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Employer Wellness Plans in the Cross-Hairs of Tobacco Surcharge Litigation

By Kate Belyayeva

In recent months, numerous class-action lawsuits have emerged surrounding tobacco surcharges, the additional fees imposed by employers on health plan participants who use tobacco and tobacco products. The common allegation is that such surcharges violate the Employee Retirement Income Security Act ("ERISA"), the Affordable Care Act ("ACA"), and the Health Insurance Portability and Accountability Act ("HIPAA") by discriminating based on a health status and failing to comply with applicable requirements.

Background

Tobacco surcharges are a part of many employer-sponsored plans. Employers have adopted tobacco surcharges as part of wellness programs in order to incentivize healthier behaviors and offset the increased healthcare costs associated with smoking-related issues. These surcharges are generally permissible under applicable law if they comply with certain requirements, such as providing a reasonable alternative standard for individuals to avoid the surcharge and effectively communicating the availability of such alternatives to employees. These requirements are further described in this month's Compliance Corner.

The employers under scrutiny in these lawsuits represent some of the largest corporations in the U.S., including Walmart, Target, PepsiCo, and Macy's. Most of the cases were filed by former or current employees; however, the DOL has previously initiated litigation, as well. The cases below are just some examples of the claims related to tobacco surcharges.

Litigation

More than two dozen class-action lawsuits have been filed against employers wherein the legality of the tobacco surcharges was challenged on the basis of health status discrimination due to the lack of appropriate alternatives and accommodations, resulting in potential ERISA fiduciary breaches.

Lippert Components Inc.

Lippert Components Inc. faced a class-action lawsuit filed by former employees who alleged that the tobacco surcharge program failed to provide a sufficient reasonable alternative standard and thus disproportionately penalized smokers. In September 2024, Lippert Components Inc. settled the lawsuit for $310,000 in order to avoid further litigation.

Tractor Supply Co.

In September 2024, a class action lawsuit was filed against Tractor Supply Co., alleging that a tobacco surcharge unlawfully forces employees to pay higher premiums for their health insurance (up to $780 per year in

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additional fees). Although the plaintiff agrees that the tobacco surcharge itself was lawful, the plaintiff maintains that the company failed to provide a reasonable alternative standard. Specifically, even after the introduction of a tobacco cessation program, the health plan materials stated that the only way to avoid the surcharge was to be tobacco-free for twelve months. Further, employees who completed the program were not reimbursed for surcharges already paid that year, which, according to the plaintiff, was in violation of the "full reward" requirement. This case is still pending.

Flying Food Group LLC

In August 2023, the DOL's Office of the Solicitor in Chicago filed a lawsuit against Flying Food Group, LLC for charging extra charges (additional $20 per month) for using tobacco without informing them of available reasonable alternatives to avoid the surcharge. In September 2023, the court entered a consent of judgment, which ordered the employer to reimburse $134,222 to employees who paid tobacco surcharges and pay a civil penalty of $13,422 for ERISA violations. Prior to the court's order, the company had already reimbursed participants an additional $79,780 for tobacco surcharges.

GardaWorld Cash Service Inc.

In September 2024, GardaWorld Cash Services, Inc. faced a class-action lawsuit alleging that the health plan placed impermissible surcharges for not only tobacco use ($100) but also COVID-19 vaccination status ($90) in violation of ERISA without offering reasonable alternative standards or adequately informing employees of such alternatives. This case is still pending.

Employer Impact

Wellness programs must adhere to nondiscrimination requirements under ERISA, ACA, HIPAA, and other applicable laws. Tobacco surcharges are considered health-contingent wellness programs, which, among other things, must offer all similarly situated individuals the opportunity to avoid the surcharge by providing a reasonable alternative standard and notify employees of such alternatives. Such programs must be also reasonably designed to avoid penalizing employees unfairly. The increased litigation underscores the necessity for employers to review the design of their tobacco surcharge programs. Specifically, employers should focus on providing clear communication regarding the availability of reasonable alternative standards and regularly review the program for compliance. Some commentators argue that tobacco surcharges disproportionately affect low-income workers, which raises a question about health disparities; however, the current guidance does not expressly address socio-economic impact.

Conclusion

Employers should not rely on a one-size-fits-all approach to tobacco cessation programs. While tobacco surcharges are widely supported as a reasonable means to encourage healthier behaviors, employer execution within the letter of the law has been scattershot and these lawsuits are holding employers accountable. It may be too early to draw definite conclusions or new guardrails, because many of these cases remain pending. In addition, the viability of some of the lawsuits is in question due to the Supreme Court's decision in Loper Bright. However, employers should nevertheless audit their tobacco surcharge programs for strict compliance with federal wellness plan regulations in accordance with this month's Compliance Corner and continue monitoring developments moving forward.

