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Navigating the Shifting State and Federal Legal Landscape Surrounding Non-Compete Agreements

By John Collier

The Federal Trade Commission ("FTC") issued its final rule banning most non-compete agreements (the "Final Rule") on April 23, 2024. As covered by Kate Belyayeva in the May edition of *Benefitting You*, this rule initiated a significant shift in the legal landscape for employers. Although it was slated to take effect on September 4, 2024, the Northern District of Texas issued a preliminary injunction blocking the Final Rule's implementation before that date.

As discussed below, while impactful, this judicial action by the Northern District of Texas is but the beginning of what will likely be a prolonged legal battle. Accordingly, Employers should be prepared for the FTC to appeal the injunction (with potentially an additional appeal to follow) while also vigilantly monitoring the rapidly evolving state regulations that govern non-compete agreements.

Legal Challenges to the Final Rule

Following announcement of the Final Rule, three lawsuits were quickly filed against the FTC contesting the agency's authority to issue the Final Rule. These cases, each arising in different federal jurisdictions, have resulted in divergent outcomes, creating uncertainty regarding the Final Rule's future and, in turn, creating uncertainty about the regulations that govern non-compete agreements.

In *Ryan LLC v. Federal Trade Commission*, the Northern District of Texas issued a nationwide preliminary injunction on August 20, 2024, indefinitely blocking enforcement of the Final Rule. The court reasoned that the major questions doctrine required the FTC to obtain congressional authorization to implement such a rule. To illustrate its point, the court borrowed language from Justice Barrett's concurring opinion in Biden v. Nebraska as follows:

> [I]f a parent gives a babysitter a credit card and says "make sure the kids have fun while we're out," the parent might expect that the babysitter would take the kids out for ice cream, but would not expect the babysitter to take the kids on an overnight trip to Las Vegas. Likewise here: without clear congressional permission, the final rule, the FTC's equivalent of a trip to Las Vegas, is unauthorized.

Accordingly, the court reasoned that because the FTC "took the kids to Vegas" by issuing the Final Rule without Congressional authority, the Final Rule was unauthorized and due to be enjoined.

In *Properties of the Villages, Inc. v. Federal Trade Commission*, the Middle

Inside this issue:

District of Florida also issued an injunction, but the court limited the effect of its ruling to the plaintiff in that case. Similar to the Ryan decision, the court reasoned that, because a major question was implicated by the FTC's Final Rule, the major questions doctrine requires the FTC to obtain clear congressional authority to issue such a rule.

Finally, in *ATS Tree Services LLC v. Federal Trade Commission*, the Eastern District of Pennsylvania denied the plaintiff's request for a preliminary injunction and upheld the FTC's authority to promulgate the Final Rule. The court reasoned that the FTC's issuance of the Final Rule fell within its broad statutory authority to "prevent" unfair methods of competition.

Accordingly, each of these three cases has resulted in differing outcomes. These conflicting rulings suggest a possible circuit split between the Third, Fifth, and Eleventh Circuits, which could eventually prompt a U.S. Supreme Court review. While review by the Supreme Court would likely provide definitive guidance, such a decision is neither certain nor imminent and may take years to materialize.

State Legislation

While federal courts continue to grapple with the FTC's authority to issue the Final Rule, state legislatures have all but remained idle. Following announcement of the FTC's proposed rule in January 2023, momentum has steadily grown toward curbing the use of non-competes. This surge in state-level activity demonstrates the strong effects of the Biden Administration's virtue signaling despite uncertainty regarding the outcome of the various federal court cases.

Additionally, as states have implemented their non-compete restrictions, there has emerged a trend regarding the structure of many state non-compete limitations. States appear to be embracing non-compete restrictions on the basis of income and/or industry. In other words, while some states may propose complete or near-complete bans on non-compete agreements, regulations restricting or banning non-compete agreements in a particular industry (i.e. health care or construction) or for employees whose income does not exceed a certain amount (typically low-wage earners earning less than six figures) are becoming increasingly common. Consider the following recent state-law developments from the 2023 and 2024 legislative sessions:

1. **Washington:** Washington passed legislation adjusting its income-based non-compete limitation strengthening its other non-compete restrictions.

2. **Illinois:** Illinois enacted regulations restricting non-compete agreements in both the healthcare and construction industries. Additionally, Illinois introduced a bill this year seeking to completely ban all non-compete and non-solicitation agreements, but the bill was not signed into law.

