Office Hours Webinar

2022 EB Year in Review: Plus What to Expect in 2023

January 10, 2023

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Newfront

Today's Topics

2022 Year in Review…

Plus What to Expect in 2023!

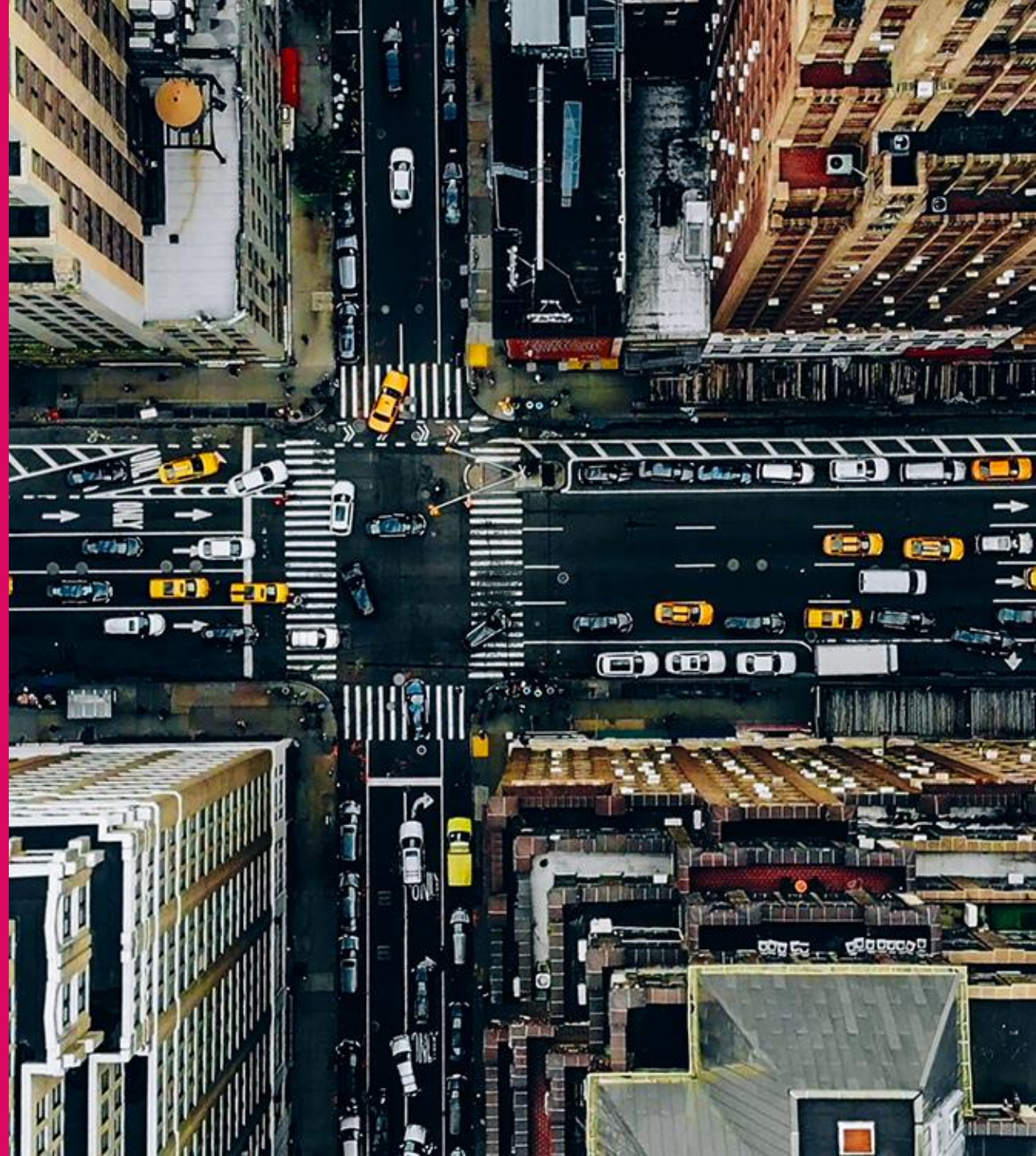
- The ACA has survived a trilogy of U.S. Supreme Court challenges plus multiple repeal/replace efforts, and now (a dozen years in) we start to have some stability
- The CAA may not have been intended as a health bill, but it is proving to be the most significant health care reform effort since ACA (and bipartisan at that!)
- Build Back Better fizzled and became the streamlined Inflation Reduction Act, which didn't affect employers directly—what's to come with divided government?
- At this point many of the Covid relief provisions have expired, but key provisions such as the "Outbreak Period" remain a major consideration for employers
- The Dobbs decision overturning Roe v. Wade spurred a wave of abortion-related travel assistance offerings, and renewed focus on the related compliance issues

Year in Review Main Topics

1	**The ACA:** With more than a dozen years down, the ACA is now firmly ingrained—particularly the employer mandate and reporting rules that employers need to be familiar with
2	**The CAA:** The mega-bill's health plan-related provisions are kicking into full gear with major changes
3	**Biden Administration:** Divided government makes major legislative moves less likely, but the administration can still implement significant changes from the executive and regulatory side
4	**Covid Continued:** An overview of what has expired, what continues in effect, and where to next?
5	**Dobbs Decision:** Employers grapple with Supreme Court decision and offer abortion-related travel HRAs

1. The ACA

Still Marching 12 Years In



The ACA's Employer Mandate "Pay or Play" §4980H Penalties

§4980H(a)—The "A Penalty" Aka: The "Sledgehammer Penalty"

- **Failure to offer MEC to at least 95% of all full-time employees (and their children to age 26)**
- The A Penalty is triggered by at least one such full-time employee who is not offered MEC enrolling in subsidized exchange coverage
- **2023 A Penalty liability is $2,880 annualized ($240/month) multiplied by all full-time employees**
  - **30 full-time employee reduction from multiplier**

§4980H(b)—The "B Penalty" Aka: The "Tack Hammer Penalty"

- Applies where the employer is not subject to the A penalty
- **Failure to:**
  1. **Offer coverage that's affordable**
  2. **Offer coverage that provides MV**
  3. **Offer MEC to a full-time employee (where the employer has still offered at a sufficient percentage to avoid A Penalty liability)**
- The B Penalty is triggered by any such full-time employee enrolling in subsidized exchange coverage
- 2023 B Penalty liability is $4,320 annualized ($360/month) multiplied by each such full-time employee who enrolls in subsidized exchange coverage
  - Note that although the B Penalty amount is higher ($4,320 vs. $2,880), the multiplier is generally much lower (only those full-time employees not offered affordable/minimum value coverage who enroll in subsidized exchange coverage)

The ACA's Employer Mandate "Pay or Play" §4980H Penalties

§4980H(a)—The "A Penalty" Aka: The "Sledgehammer Penalty"

Simplified Version

- **Must offer MEC to at least 95% of full-time employees and their children to age 26**
- To avoid the "A Penalty"
- **2023 A Penalty liability is $2,880 annualized ($240/month)** multiplied by all full-time employees (reduced by first 30)

§4980H(b)—The "B Penalty" Aka: The "Tack Hammer Penalty"

Simplified Version

- The offer of MEC must:
  a) **Be affordable; and**
  b) **Provide minimum value (MV)**
- To avoid the "B Penalty"
- **2023 B Penalty liability is $4,320 annualized ($360/month)** multiplied by each such full-time employee who enrolls in subsidized exchange coverage

2023 Affordability Safe Harbors: 9.12%

Full Alert: How the 2023 ACA Affordability Decrease to 9.12% Affects Employers

For 2023, the applicable percentage decreases significantly to 9.12% (down from 9.61% in 2022).

