Eighth Circuit Court of Appeals Allows Lawsuit Challenging EEOC's PWFA Rules to Proceed

By: Abby Blankenship

In a significant legal development, the Eighth Circuit Court of Appeals has ruled that a lawsuit brought by seventeen Republican-led state attorneys general challenging the Equal Employment Opportunity Commission's inclusion of abortion among protected pregnancy-related conditions pursuant to the Pregnant Workers Fairness Act ("PWFA") can move forward.

Background on the PWFA

The PWFA requires an employer to provide a "reasonable accommodation" to an employee affected by pregnancy, childbirth, or other related medical conditions, unless the employer can show that the accommodation would impose an undue hardship on operation of the business. The law aims to protect workers who may need temporary changes to their job duties or schedules due to pregnancy or related medical issues. Under the PWFA, employers are mandated to provide accommodations such as more frequent breaks, seating, modified work schedules, and time off for pregnancy-related medical needs, both during pregnancy and after childbirth.

The Equal Employment Opportunity Commission (the "EEOC") published its final rule (the "Final Rule") implementing the PWFA, which went into effect on June 18, 2024. The Final Rule outlines specific accommodations that employers must offer pregnant workers. The Final Rule also includes abortion as a "related medical condition" and extends accommodations to workers who need time off for abortion-related treatments or recovery.

Legal Challenge by 17 States

In response to the Final Rule, a coalition of seventeen state attorneys general, including those from Alabama, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kansas, Missouri, Nebraska, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Utah, and West Virginia, filed a lawsuit challenging the Final Rule. The states contend that the Final Rule exceeds the EEOC's statutory authority in how it defined "pregnancy-related health conditions" under the PWFA and that the Final Rule conflicts with the states' policies. Specifically, the lawsuit challenges the EEOC's interpretation of the law, particularly regarding accommodations for individuals seeking elective abortions. After the Final Rule was published, the states sought an injunction to prevent enforcement of the Final Rule and a declaratory judgment declaring it unlawful.

On June 14, 2024, the U.S. District Court for the Eastern District of Arkansas denied the states' request for a preliminary injunction, ruling that the states lacked standing to challenge the Final Rule. In particular, the district court stated that

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the states lacked standing because they did not allege an injury-in-fact arising from the Final Rule.

The Eight Circuit's Ruling

On February 20, 2025, however, the U.S. Court of Appeals for the Eight Circuit reversed the district court's decision, holding that the states do indeed have standing to bring the lawsuit. The three-judge panel concluded that the states were directly impacted by the EEOC's regulatory actions, as they would need to revise their employment policies and provide training to employees to ensure compliance with the Final Rule. According to the court, the EEOC's rule "requires immediate action by the States to conform to the Rule, and this action produces an injury in fact." The court disagreed with the EEOC's argument that any injury is too speculative, stating that the regulatory burden on state governments was substantial enough to warrant legal standing for the states to challenge the Final Rule. Notably, the ruling did not address the substantive merits of the states' legal arguments concerning the content of the Final Rule Instead, it merely allowed the case to proceed, sending it back to the district court for further proceedings. This decision marks the first appellate ruling concerning the EEOC's implementation of the PWFA, which remains a highly contentious issue in the courts.

Looking Ahead for Employers

Employers should closely monitor the ongoing litigation, as this case could ultimately influence how the PWFA is enforced across the country. While the decision allows the lawsuit to proceed, it does not indicate a final determination on whether the EEOC's interpretation of the PWFA is legally sound. Additionally, although the Final Rule and its associated employer obligations are currently in effect, it is likely that the EEOC will reconsider parts of the Final Rule once it regains a quorum under the new Trump administration.

IRS Publishes New ACA Reporting Guidance for Employer Distribution of 1095-B and 1095-C

By: Abby Blankenship

On February 21, 2025, the Internal Revenue Service ("IRS") released Notice 2025-15, providing guidance to employers and insurers regarding the alternative manner of furnishing certain health insurance coverage statements to individuals under sections 6055(c)(3) and 6056(c)(3) of the Internal Revenue Code (the "Code").