3. **Rhode Island:** Rhode Island passed legislation restricting non-compete agreements in the healthcare industry. Rhode Island also introduced a bill to completely ban all non-compete agreements, but after passing the House and Senate, the bill was vetoed by the Governor.

4. **Louisiana:** Louisiana enacted legislation restricting non-compete agreements in the healthcare industry.

5. **Maryland:** Maryland enacted legislation imposing restrictions on non-compete agreements in the veterinary and healthcare industry.

6. **New Jersey:** New Jersey enacted legislation restricting the use of non-compete agreements in contracts with domestic employees.

7. **Minnesota:** Minnesota joined California, North Dakota, and Oklahoma to become the fourth state to completely ban all non-compete agreements.

In addition to the above, at least 15 other states have proposed legislation to restrict or eliminate non-compete agreements since announcement of the proposed rule in 2023, including Arizona, California, Colorado, Connecticut, Georgia, Iowa, Kentucky, Maine, Mississippi, Missouri, Nebraska, New York, Pennsylvania, Tennessee, and Utah. Notably, many of these states have proposed multiple regulations of various types (including industry and/or income-related restrictions) in an attempt to create multi-dimensional limits on the ability of employers to enter into non-compete agreements with employees. Also, following announcement of the Final Rule and the recent Ryan decision, this legislative wave is expected to intensify. This will likely further complicate the already complex and rapidly evolving legal landscape surrounding non-compete agreements. Accordingly, employers, especially those operating in multiple states, should be especially careful as they navigate the evolving state non-compete regulations.

Employer Takeaways

The current landscape, marked by rapidly evolving state-level non-compete regulations, conflicting federal court rulings, and stark variations in non-compete restrictions across states, is causing employers to face heightened uncertainty about how to safeguard their confidential information while also remaining compliant with applicable regulations. This uncertainty is particularly challenging for companies operating across multiple states, as they must navigate a convoluted and changing patchwork of regulations. To mitigate the risk of running afoul of one of these regulations, employers should consider the following proactive steps:

- ***Stay Informed of State-Level Regulations:*** Employers must devote time and resources to determine and understand the current and upcoming state-level regulations affecting non-compete agreements. Because many states are rapidly introducing new laws or tightening existing restrictions, a thorough and ongoing review of applicable state laws is critical. Employers should also watch for regulatory trends, particularly those regulations imposing industry (especially healthcare) or income-based limitations.

- ***Review and Revise Employment Contracts:*** It is essential for employers to review their existing contracts with employees to ensure that any non-compete agreements are narrowly tailored to protect legitimate business interests. Employers should avoid overly broad language and instead craft agreements that are reasonable in terms of duration, geographic scope, and the type of employment prohibited.

- (cont.) Overly broad are increasingly at risk of being invalidated by courts.

- ***Implement Alternative Protection Mechanisms:*** As non-compete agreements face increasing scrutiny, employers should utilize alternative mechanisms for safeguarding sensitive information. Non-solicitation agreements, non-disclosure agreements, and confidentiality agreements may offer strong protections without running afoul of current or future regulations.

- ***Monitor Federal Litigation:*** Employers should keep a close watch on the lawsuits challenging the FTC's Final Rule. As federal courts continue to issue rulings, employers should be prepared for changes in federal regulations that could impact non-compete agreements nationwide.

- ***Tailor Compliance Efforts by Jurisdiction:*** Employers with operations in multiple states have not, and will not, be able to adopt a one-size-fits-all approach to non-compete agreements. Instead, multi-state businesses should tailor their non-compete and restrictive covenants to align with the specific laws of each state where they operate.

IRS Issues FAQs on Educational Assistance Programs

By: Abby Blankenship

On June 17, 2024, the Internal Revenue Service ("IRS") released Fact Sheet 2024-22, which provides important updates and clarifications on educational assistance programs under section 127 of the Internal Revenue Code ("Code"). The Fact Sheet includes nine frequently asked questions (FAQs) that address both long-standing guidance and new developments, particularly regarding student loan benefits. The Fact Sheet also includes a link to a sample plan document for employers.

To provide some context, under Code section 127, employers are permitted to offer their employees up to $5,250 annually in tax-free educational assistance for undergraduate or graduate-level courses. Furthermore, through the end of 2025, the benefits can also cover principal and interest payments on qualified education loans. The tax advantages of these programs extend to employers as well, as payments made through a Code section 127 educational assistance program are typically deductible as a business expense under Code section 162.