- **2023 Federal Poverty Line Safe Harbor:** 9.12% of the Federal Poverty Line
  - 2022 Federal Poverty Line (Contiguous 48 States): $13,590
  - 2023 Monthly Employee-Share of Premium for Lowest-Cost Plan Limit: $103.28
  - *Action Item: Always use this approach where the employer offers plan option at a cost that does not exceed $103.28/month*
- **2023 Rate of Pay Safe Harbor:** 9.12% of Rate of Pay
  - Hourly Employees: 9.12% of Employee's Hourly Rate of Pay x 130 Hours (regardless of actual hours of service)
  - Salaried Employees: 9.12% of Employee's Monthly Salary
  - *Action Item: Use this approach where the employer's cheapest plan option costs employees more than $103.28/month*
- **2023 Form W-2 Safe Harbor (Not Recommended):** 9.12% of Box 1 Wages
  - Disadvantage #1: Retrospective Determination—Form W-2 safe harbor provides no predictability because Box 1 unknown until January of following year (i.e., employer will not know until January 2024 whether it met the Form W-2 safe harbor for 2023)
  - Disadvantage #2: Disregarded Compensation—Box 1 does not include many forms of compensation, including 401(k) deferrals and Section 125 salary reductions for health and welfare plan coverage
  - Disadvantage #3: Fixed Premium—The employee-share of the premium must remain consistent as an amount or percentage for the full plan year, which means employers cannot make mid-year adjustments to address lower-than-anticipated Box 1 amounts

Full Alert: How the 2023 ACA Affordability Decrease to 9.12% Affects Employers

"Eligible Opt-Out Arrangement" Approach Avoids Affecting Affordability

- Employers often offer employees an additional amount of taxable cash compensation if they waive the health plan
- Unless they are properly structured, these "opt-out credits" (aka "cash-in-lieu") can cause the employer's offer of coverage to fail to meet one of the ACA affordability safe harbors
- Opt-out credits that are not designed to qualify as an "eligible opt-out arrangement" must be added to the employee-share of the premium when determining affordability—this is not intuitive!
- For example, if the employer's lowest-cost plan option is $100/month and the opt-out credit is $50/month, under the general rule the plan costs $150/month ($100/month premium plus $50/month opt-out credit) for affordability purposes to reflect the $50/month the employee forgoes by electing the health plan*

Eligible Opt-Out Arrangement Requirements:

1. The opt-out credit is conditioned on the employee declining to enroll in the major medical plan; and
2. The opt-out credit is conditioned on the employee providing reasonable evidence (including employee attestation) annually that the employee and all members of the employee's expected tax family have or will have minimum essential coverage under a group health plan (or Medicare/TRICARE) for the period the opt-out credit applies

**Note: The IRS has indefinitely delayed these eligible opt-out arrangement rules for arrangements in effect prior to 12/16/15*

Full Alert: How the 2023 ACA Affordability Decrease to 9.12% Affects Employers

"Health Flex Contribution" Approach Treats Flex Credits as Employer Contribution

- Some employers use a flex credit approach under the Section 125 cafeteria plan whereby employees may allocate a fixed amount of credits to different qualified benefits
- Often these flex credits can be allocated to non-health benefits or cashed-out as taxable income
- Unless the flex credits are properly structured, the flex credit amount available for employees to allocate to the health plan will be treated as an employee contribution for ACA affordability purposes
- Employers generally need to make the flex credits count as an employer contribution to meet one of the ACA affordability safe harbors—this requires that the flex credits qualify as "health flex contributions"

Health Flex Contribution Requirements:

1. The employee may not opt to receive the amount as a taxable benefit (i.e., it is not a cashable flex credit);
2. The employee may use the amount to pay for minimum essential coverage (i.e., the employee's major medical plan); and
3. The employee may use the amount exclusively for health coverage costs (e.g., medical, dental, vision, health FSA, HSA)

Full Details: When To Appeal Employer Exchange Notices (Section 1411 Certifications)

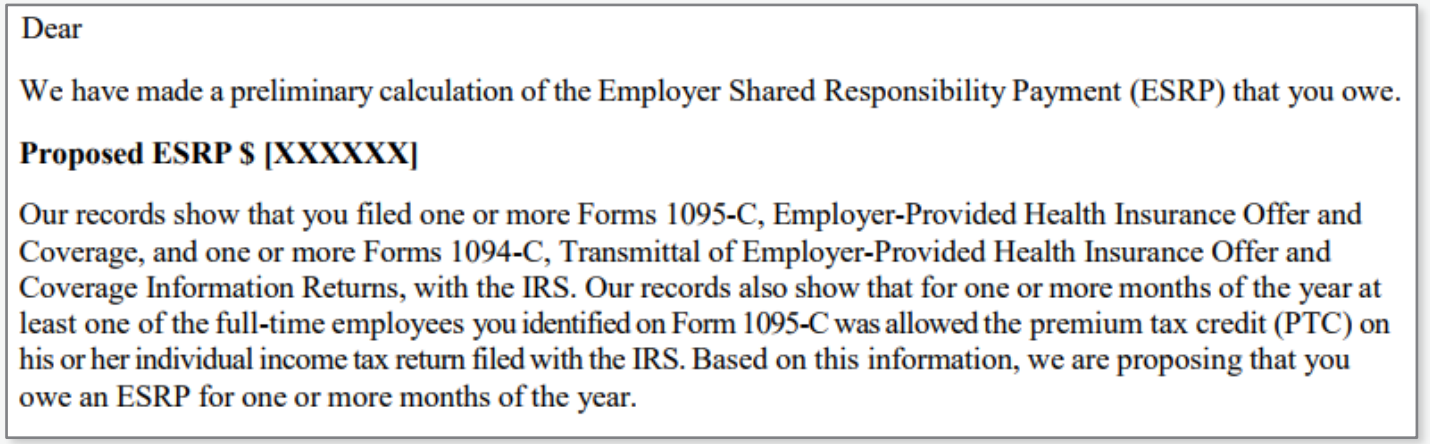
Employer Exchange Notices Are the First Bite at the Apple!

- Notifies employers that the exchange has conditionally approved the employee for the Advance Premium Tax Credit (APTC)
    - Commonly referred to as “exchange subsidies”
- These subsidies trigger ACA employer mandate pay or play penalties
- **Employers care:** Remove subsidy, remove §4980H penalty (no subsequent Letter 226J)
- **Employees care:** Remove subsidy, remove need to pay it back on tax return

Employer Exchange Notice Approach	Employer Offered Affordable/MV MEC	Employer Did NOT Offer Affordable/MV MEC
Full-Time Employee	**Strongly Recommend Appeal** • Prevent ACA Employer Mandate §4980H Penalties • Prevent Repayment of APTC	**Do Not Appeal** • Employer will receive Letter 226J with §4980H penalties
Part-Time Employee	**Consider Appeal** • Prevent Repayment of APTC	**Do Not Appeal** • Nothing to appeal here

IRS Letter 226J

- Applicable Large Employers (ALEs) have been receiving ACA employer mandate penalty assessments since late 2017
- ALEs continue to be informed of prior year penalty assessments
- Many penalties are the result of ACA reporting errors on the Forms 1094-C and 1095-C
- Explanation of reporting errors and corrected codes usually removes penalties
- Keep relevant data because Letters 226J are generally for two years prior
- Review full alert for details on how to respond to Letter 226J



Dear

We have made a preliminary calculation of the Employer Shared Responsibility Payment (ESRP) that you owe.