As context, applicable large employers (ALEs) and insurers that provide minimum essential coverage (MEC) must annually report information about each covered individual to the IRS and provide Forms 1095-B and 1095-C (documents showing proof of MEC). The Paperwork Burden Reduction Act permits employers and insurers to forgo automatically sending Forms 1095-B and 1095-C to individuals, provided that a timely notice is provided and individuals do not specifically request the forms.

The Notice clarifies that the existing alternative manner rule for furnishing statements to certain individuals (other than full-time employees) also applies to full-time employees. Specifically, employers or insurers must post a notice on their website that clearly and conspicuously informs individuals that they may request a copy of their forms. The notice must also include contact details such as an email address, physical address, and phone number for inquiries if individuals have questions. Additionally, such notice must be posted on the website by the due date for providing the statement, including any extensions.

Trump's Executive Order on Price Transparency: More Data for Employers and Employer-Sponsored Plans

By: Kate Belyayeva

On February 25, 2025, President Donald Trump signed an executive order titled "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information" (the "Order"), which generally aims at enhancing transparency in healthcare pricing. The full text of the Order can be found here: https://www.whitehouse.gov/presidential-actions/2025/02/making-america-healthy-again-by-empowering-patients-with-clear-accurate-and-actionable-healthcare-pricing-information/.

Background

The Order reinforces and builds on a prior order issued in 2019 and titled "Improving Price and Quality Transparency in American Healthcare to Put Patients First" (the "Initial Order"). Among other things, the Initial Order required hospitals to provide patients with pricing information for up to 300 shoppable services in a consumer-friendly manner and a machine-readable file with negotiated rates for all provided services, as well as their out-of-network payments to providers. Various hospital groups, such as the American Hospital Association, challenged the Initial Order on statutory and constitutional grounds, and such challenge was unsuccessful, both in the district court and on appeal.

Pursuant to the Initial Order, the Centers for Medicare and Medicaid Services (the "CMS") implemented two transparency rules: (1) the Hospital Price Transparency Rule; and (2) the Health Plan Transparency in Coverage Requirements. However, CMS noted very low compliance with the Initial Order, and, as a result, attempted to increase compliance by way of civil monetary penalties and other incentives.

The Order

The Order mandates for the Departments of Treasury, Labor, and Health and Human Services to "take all necessary steps to improve existing price transparency requirements" and do the following within 90 days with the general intent to increase price transparency:

- Price disclosure: Hospitals and insurers must disclose the actual prices of items and services instead of mere estimates. The Order seeks to ensure that consumers are aware of their true financial obligations.
- Enforcement policies: Federal agencies are required to update enforcement policies in an effort to comply with the transparency requirements.
- Pricing information: The Order calls for standardization of pricing information to ensure comparability across hospitals and health plans.

Employer Impact

While the benefits of greater transparency are self-evident for individual consumers of healthcare, employers generally welcome price transparency because better access to clear and standardized pricing information enables employers and employer-sponsored health plans to make more informed decisions regarding coverage and tailor their health plan coverage accordingly. Furthermore, more transparent pricing schemes provide employers with data to negotiate with healthcare providers and insurers in a more effective manner, which could drive down costs in the future. However, employers may need to invest in systems and processes in order to process and analyze the pricing data and subsequently relay the information to the employees. In addition, while the proponents of the Order believe it will lead to lower prices and better healthcare quality, the critics seem to think the Order will present challenges and may disrupt employer-provider negotiations.

As for any action items, employers should ensure adherence to the updated transparency requirements. For instance, employers should get in touch with their insurers and/or third-party administrators to verify that pricing information is accurately reflected and accessible. For example, impacted parties should consult their advisors as to the posting of machine-readable files and on a public website in accordance with the transparency rules. As such, ensuring compliance with the new transparency requirements may entail additional administrative efforts and costs for employers, which vary based on the size of the employer.