Key Points from Fact Sheet 2024-22

1. *Understanding Eligible Educational Assistance Benefits*

The FAQs clarify that tax-free educational assistance benefits include payments to the employee for tuition, fees and similar expenses, books, supplies, equipment and interest on qualified education loans.

However, educational assistance benefits do not include payments for the following items: (1) meals, lodging or transportation; (2) tools or supplies (other than textbooks) that are kept after completing the course of instruction; and (3) courses involving sports, games or hobbies unless they have a reasonable relationship to the business of the employer, or are required as part of a degree program.

As a general rule, an employer may choose to provide some or all of the educational assistance described above. The terms of the plan may limit the types of assistance provided to employees.

2. Annual Limit Applies Per Calendar Year

As mentioned above, under Code section 127, employees can exclude up to $5,250 annually for payments made on educational assistance, including payments on qualified education loans. The Fact Sheet clarifies that this $5,250 limit applies to payments made and expenses incurred within the same calendar year. If an employee seeks reimbursement for expenses incurred, the expenses must be paid by the employee in the same calendar year for which reimbursement is made by the employer. Additionally, the expenses must not have been incurred prior to employment. However, the FAQs clarify that qualified education loans may be incurred by the employee in prior calendar years and prior to employment, and payments of principal and interest may be made by the employer in a subsequent year. Furthermore, any unused portion of the $5,250 limit cannot be carried over to future years.

3***. Options for Making Payments on Qualified Education Loans***

For payments made between March 27, 2020, and December 31, 2025 (or later if extended by future legislation), employers can choose how to provide assistance under their Code section 127 educational assistance programs. Depending on the design of the program, the employer can either (1) pay the principal or interest on an employee's qualified education loans directly to a third party, such as a loan servicer, or (2) make the payments directly to the employee.

Typically, for an employer to offer payments on an employee's qualified education loans under Code section 127, the employer must update their plan to include this specific benefit. However, if the plan already covers all Code section 127 benefits generally, the plan may not need to be amended to include the loan repayment benefit.

4. ***Reimbursements Are Not Available to Spouses or Dependents***

Under Code section 127, an educational assistance program must be provided exclusively for the benefit of employees. As clarified in the FAQs, this means that reimbursements for qualified

education loans cannot extend to spouses or dependents of employees. The FAQs emphasize that the benefit is strictly for the employee's own education expenses and cannot be used to cover the educational costs of family members.

5. ***Employer Requirements***

As a reminder, for payments to qualify as tax-free under Code section 127, an employer must meet the following requirements:

1. The employer must have a written educational assistance plan;
2. The plan must not offer other taxable benefits or remuneration that can be chosen instead of educational assistance (cash or noncash);
3. The plan must not discriminate in favor of highly compensated employees;
4. An employee may not receive more than $5,250 from all employers combined; and
5. Eligible employees must be reasonably notified of the plan.

Final Takeaways

Educational assistance programs continue to be a popular benefit for both employees and employers. Despite ongoing efforts, the $5,250 annual limit has remained unchanged and has been impacted by inflation. Because of this, it is anticipated that future tax reform discussions are likely to focus on making student loan provisions permanent and raising this cap. Meanwhile, employers without an educational assistance program might consider starting one, and those with existing programs should review them to verify they include payments on qualified education loans.

Health & Welfare Benefits Litigation Roundup: ASD, USERRA, NSA, and AD&D

By Kate Belyayeva

It goes without saying that the Employee Retirement Income Security Act of 1974 ("ERISA") has been the backbone of employee benefits ever since its enactment. While ERISA has been formally amended multiple times over the last five decades to address an array of issues, this landmark law has nevertheless become the topic of extensive litigation, largely driven by evolving interpretations of fiduciary duties and benefit allocations

Some of the dominant trends in ERISA litigation involve claims regarding excessive fees, mismanagement of investment options, and participant rights. This article seeks to explore some of the recent cases in the health and welfare benefits landscape that may impact employers and employees alike.

Midthun-Hensen v. Grp. Health Coop. of S. Cent. Wis., Inc.

Parents of a minor child filed a class action lawsuit against the administrator of their group health plan because the plan chose not to cover the treatment for the child's autism spectrum disorder ("ASD"), specifically speech and sensory-integration therapy. The administrator justified this refusal on the basis that the plan did not cover sensory-integration therapy for ASD at any age and speech therapy for children over nine years old. However, the parents contended that the plan covered pediatric chiropractic treatment, which was analogized to the aforementioned treatment for ASD due to a similar level of lack of scientific support. In its ruling in favor of the plan administrator, the U.S. Court of Appeals for the Seventh Circuit ruled that the medical community focuses on efficacy by age due to the nature of ASD and simply reflected the differences "in the acceptance of those treatments by the medical community at large."