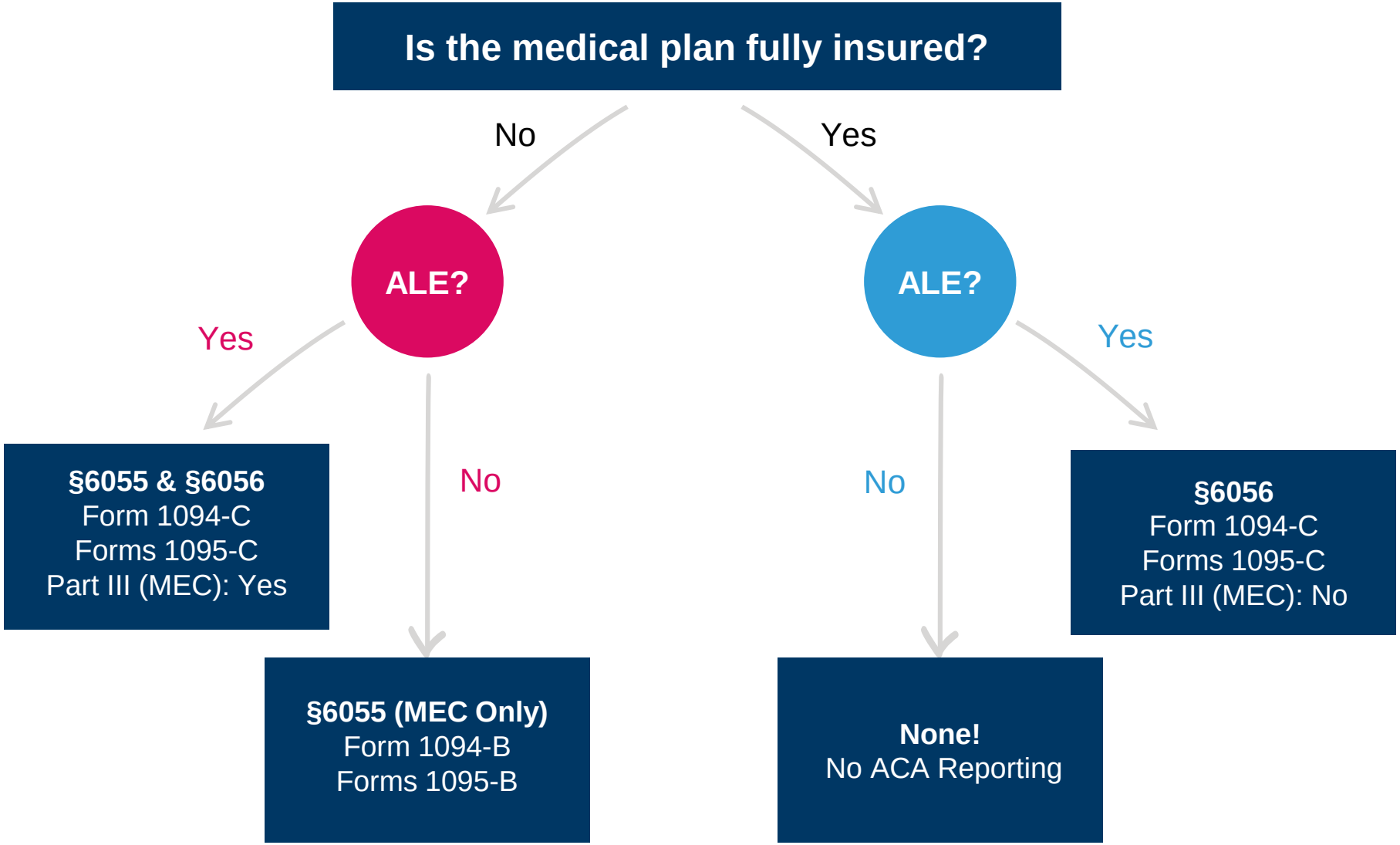
Proposed ESRP $ [XXXXXX]

Our records show that you filed one or more Forms 1095-C, Employer-Provided Health Insurance Offer and Coverage, and one or more Forms 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns, with the IRS. Our records also show that for one or more months of the year at least one of the full-time employees you identified on Form 1095-C was allowed the premium tax credit (PTC) on his or her individual income tax return filed with the IRS. Based on this information, we are proposing that you owe an ESRP for one or more months of the year.

Full Details Available Here:
Responding to IRS Letter 226J

ACA Reporting: Which Employers Need to Report?

Full Details: **Newfront Office Hours Webinar: The ACA Employer Mandate & ACA Reporting**



ACA Reporting Deadlines—Extension Stays, No More Good Faith Safe Harbor

Full Details: **ACA Reporting Deadlines and Compliance Requirements in 2023**

Extended Deadlines are Here to Stay

- The IRS finalized new regulations in December 2022 to make the 30-day extension permanent!
  - 30-day extension applies only to the deadline for providing the forms to individuals
  - Deadlines to file with the IRS remain standard
- In prior years the IRS also provided the good faith enforcement safe harbor to avoid penalties for incorrect or incomplete information (generally $290 per return)
  - **Remember:** No good-faith safe harbor available anymore—standard penalty scheme applies for incorrect information

2023 ACA Reporting Deadlines

Forms	Filing Method	Due Date
2022 Forms 1095-B and 1095-C	Furnish to Individuals	Standard: January 31, 2023 **IRS Extension to March 2, 2023**
2022 Forms 1094-B and 1094-C (+Copies of Forms 1095-B/1095-C)	File with IRS by Paper	February 28, 2023
2022 Forms 1094-B and 1094-C (+Copies of Forms 1095-B/1095-C)	File with IRS Electronically (Required for 250 or More Returns)	March 31, 2023

Due Dates: Final Regulations Confirm Automatic Extension Made Permanent

Full Details: **ACA Reporting Deadlines and Compliance Requirements in 2023**

Form 1095-C: To Employees

- Must be furnished by **March 2** of the following year
- Standard deadline is January 31, but the new IRS final regulations make the 30-day extension from previous years permanently available going forward (great news!)
- Unfortunate downside is they have also confirmed that the good faith enforcement safe harbor for incorrect/incomplete forms is no longer available

Forms 1094-C and 1095-C to the IRS

- Due date depends on whether the employer files electronically
- **Paper:** Must be furnished by **February 28** of the following year
- **Electronic:** Must be furnished by **March 31** of the following year
- Employers that file 250 or more returns must file with the IRS electronically
  - IRS intends to reduce required electronic filing threshold to just 10 returns, unclear when new standard would apply

Ongoing Relief for Carriers (Not Employers)

Full Details: **ACA Reporting Deadlines and Compliance Requirements in 2023**

IRS Provides "Section 6055 Furnishing Relief" for Insurance Carriers (and Non-ALEs)

- The TCJA effectively repealed the ACA individual mandate by reducing penalties to zero as of 2019.
  - Therefore, the Form 1095-B generally provided by the insurance carrier (or self-insured non-ALE) no longer has a clear reporting purpose under IRC §6055.
- **IRS therefore stated it will not assess penalties on insurance carriers (or self-insured non-ALE) for failure to furnish Forms 1095-B to individuals under two conditions:**
  1. The insurance carrier (or self-insured non-ALE) posts a notice prominently on its website stating that individuals may receive a copy of their Form 1095-B upon request; and
  2. The insurance carrier (or self-insured non-ALE) furnishes a Form 1095-B to any individual upon request within 30 days of the date it receives the request.

Employers Still Required to Complete ACA Reporting Via Form 1095-C

- The ACA employer mandate remains fully in effect, therefore employers still must furnish and file the Forms 1095-C.
- **Employers sponsoring a self-insured medical plan still must complete Part III of the Form 1095-C for any full-time employee.**
  - Still required even though that information in Part III is related to the §6055 reporting requirements.
- California, New Jersey, Rhode Island, and D.C. have state-based individual mandates that rely on the Form 1095-B (fully insured plan) and Part III of the Form 1095-C (self-insured plan) information.
  - May eventually need to develop a state form like the Massachusetts Form MA 1099-HC) for this purpose.

Full Details: ACA Reporting Corrections

Same Penalties as Apply for Forms W-2 (Penalty Amounts for Forms Furnished/Filed in 2023)

General penalty is $580 for each incorrect return ($290 for return furnished to individual, $290 for return filed with the IRS).

- Total fine not to exceed $3,532,500.
- Penalty reduced to $50 if the corrected return is filed within 30 days after the required filing date—total fine max reduced to $588,500.
- Penalty reduced to $110 if corrected by August 1 of the year in which the filing due—total fine max reduced to $1,766,000.

Special Good Faith Efforts Applied in Previous Years—No Longer Available

For the Forms 1094-C and 1095-C filed in previous years, a “good faith efforts” standard applied.

- The IRS would not impose the penalties described above if the employer could show that it made “good faith effort” to comply with the information reporting requirements.
- Applied to incorrect or incomplete information (including SSNs).
- IRS has confirmed the end of good faith transition relief confirmed in new proposed regulations
- Reasonable cause penalty relief is still available in some circumstances

PCORI Fee Extended to 2029 (Surprise!)

