure notice electronically to plan participants who have the ability to access electronic documents at their regular place of work, if they have access to the sponsor's electronic information system on a daily basis as part of their work duties.

The DOL's regulations for electronic delivery require that:

1. The plan administrator uses appropriate and reasonable means to ensure that the system for furnishing documents results in actual receipt of transmitted information;
2. Notice is provided to each recipient, at the time the electronic document is furnished, of the significance of the document; and
3. A paper version of the document is available on request.

Medicare Spotlight



Also, if a plan sponsor uses electronic delivery, the sponsor must inform the plan participant that they are responsible for providing a copy of the electronic disclosure to their Medicare-eligible dependents covered under the group health plan.

In addition, the guidance from CMS indicates that a plan sponsor may provide a disclosure notice electronically to retirees if the Medicare-eligible individual has indicated to the sponsor that they have adequate access to electronic information.

According to CMS, before individuals agree to receive their information via electronic means, they must be informed of their right to obtain a paper version, how to withdraw their consent and update address information, and any hardware or software requirements to access and retain the creditable coverage disclosure notice.

If the individual consents to an electronic transfer of the notice, a valid email address must be provided to the plan sponsor and the consent from the individual must be submitted electronically to the plan sponsor. According to CMS, this ensures the individual's ability to access the information and that the system for furnishing these documents results in actual receipt.

In addition to having the disclosure notice sent to the individual's email address, the notice (except for personalized notices) must be posted on the plan sponsor's website, if applicable, with a link on the sponsor's homepage to the disclosure notice.

Disclosure to CMS

Plan sponsors are also required to disclose to CMS whether their prescription drug coverage is creditable. The disclosure must be made to CMS on an annual basis, or upon any change that affects whether the coverage is creditable. At a minimum, the CMS creditable coverage disclosure notice must be provided at the following times:

- Within 60 days after the beginning date of the plan year for which the entity is providing the form;
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status of the prescription drug plan.

Plan sponsors are required to provide the disclosure notice to CMS through completion of the disclosure form on the **CMS Creditable Coverage Disclosure webpage.** This is the sole method for compliance with the CMS disclosure requirement, unless a specific exception applies.

Check out all of our compliance and legislative resources at warnerpacific.com.