Synoracki v. Alaska Airlines, Inc.

Pilots who served in the Air Force Reserve sought sick leave and vacation accruals during military leave. In a class action lawsuit filed under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), the pilots alleged that they were entitled to accrue vacation and sick leave while on military leave because non-military pilots were entitled to do so; thus, the employer did not treat military leave on par with other types of short-term paid leave provided to employees. The lower court ruled in favor of the airline and stated that military leave was not comparable to other types of paid leave. However, the U.S. Court of Appeals for the Ninth Circuit vacated the case while citing a related case of Clarkson v. Alaskan Airlines and emphasized that USERRA requires military leave be treated no less favorably than other types of comparable leave.

Texas Med. Ass'n v. HHS

The Texas Medical Association ("TMA") challenged a rule issued by the Department of Health and Human Services ("HHS") related to the Independent Dispute Resolution ("IDR") process for resolving payment disputes between insurers and health care providers under the No Surprises Act ("NSA"). TMA argued that the rule requiring arbitrators to consider the median in-network rate (also referred to as the Qualified Payment Amount) in determining payment amounts limited the consideration given to other statutory factors, which, in TMA's opinion, favored insurers and conflicted with the NSA's intent. The U.S. Court of Appeals for the Fifth Circuit held that HHS exceeded its authority in prioritizing one factor over others and imposed extra requirements on arbitrations, which, in turn, disrupted the IDR process. Thus, arbitrators must balance all statutory factors in the context of the NSA, not just the median in-network rate.

Standard Ins. Co. v. Guy

Joel Guy, Jr. had been convicted of murdering his parents and attempted to claim life insurance benefits from his mother's life

insurance and accidental death and dismemberment policies. Generally, the state-law "slayer" statute applies in such cases in order to prevent individuals from profiting from crimes, which would be preempted by ERISA. In spite of preemption, the U.S. Court of Appeals for the Sixth Circuit held that even though ERISA does not expressly address this scenario, federal common law would prevent Guy from receiving the insurance benefits.

Conclusion

Consistent litigation revolving around ERISA and the interpretation thereof reflects the ongoing scrutiny surrounding this law for the last five decades and for years to come. It is anticipated that, in light of the recent overturning of the Chevron deference doctrine, federal courts will continue to weigh in on the matters relating to employee benefit plans more so than ever. The aforementioned cases are far from a comprehensive list of litigation that may have profound impact on employers and employees. Given these litigation trends, continuous monitoring of the ERISA landscape is not only advisable but crucial in order to mitigate legal risks.

Compliance Corner: Summary Plan Descriptions (SPDs) and Summaries of Material Modifications (SMMs)

By: John Collier

One crucial aspect of ERISA compliance is the requirement that plan administrators of employee benefit plans must provide summary plan descriptions ("SPDs") to all plan participants, as well as summaries of material modifications ("SMMs") whenever there are significant changes to plan terms. The SPD must describe individuals' rights, benefits, and responsibilities under the plan in easily understandable language, and it must meet a number of requirements in terms of the content that must be included and how, when, and to whom it must be distributed. According to the Department of Labor ("DOL"), "the SPD is the primary vehicle for informing participants and beneficiaries about their rights and benefits under the employee benefit plans in which they participate."

What Plans are Subject to the SPD/SMM Requirement?

The SPD and SMM requirements apply to most ERISA "employee welfare benefit plans" ("ERISA Plans") with very few regulatory exceptions. ERISA Plans have three basic elements—there must be (1) a plan, fund or program; (2) that is established or maintained by an employer; (3) for the purpose of providing one or more of the following listed benefits to participants and beneficiaries: medical, surgical, or hospital care or benefits; benefits in the event of sickness, accident, disability, death or unemployment; vacation benefits; apprenticeship or other training programs; daycare centers; scholarship funds; prepaid legal services; holiday and severance benefits; or housing assistance benefits.

ERISA Plans include things like health (i.e., major medical) plans, dental plans, vision plans, prescription drug plans, life and AD&D plans, long and short term disability plans, health flexible spending accounts (FSAs), health reimbursement arrangements (HRAs), health "gap" or "bridge" plans (or other supplemental medical coverage), fixed indemnity coverage, employee assistance programs (EAPs), disease-management programs, telemedicine programs, on-site medical clinics, and prepaid legal plans. For any such benefits, employers must meet the SPD and SMM requirements, unless the plans fall under one of the few regulatory exemptions, the most significant of which is the exemption applicable to governmental and church plans.