Conclusion

The Trump administration anticipates that full implementation of the price transparency measures will result in a great deal of healthcare savings for insurers, employers, and consumers alike —$80 billion by 2025 to be exact—and generally calls for "a more competitive, innovative, affordable, and higher quality healthcare system." The benefitting stakeholders can then redirect the savings into other benefits and investments. On the other hand, while price transparency is generally praised and widely-accepted by consumers, the aforementioned concerns regarding the Order should be taken into account. Nevertheless, the long-term success of the Order will largely depend on its effective implementation and consistent enforcement.

Compliance Corner: ERISA Fiduciary Duties (Part 2)

By: John Collier

Background / Recap

ERISA imposes strict standards of conduct (i.e., fiduciary duties) on entities and individuals who fall within the definition of a fiduciary with respect to an employee benefit plan. The fiduciary duty rules generally apply to retirement plans, health plans, and other welfare plans alike, provided those plans are subject to ERISA. Accordingly, unless an employer's health and welfare plans fall outside of the scope of ERISA (for example, because they are exempt under the voluntary plan or payroll practice safe harbors, or because the employer is a church or state/local governmental entity), then ERISA's fiduciary duty rules will broadly apply to any entity or individual deemed to be a fiduciary with respect to those plans.

Some entities or individuals will be "automatic" fiduciaries with respect to an ERISA plan by virtue of their designated roles. For example, every ERISA plan is required to have a "plan administrator" and at least one "named fiduciary," and whoever serves in these roles are automatic fiduciaries. Often, however, the named fiduciary and plan administrator will be the same person or entity, and the employer will be the one serving in both of these roles by default. Other entities or individuals may be fiduciaries by virtue of the plan functions they perform. Under ERISA § 3(21), generally, an entity or individual is a fiduciary with respect to a plan to the extent he/she/it performs plan functions that involve discretionary authority or control over plan administration or plan assets, or rendering investment advice for compensation.

For those entities and individuals who are deemed to be fiduciaries with respect to an ERISA plan, ERISA imposes the following fiduciary duties:

1. The duty to act solely in the interests of plan participants and beneficiaries (aka, the "Duty of Loyalty"), and to use plan assets for the exclusive purpose of providing plan benefits, or for defraying the reasonable expenses of plan administration (aka, the "Exclusive Benefit Rule");
2. The duty to act with the care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims (aka, the "Prudent Expert Rule");
3. The duty to diversify the investments of the plan; and
4. The duty to administer the plan in accordance with the plan documents.

For anyone who is a fiduciary with respect to an ERISA health or welfare plan, one of the key considerations when reviewing the design and administration of your plan is whether, or when, various plan-related funds become "plan assets" for ERISA purposes, and what that designation means with respect to the receipt, transfer, and use of those funds.

When are Funds Considered to be Plan Assets?

Generally, "plan assets" include any property, interest, or right owned by an ERISA-covered plan. This can include insurance policies and/or funds held by the plan for the purpose of providing benefits or paying reasonable plan administrative expenses. An employer's general assets usually are not considered to be plan assets. Accordingly, a plan that pays benefits solely from the employer's general assets is treated as "unfunded" for ERISA purposes (we discuss the significance of "unfunded" vs. "funded" plan status in the next section of this article).

However, if funds are segregated from an employer's general assets and placed in a separate trust or account that is maintained exclusively for the purpose of paying plan benefits and/or reasonable plan administrative expenses, then that alone may be enough to cause those funds to be plan assets (and, thus, for the plan to be treated as a "funded" plan). The determination as to whether a separate account, in and of itself, is enough to create plan assets, and, thus, a "funded" plan, is a complicated one. For employers that utilize separate accounts in the plan's name (or a third party's name) and/or that are held out as being used solely for plan purposes, it is recommended that you discuss this practice with your benefits consultants or legal counsel to see whether this may create compliance issues.

Participant contributions, whether paid directly to a plan or indirectly through wage withholding by the employer, are plan assets by definition under the DOL regulations. Participant contributions become plan assets as of the earliest date on which such contributions "can reasonably be segregated from the employer's general assets" and no later than 90 days from the date on which such amounts would have been payable to the participant in cash. Pursuant to these rules, with respect to each payroll, employee contributions withheld become plan assets, at the latest 90 days thereafter, even if the employee contributions are never actually segregated from the employer's general assets. Additionally, amounts attributable to participant contributions are also plan assets. These would include, for example, forfeitures under a health FSA, and may also include refunds, rebates, demutualization payments, and similar insurer payments made in connection with an insured plan (if participant contributions were used to pay the premiums on the insurance policies).