CMS Proposes Rule to Expand Medicare and Medicaid Coverage of GLP-1 Drugs for Obesity Treatment.

By: John Collier

On November 26, 2024, the Centers for Medicare & Medicaid Services ("CMS") issued a proposed rule seeking to expand Medicare and Medicaid coverage to include anti-obesity drugs ("GLP-1s") for weight loss purposes (the "Proposed Rule"). This initiative comes as obesity has continued to escalate into a critical public health challenge, contributing to significant medical and economic burdens.

For employers, the Proposed Rule underscores the importance of understanding both the broader implications of the obesity epidemic and the potential costs and benefits of offering coverage for GLP-1 medications. As the regulatory landscape evolves, careful consideration of these issues is essential for informed decision-making and proactive benefits planning.

Background

In 2024, obesity surpassed joint and soft tissue disease as one of the top five telehealth diagnostic categories in the United States. Further, according to the Centers for Disease Control and Prevention ("CDC"), over 40% of adults in the United States are classified as obese—a condition closely linked with chronic illnesses like diabetes, cardiovascular disease, and certain cancers. Beyond health consequences, obesity imposes a significant economic burden, with annual medical costs exceeding $173 billion.

Given these alarming statistics, it is unsurprising that GLP-1 drugs, such as Wegovy and Ozempic, have surged in popularity. However, their cost—often exceeding $1,000 per month—places them out of reach for many Americans, particularly those living in low-income households (which statistically have the highest prevalence of obesity).

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Current GLP-1 Coverage Landscape

Under existing law, Medicare and Medicaid programs provide coverage for GLP-1 medications only for FDA-approved purposes, such as managing diabetes or cardiovascular disease. Only 13 state Medicaid programs have elected to include coverage for weight-loss-related GLP-1s. Similarly, coverage under ACA Marketplace Plans is sparse, with many plans excluding GLP-1s for obesity treatment.

In the private sector, the landscape is mixed. A growing number of employers are adding GLP-1 coverage for weight loss to their health plans, recognizing the medications' potential to improve employee health and productivity. However, these employers are still in the minority, as surveys show that fewer than 1 in 5 employers currently offer such coverage, citing concerns regarding the high cost of the drugs.

For self-funded employers, the decision is particularly complex. While covering GLP-1s could mitigate future costs associated with obesity-related conditions like diabetes and heart disease, the immediate financial commitment is substantial. Balancing these competing considerations has made many employers hesitant to move forward with expanded coverage.

As regulatory and societal attitudes toward obesity evolve, this fragmented coverage landscape highlights the need for greater alignment between public policy and private-sector health benefits strategies.

The Proposed Rule

Announced on November 26, 2024, the Proposed Rule, among other issues, seeks to address the inequities in access to GLP-1 medications for obesity treatment by expanding coverage under Medicare and Medicaid. Specifically, the Proposed Rule provides for:

1. *Mandatory Medicaid Coverage*.

The Proposed Rule requires state Medicaid programs to cover GLP-1 medications for the treatment of obesity.

2. *Medicare Inclusion*.

The Proposed Rule authorizes Medicare to include GLP-1 drugs in its coverage for obesity treatment.

Issuance of the Proposed Rule indicates that CMS coming into alignment with the general medical consensus that obesity is a disease akin to diabetes or heart disease and treatable by medication rather than a lifestyle issue.

Employer Considerations

The Proposed Rule, coupled with the broader recognition of obesity as a medical condition, carries significant implications for employers. It is important for employers to carefully evaluate the potential financial and strategic impacts of adding GLP-1 coverage for weight loss to their health plans. Key factors to consider include:

1. *Costs of GLP-1 Medications.*

GLP-1 medications are expensive, with monthly costs often exceeding $1,000/month per user. Moreover, effective treatment typically requires continuous use for at least 12–18 months and, in some cases, may necessitate lifelong maintenance. Thus, covering these medications represents a substantial long-term financial commitment, especially for self-funded plans. Employers should assess whether their budgets and cost-containment strategies can accommodate this expense.

1. *Costs of Untreated Obesity.*

Conversely, untreated obesity is associated with significantly higher healthcare costs due to its strong correlation with chronic conditions such as diabetes, hypertension, and heart disease. Studies suggest that reducing obesity rates could lead to measurable savings in overall healthcare expenditures. Employers should conduct a cost-benefit analysis to determine whether investing in GLP-1 coverage could ultimately offset costs associated with obesity-related claims.