To Whom Must SPDs/SMMs Be Provided?

Under DOL regulations, the plan administrator of a welfare benefit plan is required to furnish SPDs (and SMMs) only to participants covered under the plan and not to beneficiaries (note that the same is not true for retirement plans). The term "participant" is defined under ERISA as an employee or former employee of any employer who is or may become eligible for benefits under an ERISA Plan or whose beneficiaries are or may be eligible for benefits. Because the definition is not limited to current employees, it can include COBRA qualified beneficiaries, covered retirees, and other former employees who may remain eligible under a plan; however, the term participant does not specifically include a beneficiary.

A participant becomes "covered" under a plan on the earlier of (1) the date on which the plan provides that participation begins, (2) the date on which the individual becomes eligible to receive a benefit "subject only to the occurrence of the contingency for which the benefit is provided," or (3) the date on which the individual makes a plan contribution, whether voluntary or mandatory. Generally, SPDs need not be distributed to employees before they join a plan. If SPDs are furnished to eligible employees before they enroll in coverage, such SPDs should make clear that enrollment (and payment of premiums) is a condition of receiving benefits under the plan.

When Must SPDs/SMMs Be Provided?

SPD Distribution Timing:

Generally, an SPD must be furnished when a participant first becomes covered by a plan and then at regular intervals thereafter. For a participant who is newly covered under an existing plan, an SPD must be furnished within 90 days after the participant first becomes covered under the plan (along with any SMMs previously furnished to participants, the content of which has not yet been incorporated into the SPD). For new plans, an SPD must be furnished to covered participants (and others so entitled) within 120 days after the plan first becomes subject to ERISA.

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An updated SPD must be furnished at least every five years if there have been any material changes made within that five-year period. If no such material changes were made during the immediately preceding ten-year period, then a copy of the most recently distributed SPD must be re-furnished by the plan administrator at least once every ten years.

SMM Distribution Timing:

An SMM is required anytime there is a "material modification" in the terms of the plan or any change in the information required to be in the SPD. Whether a modification or reduction is considered to be "material" generally is a facts-and-circumstances determination; however, plan administrators should consider erring in favor of furnishing SMMs whenever plan changes are made. Among other things, changes in any of the information required to be included in the SPD will require an SMM, and adoption of new legislation or regulations may require an SMM. It is important to note that plan administrators need not furnish an SMM if the modifications in question are, instead, incorporated into an updated SPD, which is distributed by the applicable SMM deadline.

As a general rule, the plan administrator must furnish an SMM within 210 days after the end of the plan year in which a modification is adopted. However, any modification to a group health plan that is considered a "material reduction in covered services or benefits provided under the plan," must be disclosed no later than 60 days after the date of adoption of the change. As with material modifications in general, the determination of whether a change results in a "material reduction" with respect to a group health plan is based on the facts and circumstances. Generally speaking, however, any modification that, independently or in conjunction with other contemporaneous modifications, would be considered by the average plan participant to be an important reduction in covered services or benefits constitutes a "material reduction."

SPDs and SMMs must also be furnished to a participant or beneficiary within 30 days after his or her written request. Failure to do so may result in penalties under ERISA § 502(c)(1) of up to $110 per day.

How Must SPDs/SMMs be Distributed?

SPDs and SMMs must be furnished in a way "reasonably calculated to ensure actual receipt of the material." Probably the two most common methods of distributing SPDs (and SMMs) are by first-class mail or through electronic delivery. DOL regulations provide several examples of acceptable SPD distribution methods, including first-class mail (and second- or third-class mail, if return and forwarding postage is guaranteed and address correction is requested). DOL regulations also expressly provide that SPDs and SMMs may be furnished electronically (including, for example, through email or intranet postings, if certain specific requirements are met). Note that the electronic disclosure rules are complicated and are beyond the scope of this article. Employers that utilize electronic methods for delivering SPDs, SMMs, and other required documents to plan participants, or those that wish to do so, are encouraged to reach out to their consultants/advisors for guidance as needed.

What Information Must be Included in an SPD?

SPDs must include certain basic plan-identifying information, as enumerated in DOL Regulation § 2520.102-3. The DOL regulations also require that SPDs include a statement of the eligibility requirements for participation and any conditions that must be met in order to receive benefits. Satisfying this SPD content requirement in most cases will require describing not only employee eligibility requirements but also enrollment and open enrollment requirements, special enrollment, and eligibility for spouses, domestic partners, and children.