Full Alert: **ACA PCORI Fee Increases to $2.79 for 2021 Calendar Plan Years Filing July 2022**

Congress Extended the PCORI Fee for Another Decade (to 2029)

- 2019 was originally to be the final year Patient Centered Outcomes Research Institute (PCORI) fees and filings were required
- Major industry groups (AHIP, BCBSA, ERIC, NRF, US Chamber) pushed for 10-year extension to 2029
- That legislation was ultimately incorporated into the same massive "Further Consolidated Appropriations Act, 2020"
- Employers with self-insured medical plans (including level funded plans) need to file and pay for the PCORI fee!
- Only employers with a self-insured major medical plan (including level funded plans) and/or HRA (special HRA rules apply) must file for and pay the PCORI fee (the insurance carrier files/pays for fully insured plans)

PCORI Fees	July 31, 2022 Form 720 PCORI Filing	July 31, 2023 Form 720 PCORI Filing
Plan Year Ends January 1 – September 30	Applicable Rate: • $2.66 per covered individual	Applicable Rate: • $2.79 per covered individual
Plan Year Ends October 1 – December 31	Applicable Rate: • $2.79 per covered individual	Applicable Rate: • $3.00 per covered individual

Full Alert: Cadillac Tax Fully Repealed

The CAA Repealed the Cadillac Tax

- On December 20, 2019, President Trump signed into law a massive appropriations bill that finally and mercifully put an end to the Cadillac Tax delay charade with a full repeal
- The Cadillac Tax was previously delayed twice (from 2018 to 2020, from 2020 to 2022)
- The Cadillac tax would have provided that health coverage exceeding a statutory dollar limit (generally a baseline of $10,200 for employee-only coverage, $27,500 for family coverage) be considered an “excess benefit” subject to a 40% excise tax

Two Main Reasons Why Congress Previously Only Delayed the Tax:

1. **Political:** Preserve the argument that the ACA was fully paid for. President Obama also supported it to discourage “fancy plans that end up driving up costs.”
2. **Revenue:** Congressional Budget Office (CBO) and Joint Committee on Taxation (JCT) scored the Cadillac Tax as an enormous revenue raiser (roughly $90 billion over ten-year budget window). Previous full repeal efforts stalled because of attempts to replace the lost revenue—which ultimately did not occur.

- Repeal of the Cadillac Tax is still an enormous victory for employer-sponsored coverage three years later
- Employers would have been forced to make serious benefit cuts to avoid the tax if it actually took effect—and it’s very questionable whether employers would have accounted for such benefit decreases by providing commensurate taxable cash compensation

The Insurance Premium Tax Fully Repealed!

Full Alert: Cadillac Tax Fully Repealed

The CAA Repealed the Insurance Premium Tax

- In the same massive appropriations bill that repealed the Cadillac Tax, the health insurance premium tax was also repealed effective in 2021
- The repeal comes after two moratoriums of the tax in previous years
- The ongoing saga of this on again, off again tax has finally ended

When Did the Health Insurance Premium Tax Apply?

- The Moratorium Mania:
  - 2014 – 2016: Premium tax in effect
  - 2017: Moratorium year (tax did not apply)
  - 2018: Premium tax in effect
  - 2019: Moratorium year (tax did not apply)
  - 2020: Tax in effect
  - 2021 and Beyond: Premium tax repealed
- Most estimates are that the premium tax added roughly 2.5% to 4% to the premium cost
- The tax applied only to fully insured health plans (self-insured plans were not subject)

Health FSA Indexed Salary Reduction Contribution and Carryover Limits

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Full Alert: 2023 Health FSA Limit Increased to $3,050

2023 Health FSA Limit Increased to $3,050—Carryover Limit Up to $610

Salary Reduction Contribution Limit:

$3,050 for Plan Year Beginning On or After 1/1/2023

ACA Original $2,500 Limit Indexed for Inflation

- Adjusts in $50 increments based on a complex cost-of-living calculation tied to the chained and standard consumer price index increases for the preceding calendar year
- After two years in a row stuck at the $2,750 limit (plan years beginning on or after January 1, 2020 and 2021), the cost-of-living increases in 2021 were sufficient to boost the limit by two $50 increments ($100 total) for the $2,850 2022 limit
- Cost-of-living increases in 2022 were significant enough to boost the limit by four $50 increments ($200 total) for 2023
- Means that for plan years beginning on or after January 1, 2023, the health FSA salary reduction contribution limit increases to $3,050

Carryover Limit:

$610 for Plan Year Starting in 2023 to Plan Year Starting in 2024

IRS Now Indexes the Carryover Limit

- President Trump's Executive Order 13877 in June 2019 directed the IRS to increase the $500 carryover limit
- The IRS announced in Notice 2020-33 that it was increasing the carryover limit to an amount equal to 20% of the maximum health FSA salary reduction contribution
- The carryover limit for plan years starting in 2022 to plan years starting in 2023 was at $570 (20% of $2,850)
- The carryover limit for plan years starting in 2023 to plan years starting in 2024 is now set at $610 (20% of $3,050)
- Reminder: CAA FSA relief provisions permitted full carryovers for both the health FSA and the dependent care FSA for plan years ending in 2020 and 2021 into the subsequent plan years ending in 2021 and 2022, respectively. That provision has now sunset.

ACA Individual Mandate Tax Penalty (Effectively) Repealed

Full Alert: **Tax Cuts and Jobs Act Provisions that Affect Employee Benefits**

Tax Cuts and Jobs Act (TCJA) Removed Tax Penalty

- Effective as of 2019, the TCJA zeroed out all penalties for failure to maintain minimum essential coverage (MEC)
- The reconciliation rules prevented full repeal, but zeroing out penalties is the functional equivalent
- The U.S. Supreme Court declined to rule on the merits of case related to how it affects the rest of the ACA (see earlier slide for details)
- For these purposes, the key is that employees may choose to go uninsured without any federal tax consequences
- Somewhat of a mystery why §6055 reporting (Part III of the Form 1095-C for self-insured) is still required by IRS

Individual Mandate ACA vs. TCJA	ACA: 2018 Last Year Individual Mandate in Effect	TCJA: 2019 and Beyond Individual Mandate Tax Penalty Removal
Percentage Amount	• 2.5% of Income Above Filing Threshold	• 0% of Income Above Filing Threshold
Flat Dollar Amount	• $695/Adult • $347.50/Child • $2,085 Family Max	• $0/Adult • $0/Child • $0 Family Max

Full Alert: California Enacts State-Based Individual Mandate

Multiple States Have Imposed State-Based Individual Mandates

- The ACA originally modelled its federal individual mandate (which took effect in 2014) on the state individual mandate first imposed in Massachusetts during the Governor Romney administration in 2006
- Since the removal of the ACA federal individual mandate tax penalty, a number of states have considered a state-based approach to protect the individual market risk profile
- These new state individual mandates typically mirror the tax penalty scheme previously applied under the ACA
- For example, California's tax penalty is generally the greater of 2.5% of gross income over the filing threshold or $800/adult and $400/child
- States with individual mandates now include Massachusetts, California, New Jersey, Rhode Island, Vermont, and Washington D.C.

What About State Individual Mandate Reporting?

- States are mostly relying on the Forms 1095-B (carrier reporting for fully insured) and 1095-C (self-insured) to gather coverage information for residents
- Generally the carrier's obligation to provide the Form 1095-B to the state where the plan is fully insured
- Generally the employer's obligation to provide the Form 1095-C to the state where the plan is self-insured (including level-funded)
- Note that some states have not provided the same 30-day extension available from IRS for furnishing Form 1095-C
- What happens if §6055 reporting is eliminated? States will have to devise their own forms, likely modelled after the Form 1099-HC in Massachusetts

2. The CAA

New Law Launches Into Spotlight in 2022 and 2023

CAA Effective Dates Timeline

December 27, 2020

- Prohibition on Gag Clauses
  - Annual attestation provision delayed pending guidance

February 10, 2021

- Mental Health Parity Comparative Analysis

Plan Years Beginning on or After January 1, 2022

- Primary Care Provider Designation
  - Expanded to non-grandfathered plans
- Preventing Surprise Medical Bills: Emergency Services (No Surprises Act)
- Preventing Surprise Medical Bills: Non-Emergency Services (No Surprises Act)
- Ending Surprise Air Ambulance Bills (No Surprises Act)
  - Reporting requirement delayed to 3/1/23 for 2022 data, 3/30/24 for 2023 data
- Continuity of Care (No Surprises Act)
  - Good faith, reasonable interpretation of the CAA provisions until regulations issued
- Medical ID Card Cost-Sharing
  - Good faith, reasonable interpretation of requirements until the Departments issue regulations