Why is it Important to Know When Funds are Plan Assets?

It is important to know when funds are plan assets because a number of significant ERISA requirements are affected by the existence of plan assets and the treatment and handling of those plan assets. For example, self-insured (aka, self-funded) plans may be considered to be "funded" or "unfunded" for ERISA purposes depending on whether they have plan assets. Funded plans are subject to ERISA's trust requirement (i.e., plan assets be held in a formal trust administered by one or more trustees), fidelity bond requirement (i.e., every fiduciary with respect to the plan and every person who handles plan funds must be bonded), and numerous Form 5500 requirements, including the Schedule H financial reporting and independent qualified public accountant's opinion (IQPA) requirements.

These additional requirements can be particularly onerous, and for that reason, most employers attempt to maintain unfunded plan status with respect to their self-funded ERISA plans by having benefits paid solely from the company's general assets. Although plans that accept participant contributions technically have plan assets, pursuant to EBSA Technical Release 92-01, the DOL will not enforce the trust requirement for plans that would

be considered funded solely because of participant contributions made through a cafeteria plan. Furthermore, pursuant to DOL regulations, the same exception effectively applies with respect to ERISA's fidelity bond and Form 5500, Schedule H and IQPA requirements. Note, however, that this non-enforcement relief is unavailable if the employer segregates participant contributions from the employer's general assets or transmits plan assets to an intermediary account outside of the employer's general assets to pay benefits.

Another reason why it is important to know when funds are plan assets is because of the Exclusive Benefit Rule, which states that plan fiduciaries must use plan assets exclusively for the purposes of providing plan benefits or defraying reasonable plan administrative expenses. Thus, for any funds that constitute plan assets, plan fiduciaries must carefully monitor how those funds are being used, and when making decisions as to whether an expense is payable from plan assets, the plan fiduciary must act prudently and solely in the interests of participants and beneficiaries and in accordance with the terms of the plan's governing documents (i.e., in accordance with the Duty of Loyalty and Prudent Expert Rule).

Reasonable expenses of administering a plan include direct expenses properly and actually incurred in the performance of a fiduciary's duties to the plan. The analysis of whether an expense is reasonable is a fiduciary determination made at the time the expense arises based on all relevant facts and circumstances. For the most part, if an expense is incurred at arm's-length and in good faith, the reasonableness requirement may not be a major concern. However, close scrutiny should be given to situations where plan assets are being used to pay for services provided by a "party in interest" (i.e., a person or entity directly or indirectly related to the plan) or to reimburse the employer for expenses it incurs in administering the plan.

Only expenses related to non-settlor (i.e., administrative) functions are payable from plan assets. As a general rule, all plan design decisions relating to the establishment, amendment, or termination of a plan are considered to be settlor functions. Of course, from a practical standpoint, whether something is a settlor or non-settlor function can be a fine distinction in many cases. For example, if a plan sponsor incurs legal fees to amend its plan to add a new coverage feature, those legal fees would be expenses related to a settlor function, which are not eligible for payment from plan assets. However, if the plan sponsor incurs legal fees to amend its plan to comply with legal changes, those would be non-settlor (administrative) expenses eligible for payment from plan assets (since the amendment is merely for compliance purposes). Overhead expenses generally should not be paid or reimbursed from plan assets. For employees whose time is not devoted entirely to plan administration, DOL guidance suggests that an employee's compensation expenses will not be reimbursable at all unless the employee spends at least 80% of his or her time on plan administrative functions.

Prohibited Transaction Rules

ERISA prohibits certain listed transactions, unless a statutory or regulatory exemption applies to permit the transaction. There are two categories of prohibited transactions: (1) transactions between plans and "parties in interest" ("PIIs") and (2) transactions involving fiduciary self-dealing. The prohibitions apply whether a transaction is fair or beneficial to the plan and regardless of whether the plan suffers a loss.