2. *Potential Side Effects.*

While GLP-1s are widely considered safe and effective for diabetes management, their long-term effects when used specifically for weight loss for extended periods of time are unknown. Uncertainty surrounding potential side effects and future liabilities or unforeseen health risks warrant careful consideration. Employers should monitor emerging research to stay informed about the evolving safety profile of these medications.

3. *Employee Demand and Retention.*

Offering GLP-1 coverage could enhance an employer's ability to attract and retain top talent. As these medications gain recognition and demand rises, coverage may become a sought-after benefit. Employers who adopt such coverage could differentiate themselves in competitive labor markets, particularly among employees prioritizing wellness and comprehensive healthcare options.

4. *Regulatory Uncertainty.*

It is important to note that the Proposed Rule is not yet final. With a proposed implementation date of January 1, 2026, its future depends on political and regulatory developments. The transition to a Trump administration introduces uncertainty, as shifts in policy priorities could delay, amend, or block its enactment. Employers should closely monitor regulatory updates and prepare for multiple scenarios, including the possibility that GLP-1 coverage remains optional.

5. *Impact on Plan Design and Communication.*

If an employer decides to offer GLP-1 coverage, adjustments to plan design will likely be necessary to balance costs with access. Employers may also need to implement cost-containment strategies and employee education initiatives to raise awareness of the benefit and its appropriate use.

Conclusion

The Proposed Rule highlights a growing legislative focus on

expanding access to GLP-1 medications, indicating a potential shift in the healthcare benefits landscape. As more employers begin to cover GLP-1s for obesity treatment, it is crucial for those considering this addition to thoroughly assess the financial, competitive, and operational impacts such coverage may have on their health plans. By thoughtfully assessing these factors and engaging in ongoing discussions with benefits advisors, employers can make informed decisions that align with evolving regulatory and market trends while preparing for future needs.

ERISA-Related Deadlines Extended for Those Affected by Hurricanes Helene and Milton

By: Abby Blankenship

On November 8, 2024, the U.S. Treasury Department (the "Treasury") and the Internal Revenue Service (the "IRS"), along with the Department of Labor (the "DOL"), issued joint guidance providing an extension of certain deadlines for group health plans, disability and other welfare plans, pension plans, and participants, beneficiaries, qualified beneficiaries, and claimants of these plans affected by the recent disasters of Hurricane Helene, Tropical Storm Helene, and Hurricane Milton. The DOL also issued Notice 2024-01, which grants plan sponsors, fiduciaries and service providers extra time to provide required notices and disclosures under the Employee Retirement Income Security Act ("ERISA"), and a set of FAQs to help retirement and health plan participants, beneficiaries and sponsors understand their rights and responsibilities. Additionally, on November 14, 2024, the Department of Health and Human Services ("HHS") issued a similar Bulletin providing guidance and relief.

Background

In response to individuals affected by the recent natural disasters, the joint guidance was primarily issued to minimize the possibility of such individuals losing plan benefits due to a failure to comply with certain pre-established timeframes. The DOL and Treasury joint notice allows additional time for participants and beneficiaries directly affected by a covered disaster to comply with certain deadlines affecting health and welfare benefits. For purposes of the notice, "directly affected" means the individual resides, lived, or worked in one of the disaster areas (as designated by the Federal Emergency Management Agency ("FEMA")) at the time of the hurricane or tropical storm or whose coverage was under an employee benefit plan that was directly affected. As a general rule, a plan is directly affected if the principal place of business of the plan sponsor or office of the plan administrator or primary recordkeeper is in a disaster area. The relief applies to those directly affected by a covered disaster in Florida, Georgia, North Carolina, South Carolina, and portions of Tennessee and Virginia.

Extended Relief Periods

FEMA established different incident periods for affected areas beginning in late September and early October 2024. The joint notice suspends the following timeframes for affected participants from the first day of the applicable incident period until May 1, 2025 (the "Relief Period"):

(1) The 30-day period (or 60-day period, if applicable) to request special enrollment under the Health Insurance Portability and Accountability Act ("HIPAA");

(2) The 60-day election period under the Consolidated Omnibus Budget Reconciliation Act ("COBRA");

(3) The 30-day period (or 60-day period, if applicable) to notify the plan of a COBRA qualifying event (and the 60-day period to notify the plan of a determination of a disability);

(4) The 45-day period to make a first COBRA premium payment and the 30-day period for subsequent premium payments; and

(5) The dates within which individuals may file (i) a benefit claim, (ii) an appeal of an adverse benefit determination, (iii) a request for an external review, or (iv) information to complete a request for external review under the plan's ERISA claims procedures.