CAA Effective Dates Timeline

July 1, 2022

- Machine-Readable In-Network Rates and Out-of-Network Allowed Amounts with Detailed Pricing Information
  - Delayed from first plan year beginning on or after January 1, 2022

December 27, 2022

- Annual Reporting on Pharmacy Benefits and Drug Costs
  - Departments issued FAQ guidance on December 23, 2022 providing a grace period for first submission through January 31, 2023, and announcing a good faith efforts standard for enforcement of initial report

First Plan Year on or After January 1, 2023

- Price Comparison Tool for First 500 Shoppable Items/Services
  - ACA regulations and CAA have nearly identical provisions, ACA provision delayed from 1/1/22
- The New CAA Surprise Billing Notice (Version 2)
  - For employers that maintain a public website for their group health plan

First Plan Year on or After January 1, 2024

- Price Comparison Tool for Remaining Shoppable Items/Services
  - In addition to first 500 required by first plan year on or after 1/1/23

The New/Modified CAA Patient Protections: No Surprises Act

Full Alert: The ACA and CAA Patient Protections

Four CAA Patient Protections for Plan Years Beginning On or After January 1, 2022

1	Primary Care Provider Designation (originally in ACA, expanded by CAA)
2	Preventing Surprise Medical Bills (added by CAA—No Surprises Act)
3	Ending Surprise Air Ambulance Bills (added by CAA—No Surprises Act)
4	Continuity of Care (added by CAA—No Surprises Act)
*	Emergency Services Coverage (ACA protection replaced by broader No Surprises Act)

Full Alert: **The ACA and CAA Patient Protections**

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Primary Care Provider Designation (originally in ACA, expanded by CAA)

- Medical plans that require designation of a primary care provider must permit enrolled employees and dependents to designate any primary care provider who is available to accept such individual
- This right extends to designation of an in-network pediatrician for covered children
- Women also generally have the right to access care from an OB/GYN without prior authorization.
- Employers sponsoring a group health plan with medical plan options that require designation of a primary care provider (e.g., HMOs) must provide the patient protection notice to plan participants whenever an SPD or other similar description of benefits is provided

CAA Changes:

- As of the first plan year beginning on or after January 1, 2022, the primary care provider designation patient protection provisions apply to ACA grandfathered plans
- Prior to 2022, this patient protection applied only to non-grandfathered health plans
- This continues the trend of moving toward the near irrelevance of maintaining ACA grandfathered plan status

Full Alert: The ACA and CAA Patient Protections

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Preventing Surprise Medical Bills (added by CAA—No Surprises Act)

Medical plans that cover emergency services must generally cover such services:

1. Without any prior authorization requirement;
2. Regardless of whether the provider is in-network;
3. Without imposing any requirement or limitation that is more restrictive for out-of-network emergency providers than in-network emergency providers;
4. Without any greater cost-sharing than would apply for in-network emergency services (no balance billing); and
5. By applying the cost-sharing payments for out-of-network emergency services toward any in-network deductible or out-of-pocket maximum in the same manner as if the services were provided in-network

- "Cost-sharing" for these purposes includes copayments, coinsurance, and (unlike the original ACA protection) deductibles

Full Alert: The ACA and CAA Patient Protections

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Preventing Surprise Medical Bills (added by CAA—No Surprises Act)

Medical plans that cover out-of-network non-emergency services must generally cover such services:

1. Without any cost-sharing requirement that is greater than would apply if provided in-network (no balance billing);
2. By calculating the cost-sharing as if the total amount charged by the provider is the "recognized amount" for such items and services;
3. With initial notice of payment or denial transmitted to the provider within 30 calendar days of the bill for such services;
4. With payment to the provider within 30 days of the determination date for any amounts exceeding the cost-sharing owed by the participant; and
5. By counting the cost-sharing payments toward any in-network deductible and out-of-pocket maximum in the same manner as if the services were provided in-network

- The "recognized amount" is generally an averaging of cost determination, with the specific determination set based on state law if applicable, or otherwise set based on the Social Security All-Payer Model Agreement
- The CAA adds an independent dispute resolution process that permits the plan to engage in a 30-day negotiation process with the out-of-network provider
- Notice and Consent Exception: Protections against balance billing do not apply where health care provider provides notice and obtains participant's consent meeting a number of strict requirements for exception to apply

Full Alert: The New CAA Surprise Billing Notice

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Preventing Surprise Medical Bills (added by CAA—No Surprises Act)

New Model Notice to Post by First Plan Year Beginning on or After January 1, 2023:

- Available via CMS website, use “Version 2”
- No Surprises Act (NSA) rules require that health plans and insurance carrier post the notice on a public website of the plan
- Website must be “publicly available” to satisfy rules
- For employers with a public group health plan website, post version 2 of the Notice to that site
- For employers with a fully insured plan but without a public group health plan website, insurance carrier is required to post on their site
- For self-insured plans, Tri-Agency FAQ Guidance confirms that employers without a public website for the group health plan can rely on third-party administrator (TPA) where there is a written agreement for the TPA to post the files on its website on behalf of the plan

Full Alert: The New CAA Surprise Billing Notice

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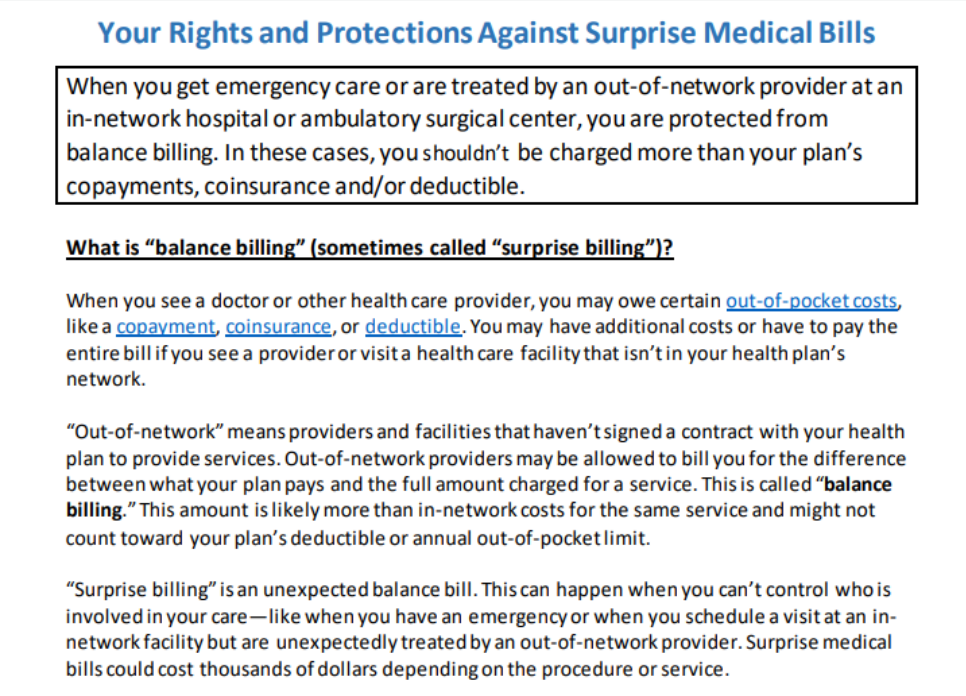
Preventing Surprise Medical Bills (added by CAA—No Surprises Act)

New Model Notice Issued to Post by First Plan Year on or After January 1, 2023:

- Available via CMS website, use “Version 2”



Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

Full Alert: The ACA and CAA Patient Protections

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Ending Surprise Air Ambulance Bills (added by CAA—No Surprises Act)

Medical plans that cover air ambulance services must generally cover such services by an out-of-network air ambulance provider in the following manner:

1. By applying the same cost-sharing that would apply if the air ambulance provider were in-network; and
2. Counting the cost-sharing amounts towards the in-network deductible and in-network out-of-pocket maximum in the same manner as if the services were provided in-network.