Specifically, ERISA § 406(a)(1) prohibits a fiduciary from causing a plan to engage in a transaction if the fiduciary knows or should know that the transaction constitutes a direct or indirect—

- Sale, exchange, or leasing of any property between the plan and a PII;
- Lending of money between the plan and a PII;
- ·Furnishing of goods, services, or facilities between the plan and a PIIt;
- Transfer to, or use by or for the benefit of, a PII of any plan assets; or
- Acquisition, on behalf of a plan, of any employer security or real property in violation of ERISA § 407(a).

ERISA § 406(b) prohibits a fiduciary from—

- Dealing with plan assets in the fiduciary's own interest or for the fiduciary's own account;
- Acting in any transaction involving the plan on behalf of a party whose interests are adverse to those of the plan or its participants or beneficiaries; and
- Receiving any consideration (i.e., a kickback) from any party in connection with a transaction involving plan assets.

There are a number of statutory and administrative exemptions that allow common transactions necessary to the conduct of plan business to fall outside of the scope of the prohibited transaction rules. Most notably, for example, even though the furnishing of goods and services between a plan and PII is prohibited under ERISA § 406(a)(1), an exemption is provided by ERISA § 408(b)(2) for reasonable arrangements with PIIs for services necessary for the operation of a plan if no more than reasonable compensation is paid.

On the other hand, there are also several prohibited transaction pitfalls in the health and welfare plan context. These are transactions that will, in most cases, be deemed to be non-exempt prohibited transactions and will subject responsible plan fiduciaries to potential liability under ERISA for having engaged in such transactions. For example, an employer's retention of prescription drug, medical loss ratio, or other medical rebates when the coverage was paid for, in whole or in part, with plan assets would be a prohibited transaction. Additionally and more broadly, an employer's retention or reversion of plan assets for its own account without having properly substantiated that the amounts qualify as reimbursements for reasonable plan administrative expenses would be a prohibited transaction.

Lastly, plan fiduciaries (including employers that are fiduciaries with respect to the plans they sponsor) must be careful not to engage in transactions on a plan's behalf where the service provider on the other side of the transaction either is the fiduciary or is another party in which the fiduciary as an interest (thus, creating a conflict of interest). Being involved in the decision to retain such a service provider is a prohibited transaction for the affected fiduciary for which there is no exemption. This can occur, for example, where a plan fiduciary makes the decision to choose itself or its affiliate to provide services to the plan in exchange for a fee.

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- In response to President Trump's executive order rescinding Executive Order 11246, the U.S. Department of Labor last month issued a directive to the Office of Federal Contract Compliance Programs ("OFCCP") to immediately "cease and desist all investigative and enforcement activity under the rescinded Executive Order 11246 and the regulations promulgated under it." Federal contractors, who had been subject to the affirmative action requirements of Executive Order 11246 since the 1960s still have compliance obligations under Section 503 of the Rehabilitation Act and the Vietnam Era Veterans Readjustment and Assistance Act, but even those compliance obligations remain unclear in the wake of federal policy changes related to affirmative action.

- Historically, when defined contribution plans were terminated, the Department of Labor ("DOL") designated IRAs as the preferred destination for missing participant account balances. However, on January 14, 2025, the DOL issued Field Assistance Bulletin 2025-01, introducing a new option for sponsors and administrators of ongoing defined contribution plans. Under this guidance, missing participant balances of $1,000 or less may now be transferred to the state unclaimed property fund associated with the participant's last known address, providing an alternative to traditional rollover options.

- In September 2024, the Federal Trade Commission filed suit against three largest PBMs, CVS/Caremark, Cigna/Express Scripts, and UnitedHealth/OptumRx, and alleged that they played a key role in inflating the price of insulin. The PBMs argued that the FTC's actions were unconstitutional in a countersuit. A district court in Missouri has now ruled that the FTC could proceed with its case, and in response, all three PBMs have appealed that decision to the Eight Circuit Court Appeals. PBMs remain under attack by the plaintiffs' bar, federal and state agencies, and lawmakers of both parties.

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