As stated above, the commencement of the relevant Relief Period ranges from September 23 to October 5, 2024, depending upon each specific affected area, and ends on May 1, 2025. For example, for designated disaster areas in Florida, the Relief Period begins on September 23, 2024. For designated disaster areas in Georgia, the Relief Period begins on September 24, 2024. For designated disaster areas in North Carolina, South Carolina, and Virginia, the Relief Period begins on September 25, 2024. For designated disaster areas in Tennessee, the Relief Period begins on September 26, 2024. Finally, for disaster areas in Florida not designated as disaster areas from Hurricane Helene (but designated as disaster areas from Hurricane Milton), the Relief Period begins on October 5, 2024.

Plan sponsors with directly affected plans or individuals should review the joint notice to determine the applicable Relief Period for their affected area.

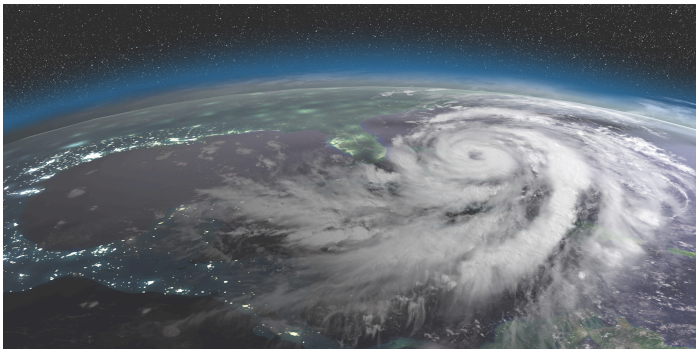
Additional Relief Under Notice 2024-01

Under Notice 2024-01 (the "Notice"), a plan and its responsible fiduciary will not be treated as violating ERISA for failing to timely deliver any ERISA-required notice, disclosure or other documents due during the Relief Period, as long as they act in good faith and furnish the notice, disclosure, or document "as soon as administratively practicable under the circumstances." Additionally, the Notice provides that good faith delivery includes use of electronic-delivery methods, such as text messages, emails or websites, as long as the plan fiduciary reasonably believes participants have effective access to those means of electronic communication. The Notice also provides certain relief related to pension plan loan and distribution verification procedures, participant contributions and loan

repayments, blackout notices, and Form 5500 filings.

Key Takeaways

The guidance explicitly states that the agencies will continue to monitor the effects of Hurricane Helene, Tropical Storm Helene, and Hurricane Milton and may provide additional relief as warranted. Therefore, employers, plan sponsors, and plan administrators should continue to monitor for any updates relating to later extensions.



Compliance Corner: Understanding the Recent Tobacco Surcharge Litigation: What Employers Need to Know

By: Abby Blankenship

Recently, tobacco surcharges have become the focal point of a wave of class-action lawsuits filed under the Employee Retirement Income Security Act ("ERISA"). These lawsuits have been filed against companies of all sizes alleging that their tobacco-free wellness programs are not compliant with ERISA and that plan fiduciaries are violating their fiduciary duties when imposing and collecting these surcharges. In light of the growing legal scrutiny surrounding tobacco surcharges, this month's Compliance Corner provides employers with an overview of the recent litigation and offers key takeaways for ensuring compliance with current regulations.

Background on Tobacco-Free Wellness Programs

ERISA Section 702(b) allows a plan to charge a participant an insurance premium based on a health-status related factor if that participant fails to adhere to a program "of health promotion and disease prevention," i.e., a wellness program. A tobacco-free wellness program is a program designed to incentivize participants to quit using tobacco products. Since tobacco use can increase healthcare costs, tobacco-free wellness programs can help offset the costs associated with a participant's tobacco use. Participants who do not use tobacco products are automatically rewarded, usually by avoiding an increased insurance premium (i.e., a surcharge). Generally, those participants who use tobacco products are provided the opportunity to attend a tobacco cessation program to earn the reward and avoid the surcharge. Employers often use these surcharges as part of broader wellness initiatives aimed at improving employee health outcomes. In addition to considerations under ERISA, tobacco surcharges touch on issues under the Health Insurance Portability and Accountability Act ("HIPAA") and the Affordable Care Act ("ACA"). ERISA expressly permits these programs so long as they comply with certain requirements. Additionally, the ACA and HIPAA require that such surcharges be part of a compliant wellness program, providing tobacco users with a clear path to reduced premiums by meeting a reasonable alternative standard (RAS), such as enrolling in a cessation program. A tobacco-free wellness program complies with ERISA if the following requirements are met:

(1) the employer has a wellness program that has a tobacco cessation program and allows the person the opportunity to qualify for the "reward";

(2) the tobacco cessation program is reasonably designed to promote health or prevent disease, not to penalize the participant;

(3) the surcharge is not more than 50 percent of the total cost of the participant's premium;

(4) the promise of a lower health insurance premium is available to all similarly situated participants; and

(5) plan materials discussing the wellness program communicates the requirements of the tobacco cessation program and ensures that participants understand their options to avoid surcharges.

Failing to meet these requirements can lead to compliance issues and increase the likelihood of ERISA-based legal challenges. Additionally, employers should verify whether state-specific laws impose any additional requirements on implementing tobacco surcharges.

Recent Litigation

A growing number of ERISA class-action lawsuits are targeting tobacco surcharge programs in employer-sponsored health plans across the United States as further detailed in this month's issue. Please see the article titled "Employer Takeaways From the Recent Tobacco Surcharge Litigation" for more information. In sum, plaintiffs generally allege that their employers failed to provide a reasonable alternative standard to a smoking cessation program (such as counseling), failed to properly notify employees of such an alternative, failed to provide a full refund of the surcharge for individuals who satisfied the alternative standard, violated ERISA's anti-discrimination standards by failing to meet the legal requirements of a bona fide wellness program, and/or breached alleged fiduciary duties. These cases essentially argue that tobacco surcharges unfairly burden tobacco users by raising the costs of their premiums without offering sufficient opportunities to avoid the surcharges. As a result, the plaintiffs allege that these employers are violating ERISA's fiduciary obligation to act in the best interests of the participant.

Key Takeaways for Employers

Based on the wave of ERISA class action litigation, employers who have established wellness programs should review them to ensure they comply with ERISA and the applicable regulations prior to implementation. Additionally, employers who intend to implement wellness programs in 2025 should also ensure that their tobacco surcharge polices are compliant with ERISA, the ACA, HIPAA, and

other applicable regulations. As demonstrated by these lawsuits, employers should review their wellness program design with a focus on two main concepts: (1) transparency and (2) accessible alternatives.

(1) **Transparency:** As a practical matter, employers should ensure that all information relating to the tobacco-free wellness program is provided to each participant. This includes ensuring that all program materials detail the availability of reasonable alternative standards and pertinent contact information. Failure to effectively communicate the availability of alternatives and how to access them within wellness program materials can lead to non-compliance with ERISA's fiduciary standards and HIPAA requirements.

(2) **Accessible Alternatives:** Employers should ensure that they are adequately providing reasonable alternatives, such as a smoking cessation program, so that employees are given the opportunity to qualify for the lower premium. These surcharges may be viewed as discriminatory and punitive when employers do not provide clear, accessible, reasonable alternative standards.

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- Under the Consolidated Appropriations Act ("CAA"), health plans and insurance issuers must submit a Gag Clause Compliance Attestation (the "Attestation") by December 31, 2024. The regulation prohibits health plans from including gag clauses—provisions that limit transparency around provider pricing, quality, and claims data. Fully insured and self-insured group health plans must file the Attestation, stating that service providers have removed gag clauses from health care contracts by December 31, 2024. The Attestation is completed electronically and can be found on the Centers for Medicare & Medicaid Services ("CMS") website.

- Last month, the U.S. Department of Labor's ("DOL") Wage and Hour Division issued a new Opinion Letter providing clarification regarding the use of FMLA leave for participation in clinical medical trials. The DOL opined that FMLA-qualifying employers are required to grant FMLA leave to eligible employees who request it for participation in clinical trials, even when the interventions involved are experimental or may include placebos. This opinion broadens the FMLA's scope, underscoring its purpose to support employees managing serious health conditions and ensuring access to innovative or emerging treatments through clinical research.

- On November 15, 2024, a federal court in Texas issued a nationwide injunction against the DOL's rule increasing the minimum salary to qualify for an FLSA white collar exemption. The court order retroactively enjoins the increase that took effect under the rule on July 1, 2024, in addition to all other aspects of the rule, including its scheduled January 1, 2025 increase. As a result, the Trump-era DOL rule on minimum salary ($684/wk), remains the law of the land. DOL has pledged to appeal the decision, but the President-elect is expected to direct DOL to drop that appeal shortly after taking office in January 2025.

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