- The plan has 30 days after receiving the bill for the out-of-network air ambulance services to respond to the provider with the initial notice of payment or denial
- There can be no balance billing charged to the participant in the process
- An independent dispute resolution will apply where the parties cannot agree to the appropriate out-of-network rate
- Plans will have a two-part, Tri-Agency reporting requirement to provide claims data related to air ambulance services (proposed rules delay reporting requirement to 3/31/23 for 2022 data, 3/30/24 for 2023 data)

Full Alert: The ACA and CAA Patient Protections

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Continuity of Care (added by CAA—No Surprises Act)

Medical plans are generally subject to the continuity of care patient protections for "continuing care patients" with respect to a provider or facility where:

1. The in-network contractual relationship terminates;
2. Plan benefits terminate because of a change in the plan's terms of participation for the provider or facility; or
3. The termination of a group health plan's contract with a health insurance carrier causes loss of benefits for the provider or facility.

- Plan must offer "continuing care patients" the opportunity to elect to continue benefits with the provider or facility for up to 90 days of transitional care under the same terms and conditions that would have applied with respect to such items and services had the termination not occurred
- Plan must notify each individual who is a "continuing care patient" of the right to elect transitional care from the provider upon one of the events described above
- Plan must also provide the "continuing care patient" the opportunity to notify the plan of the need for transitional care
- Departments advise to follow a good faith, reasonable interpretation of the CAA until regulations issued

Full Alert: The ACA and CAA Patient Protections

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Continuity of Care (added by CAA—No Surprises Act)

"Continuing care patients" are individuals who, with respect to a provider or facility, are:

1. Undergoing a course of treatment for a serious and complex condition;
2. Undergoing a course of institutional or inpatient care;
3. Scheduled to undergo nonelective surgery from the provider (including postoperative care);
4. Pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. Determined to be terminally ill and receiving treatment for such illness.

Full Alert: The ACA and CAA Patient Protections

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Emergency Services Coverage (ACA protection replaced by broader CAA protection)

- Original ACA provision primarily required medical plans that cover emergency services to provide out-of-network emergency coverage and impose the same copay and coinsurance cost-sharing that apply to an in-network emergency provider for any out-of-network emergency services
- The plan may impose a deductible for out-of-network emergency services only as a part of a deductible that generally applies to out-of-network benefits
- Similarly, if an out-of-network out-of-pocket maximum generally applies under the plan, it must also apply to out-of-network emergency services
- This patient protection also provides that the plan cannot impose prior authorization or any other coverage limitation that is more restrictive than those imposed on in-network providers.

CAA Changes:

- As of the first plan year beginning on or after January 1, 2022, the emergency services coverage patient protection provision no longer applies in its original form.
- The original ACA provision is replaced by the broader CAA patient protection provision designed to prevent surprise medical bills, known as the “No Surprises Act.”

Full Alert: The CAA Prescription Drug Data Collection Reporting Requirements

New Annual Reporting on Pharmacy Benefits and Drug Costs

- Reporting is designed "as a means to promote competition and bring down overall health care costs" by collecting:
  - General information regarding the plan or coverage;
  - Enrollment and premium information, including average monthly premiums paid by employees versus employers;
  - Total health care spending, broken down by type of cost (hospital care; primary care; specialty care; prescription drugs; and other medical costs, including wellness services), including prescription drug spending by enrollees versus employers and issuers;
  - The 50 most frequently dispensed brand prescription drugs;
  - The 50 costliest prescription drugs by total annual spending;
  - The 50 prescription drugs with the greatest increase in plan or coverage expenditures from the previous year;
  - Prescription drug rebates, fees, and other remuneration paid by drug manufacturers to the plan or issuer in each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates; and
  - The impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs.

First Report Initially Due December 27, 2022—Grace Period Through January 31, 2023

- FAQ guidance issued 12/23/22 extended grace period for initial 2020/2021 reporting from 12/27/22 through 1/31/23
  - Guidance also announced a good faith efforts standard for enforcement for this initial reporting submission
- Employers rely on their insurance carrier or third-party administrator/PBM to submit the Rx Data Collection report
  - For self-insured plans, the obligation lies with the employer, but the rules permit (and expect) employers to delegate to TPA/PBM
  - 2022 report is due by June 1, 2023, and for all future years the report will be due by June 1 of subsequent year

Full Details: The CAA Mental Health Parity Comparative Analysis Requirement

MHPAEA Overview

- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally provides that financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health or substance use disorder (MH/SUD) benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits within its set classification
- Group health plans and insurance carriers may not impose non-quantitative treatment limitations (NQTL) with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation to medical/surgical benefits in the same classification

CAA Imposes New MHPAEA Documentation Requirement

- CAA expands upon the MHPAEA by requiring group health plans and insurance carriers that offer both medical/surgical benefits and MH/SUD benefits, and that impose NQTLs on MH/SUD benefits, to perform and document a comparative analysis of the design and application of the NQTLs.

Comparative Analysis Disclosure (Effective February 10, 2021)

- The CAA requires group health plans and insurance carriers that offer both medical/surgical benefits and MH/SUD benefits, and that impose NQTLs on MH/SUD benefits, to make their comparative analysis of the design and application of NQTLs available to the Departments (DOL/HHS/IRS) or applicable state authorities upon request.
- First Tri-Agency MHPAEA Report to Congress found “None of the comparative analyses reviewed to date have contained sufficient information upon initial receipt,” and “EBSA believes that authority for DOL to assess civil monetary penalties for parity violations” needed

CAA Other Items of Note: ID Card, EOB, Gag Clauses

Full Details: **Tri-Agency ACA and CAA FAQ, Part 49**

New Medical Plan ID Card Content Requirements

- Effective for plan years beginning on or after January 1, 2022, the medical plan ID card must include the plan deductible and out-of-pocket maximum, as well as a phone number and website for assistance understanding
- Good faith compliance with reasonable interpretation of requirements until the Departments issue regulations

Advanced Explanation of Benefits (EOB) Requirements

- Requires that medical providers and facilities provide a good faith estimate of the expected cost of services to the health plan when the participant schedules the procedure
- Health plan then sends the participant an advanced EOB with specific information detailing the expected cost
- Originally effective for plan years beginning on or after January 1, 2022, now delayed until regulations issued

Gag Clause Prohibition

- Effective as of December 27, 2020 (date of CAA enactment), plans cannot enter into agreements with providers, networks, association of providers, TPAs, or other service providers that restrict the plan from disclosing:
  - Cost or quality of care information;
  - Electronic de-identified claims information; or
  - Sharing this information with HIPAA business associates of the plan
- Plans and carriers will eventually need to provide annual attestation to compliance with rule (pending guidance)

Price Transparency Revolution Underway with ACA and CAA

Full Alert: Transparency in Coverage: Machine-Readable Files Posting

The Trump administration issued the final price transparency rules late in 2020 (November 12, 2020). Those rules were then solidified and expanded upon by the CAA. Good news: There now seems to be bipartisan support for transparency.

Machine-Readable Files (MRF):

Enforced as of July 1, 2022 (Delayed from January 1)

Detailed Pricing Information Covering the Individual and Group Markets

- Available to consumers, researchers, employers, third-party developers, and the rest of the public
- Standardized format with monthly updates required
- Three separate machine-readable files with detailed pricing information:
  1. **In-Network:** Negotiated rates for all covered items and services between plan and in-network providers
  2. **Out-of-Network:** Historical payments to, and billed charges from, out-of-network providers
  3. **Prescription Drugs:** Delayed pending implementation of broader CAA Rx reporting rules

Employer Issues:

The Public Group Health Plan Website Conundrum

Employers Must Post Links to Machine-Readable Files in Some Situations

- Transparency in Coverage (TiC) rules require that "group health plan or health insurance issuer must make available on an internet website" the machine-readable files
- Website must be "publicly available" to satisfy rules
- For fully insured plans, this requirement is simply satisfied by the plan's insurance carrier
- For self-insured plans, issue is that many employers do not have a public website for the group health plan
- CMS Technical Guidance and Tri-Agency FAQ Guidance both confirmed that employers without a public website for the group health plan can rely on TPA where there is a written agreement for the TPA to post the files on its website on behalf of the plan

Price Transparency Revolution Underway with ACA and CAA

Full Alert: Transparency in Coverage: Participant-Level Disclosures via Internet-Based Tool

The Trump administration issued the final price transparency rules late in 2020 (November 12, 2020). Those rules were then solidified and expanded upon by the CAA. Good news: There now seems to be bipartisan support for transparency.