DOL regulations also require that SPDs include: (1) a description of the benefits the plan provides; (2) a statement clearly identifying circumstances that may result in disqualification and ineligibility, and in denial, loss, forfeiture, suspension, offset, reduction, or recovery of any benefits that a participant or beneficiary may reasonably expect the plan to provide; (3) relatively detailed descriptions regarding plan amendment and termination authority/rights; (4) provisions regarding a plan's subrogation and reimbursement rights; (5) disclosures regarding the sources of contributions to the plan (e.g., employer contributions, employee contributions, or both), the method by which the amount of contributions are calculated (and information about other plan costs, if any), and the plan's funding method; (6) detailed benefits claims and appeals procedures; and (7) a statement describing the ERISA rights of participants and beneficiaries.

Additional SPD content requirements apply to ERISA Plans that are group health plans. DOL regulations require a more detailed description of the benefit provisions of a group health plan, as laid out in DOL Regulation § 2520.102-3(j)(3). ERISA and DOL regulations require group health plan SPDs to describe certain information when a "health insurance issuer" is responsible in whole or in part for the financing or administration of a group health plan. In such a case, the SPD must include (a) the name and address of the health issuer; (b) whether, and to what extent, benefits under the plan are guaranteed under a contract or policy of insurance issued by the health issuer; and (c) the nature of any administrative services (e.g., claims processing and payment) provided by the health issuer.

In addition to the description of plan claims procedures required in the SPDs of all welfare plans, the SPD of a group health plan must provide information regarding procedures for obtaining pre-authorizations, approvals, or utilization review decisions. A group health plan SPD must also disclose the "office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under [HIPAA] with respect to health benefits that are offered through a group health plan." Finally, a group health plan must include specific disclosures required under COBRA, HIPAA, the ACA, and other applicable federal laws.

Using "Wrap" Plans to Meet SPD Requirements

Although an employer as plan administrator is legally responsible for SPDs, insurers often provide descriptive documents intended for distribution to eligible individuals. Such documents may even be called summary plan descriptions. However, these documents often do not contain all of the required elements for an SPD in general, and they may not include certain information that needs to be reflected in the SPD (e.g., multiple locations, controlled group issues, accurate

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plan number(s)). On the other hand, the description of benefits contained in such documents is typically very thorough. Therefore, one recommended approach is to supplement the insurers' benefits documents with a "wrap plan" SPD (which also, among other things, permits an employer to file a single annual Form 5500 for all ERISA Plans the employer sponsors, rather than having to file separate 5500s for each benefit).

As the name implies, the wrap plan SPD "wraps" around the insurer-provided documents, and together, the two documents satisfy the SPD requirements. In other words, the wrap plan SPD includes required SPD content that the insurers' documents do not include, and the insurers' documents typically include detailed benefits descriptions that a wrap plan SPD would not include. Employers that do not currently have wrap plan SPD documents in place are encouraged to reach out to their advisors and/or legal counsel for assistance.

STAY IN THE KNOW...

(I) On August 21, 2024, the IRS announced in IR-2024-220 that there will be no change in interest rates for the fourth quarter of 2024. For individuals, the rate for overpayments and underpayments will be 8% per year, compounded daily.

Below is a complete list of the interest rates for the fourth quarter of 2024, which have remained unchanged since the last quarter of 2023:

- 8% for overpayments (payments made in excess of the amount owed), 7% for corporations.
- 5.5% for the portion of a corporate overpayment exceeding $10,000.
- 8% for underpayments (taxes owed but not fully paid).
- 10% for large corporate underpayments.

Under the Internal Revenue Code, the rate of interest is determined on a quarterly basis. For taxpayers other than corporations, the overpayment and underpayment rate is the federal short-term rate plus three percentage points.

(II) Express Scripts is removing Humira from its largest commercial formularies beginning in 2025 in favor of biosimilar options. Similarly, CVS Caremark removed Humira last April.

(III) As open enrollment season approaches, employers should prepare for a significant increase in the cost of employer-sponsored healthcare coverage for 2025. Recent data indicates that the average cost is expected to rise by 9%, with the average annual expense per employee surpassing $16,000 (up from $14,823 in 2024). Small businesses may face an even steeper increase, with projections ranging from 14-18%. This surge is driven largely by the rising costs of specialty medications and increased utilization of treatments for chronic conditions such as diabetes and obesity.

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