Internet-Based Tool:
Personalized & Real-Time Out-of-Pocket Cost Information

The New State of the Art for Shopping and Comparing Prices Before Receiving Care

- Employees will be able to access actual out-of-pocket cost information prior to receiving service or purchasing item
- Four main components of the internet-based tool:
  1. **Cost-Sharing Information:** The deductible, coinsurance, and copay for any covered item or service
  2. **Accumulated Amounts:** The participant's YTD amounts incurred toward the deductible and out-of-pocket maximum
  3. **In-Network Rate:** The plan's negotiated rate (reflected as dollar amount) for an in-network provider for the covered item or service
  4. **Out-of-Network Allowed Amount:** How much the plan will pay for an out-of-network item or service (dollar or percentage)

Staggered Availability:
First Phase of Tool Available in 2023

First Plan Year Beginning On or After January 1, 2023

- For the first plan year these rules are in effect, the plan is required to disclose an initial list of 500 shoppable services
- CMS summary: 500 Items and Services List for Price Comparison Tool

First Plan Year Beginning On or After January 1, 2024

- The remaining prices for covered items and services must be disclosed via the internet-based tool

Employers Will Rely On Insurance Carrier or TPA

- Rules provide that employer can enter into a written agreement for carrier/TPA to maintain this internet-based tool
- Potential $100/day penalties apply for non-compliance

Full Alert: Employer Tax-Free Student Loan Repayment Available Through 2025

CARES Act Expanded Upon Educational Assistance, CAA Extended Through 2025

The CARES Act expanded upon the existing §127 qualified educational assistance provisions to include student loan reimbursement in 2020. The CAA extended the optional employer tax-free offering through the end of 2025.

IRC §127 Permits Tax-Free Educational Assistance

- Allows employers to cover the cost of educational expenses for an employee tax-free
- Did not include student loan repayments prior to CARES Act
- Capped at $5,250 per calendar year

Tax-Free Student Loan Repayment Permitted Through 2025

- The CARES Act permitted employers to offer an educational assistance program to reimburse student loans tax-free in 2020
- The CAA extended the availability of this tax-free student-loan repayment assistance option through the end of 2025
- Employer payment can be made to the employee or directly to the lender
- For principal or interest on a “qualifying education loan” incurred by the employee
- Capped at the same standard $5,250 limit under §127, and includes any other forms of assistance (tuition, books, fees, etc.)

What Does the Future Hold for Tax-Advantaged Employer Student Loan Repayment Assistance?

- Could this be the launching point for a permanent expansion of §127? Hard to imagine it sunsetting in 2026 after six years
- For the feature to become even more useful, Congress could allow employee pre-tax contributions (e.g., through the cafeteria plan) to count toward the limit.
- Also should look to index the $5,250 limit to inflation given increases in costs (that fixed amount dates back to 1979!)

3. Biden Admin

Inflation Reduction Act, Family Glitch Fix, and Regulatory Options in 2023

Inflation Reduction Act (IRA) Left Out Many Key Build Back Better (BBB) EB Items

Full Text: Inflation Reduction Act

Inflation Reduction Act Enacted August 16, 2022

Most of the EB-related provisions from BBB were left on the cutting room floor in the IRA that eventually passed, but a few remained

- Extended ACA subsidies for household income in excess of 400% of the federal poverty line through 2025
- Medicare will negotiate certain prescription drug costs (does not apply to employer-sponsored group health plans)
- Drug price increases through Medicare are capped at an inflation metric (does not apply to employer-sponsored group health plans)
- Insulin prices for Medicare beneficiaries capped at $35/month (does not apply to employer-sponsored group health plans)
- Codifies IRS guidance treating insulin as a HDHP preventive expense, permitting first-dollar coverage without affecting HSA eligibility

BBB Bill (Only Passed House) Would Have Done Much More

- Made the ARPA 2021 dependent care FSA limit increase to $10,500 permanent and indexed for inflation
- Reduced the ACA employer mandate affordability threshold from 9.5% (indexed) to 8.5% (not indexed)
- Increased availability of Exchange subsidies extending the ARPA 2021 elimination of the 400% FPL cap on income through 2027
- Increased availability of Exchange subsidies by reducing percentage of income cost (from 9.5% to 8.5%)
- Increased availability of Exchange subsidies by allowing access even if employer offers affordable coverage
- Imposed $100/day penalties for failure to comply with MHPAEA mental health parity requirements
- Added back the option for employers to reimburse bicycle commuting expenses with increased limit (previously removed by TCJA)
- Eliminated after-tax 401(k) contributions and ability to convert after-tax to Roth (so-called “Mega Backdoor Roth”)

Realistic Outlook

- BBB is now officially dead for this term of Congress, but look to the above BBB items as Democrat campaign priorities moving forward

IRS Fixes the ACA "Family Glitch"

Moves the Premium Tax Credit (PTC) Eligibility Analysis to Employee Cost for Each Family Member

The ACA Family Glitch

- **The PTC subsidy structure was previously based only on cost of employee-only coverage**
- Employer mandate requires ALEs to offer coverage that is "affordable" to avoid B Penalties
- Affordability is based solely on the employee-share of the premium for self-only coverage
- Individuals do not have access to PTC subsidies for exchange coverage if employer offer of coverage is affordable
- If the employer plan is affordable under employee-only standard, prior interpretation was that plan was affordable for all family members—even if cost was very expensive for family members

The Family Glitch "Fix"

- **New regulations analyze affordability for each family member individually**
- Means that if the employee is offered affordable self-only coverage, family members may now be treated as not having received affordable offer
- This opens the door to family members having access to the PTC for subsidized exchange coverage
- Does **not** affect the employer analysis from employer mandate perspective—penalty liability still based on whether employee-only coverage is affordable
- Does **not** affect ACA reporting via Forms 1094-C/1095-C

The Cafeteria Plan "Fix"

- **IRS created a new Exchange-related permitted election change event to address family member PTC access**
- Allows employees to revoke coverage for dependents to access PTC where:
  1. Family member is eligible for SEP to enroll in Exchange coverage or seeking to enroll in Exchange during its open enrollment period; **and**
  2. Employee is revoking coverage for family member who will enroll in Exchange no later than the day immediately following the last day coverage revoked
- Employer may rely on employee's reasonable representation
- New event available for cafeteria plan elections on or after January 1, 2023
- Plan amendment generally required by end of plan year—extended option for 2023 allows amendment through 2024

Fully Insured Nondiscrimination Rules Delayed Until…?

Full Alert: What's Left to be Implemented Under the ACA?

ACA Added Fully Insured Nondiscrimination Rules

- The ACA provides that insured group health plans will be subject to rules "similar to" the nondiscrimination requirements that have long applied to self-insured plans under Internal Revenue Code §105(h)
- These rules technically were scheduled to apply at the same time as the first wave of market reforms (first plan year on or after September 23, 2010)
- However, the IRS issued Notice 2011-1 at the end of 2010 confirming that employers are not required to comply until the Departments issue regulations or other administrative guidance to implement the rules

Will Biden Administration Finally Implement/Enforce?

- The Notice states that any such guidance will not apply until plan years beginning a specified period after issuance
  - For example, they may not apply until the first plan year beginning on or after six months following the regulatory issue date
- One of the few employer-side ACA items that may have actually been affected by Trump's ACA executive order
- Will Treasury/IRS now take up these rules under a Biden administration? They seem to have largely slipped off the radar
- If they do implement the rules, we should still have plenty of time before they take effect to revise any problematic plan structures

Full Alert: Providing SBCs to Employees

New Summary of Benefits and Coverage (SBC) Template Took Effect as of 2021

- Included some minor revisions, primarily to address elimination of individual mandate penalties and to update the converge examples (having a baby, type 2 diabetes, broken bone)
- Potential penalties are up to $1,190 per failure to provide the SBC
- Each employee or dependent is a separate offense (potential $4,760 penalty for failure to provide SBCs to a family of four)

Will Biden Administration End the Good Faith Enforcement Safe Harbor?

- Since SBCs took effect in 2012, Tri-Agencies (DOL/IRS/HHS) have stated that they "will not impose penalties on plans and issuers that are working diligently and in good faith to provide the required SBC content in an appearance that is consistent with the [SBC rules]"
- Tri-Agencies reiterated in 2014 that this good faith enforcement safe harbor from potential penalties applies "until further guidance is provided"
- No further guidance has wound down this long-lasting safe harbor
- Trump's day one ACA executive order to avoid penalties and enforcement where possible likely prevented enforcement during his administration
- As Biden administration is returning to normal ACA implementation and enforcement mode, it is likely that we will also see an end to the SBC good faith standard

4. Covid Cont’d

What Expired?

What Continues?

What’s Next?

Sunsetted Provisions That No Longer Apply

1	**Health FSA and Dependent Care FSA Full Carryovers:** Applied for plan years ending in 2020 and 2021 into the subsequent plan years ending in 2021 and 2022 • For health FSA carryovers for plan years starting in calendar year 2022 to a new plan year starting in calendar year 2023, the standard $570 carryover limit applied (no carryover for dependent care FSA)
2	**Health FSA and Dependent Care FSA Extended 12-Month Grace Periods:** Applied after the end of plan years ending in 2020 and 2021 • Returns to standard 2 ½ month grace period after plan years ending in 2022
3	**Mid-Year Health Plan Enrollment for Waived Employees:** Applied to plan years ending in 2021 • For plan years ending in 2022, return to standard Section 125 permitted election change event rules
4	**Mid-Year Health Plan Option Change or to Add Dependents:** Applied to plan years ending in 2021 • For plan years ending in 2022, return to standard Section 125 permitted election change event rules
5	**Mid-Year Dropping of Health Plan Coverage:** Applied to plan years ending in 2021 • For plan years ending in 2022, return to standard Section 125 permitted election change event rules

Sunsetted Provisions That No Longer Apply

6	**Mid-Year Health FSA and Dependent Care FSA Election Changes:** Applied to plan years ending in 2021 • For plan years ending in 2022, return to standard Section 125 permitted election change event rules
7	**Health FSA Spend-Down** Applied for employees who terminate mid-year during calendar year 2020 or 2021 • Optional spend-down feature reverts back to only the dependent care FSA for 2022 mid-year terminations
8	**Dependent Care FSA Relief for Children Who Reached Age 13 to Treat Child as Eligible Up to Age 14:** Applied to the last plan year for which the enrollment period was on or before January 31, 2020 (and in the subsequent plan year with respect to unused amounts) • We have returned to the standard rule that child day care expenses are eligible only up to age 13
9	**ARPA COBRA Subsidies:** Applied for coverage period from April 1, 2021 – September 30, 2021 • Unlike 2009-2010 ARRA COBRA subsidies extended to 15 months, ARPA subsidies stayed at six months

Covid Relief Provisions Continuing Into 2023

Relief Based on Period of Ongoing Covid-Related National Emergency Continues to Apply

1	**Outbreak Period: HIPAA Special Enrollment Periods** Applies until the earlier of a) 60 days after National Emergency Period, or b) one-year of relief after event • The rules extend the 30-day and 60-day HIPAA SE period by disregarding the Outbreak Period
2	**Outbreak Period: COBRA Election Notice** Applies until the earlier of a) 60 days after National Emergency Period, or b) one-year of relief after event • The rules extend the 44-day deadline for employer to provide, and 60-day deadline for employee to elect
3	**Outbreak Period: COBRA Premium Payment Period** Applies until the earlier of a) 60 days after National Emergency Period, or b) one-year of relief after event • The rules extend the 45-day deadline for initial premium, 30-day grace period for subsequent premiums
4	**Outbreak Period: Employee Qualifying Event Notice** Applies until the earlier of a) 60 days after National Emergency Period, or b) one-year of relief after event • The rules extend the 60-day deadline to notify of divorce, child reaching age 26, and disability extension
5	**Outbreak Period: ERISA Plan Run-Out Period** Applies until the earlier of a) 60 days after National Emergency Period, or b) one-year of relief after event • The rules extend any ERISA plan (including health FSA) run-out period deadline set by the plan terms

Covid Relief Provisions Continuing Into 2023

Relief Based on Period of Ongoing Covid-Related National Emergency Continues to Apply

6	**Outbreak Period: ERISA Adverse Benefit Determination Appeal Deadline** Applies until the earlier of a) 60 days after National Emergency Period, or b) one-year of relief after event • The rules extend the 60-day and 180-day appeal period by disregarding the Outbreak Period
7	**Outbreak Period: ERISA External Review Deadlines** Applies until the earlier of a) 60 days after National Emergency Period, or b) one-year of relief after event • The rules extend the four-month period to request an external review by disregarding the Outbreak Period
8	**FFCRA/CARES Act Mandates: Free Covid Testing and Vaccine Mandates** Applies until the end of the public health emergency declared by the Secretary of HHS • The rules require the group health plan to cover these testing/vaccine costs without cost-sharing
9	**First-Dollar Telehealth Permitted for HSA Eligibility:** Initially available under CARES Act, CAA 2022 extended through the end of 2022 • CAA 2023 extension applies to plan years beginning after December 31, 2022 and before January 1, 2025

Outbreak Period Extended Timelines

Understanding the "Outbreak Period"

The Departments of Labor and the Treasury extended multiple key employee benefits deadlines **by disregarding the "Outbreak Period"** from the timeline calculation.

The National Emergency: From March 1, 2020 to TBD

President Trump declared a national emergency and invoked a nationwide emergency determination under the Stafford Act related to COVID-19 effective March 1, 2020.

- FEMA has also issued emergency declarations for every state, territory, and possession in the U.S.
- Collectively, this is referred to as the "National Emergency"
- President Biden has continued the period of National Emergency

In light of the National Emergency, the Departments have extended multiple key employee benefits timelines.

The Outbreak Period: National Emergency + 60 Days

The Outbreak Period is defined as the National Emergency period through 60 days after the end of National Emergency period.

- Means the Outbreak Period begins March 1, 2020 and ends 60 days after the announced end of the National Emergency period
  - No indication yet of the possible end date

EBSA Disaster Relief Notice 2021-01 caps the maximum period disregarded at one year per event

- Outbreak Period will therefore end the earlier of one year from the date the individual was first eligible for the relief, or 60 days after the end of the National Emergency

Outbreak Period Extended Timelines

Extension of HIPAA Special Enrollment Period

The Departments of Labor and the Treasury extended multiple key employee benefits deadlines **by disregarding the "Outbreak Period"** from the timeline calculation.

HIPAA Special Enrollment Rules: 30-Day and 60-Day Windows

30-Day Special Enrollment Period

- Loss of eligibility for group health coverage or individual health insurance coverage
- Acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption

60-Day Special Enrollment Period

- Loss of Medicaid/CHIP eligibility
- Becoming eligible for a state premium assistance subsidy under Medicaid/CHIP

The Outbreak Period: Disregarded for Deadlines

The rules extend the 30-day and 60-day HIPAA special enrollment timeframes by disregarding the Outbreak Period

- **Example:** Employee has new child on 3/31/23 and wants to use HIPAA special enrollment event to enroll child in health plan
- **Assume:** National Emergency period ends April 30, 2023, and therefore the Outbreak Period ends June 29, 2023
- **Result:** Employee would have until 30 days after the end of the Outbreak Period (by July 29, 2023) to enroll
  - No indication yet of actual Outbreak Period end date

Outbreak Period Extended Timelines

Extension of COBRA Election Notice

The Departments of Labor and the Treasury extended multiple key employee benefits deadlines **by disregarding the "Outbreak Period"** from the timeline calculation.

COBRA Election Notice: 44-Day Timeframe to Provide

Election Notice to Qualified Beneficiary:

- 44 days from loss of coverage
  - 30 days from employer to plan administrator
  - 14 days from plan administrator to qualified beneficiary
  - DOL enforces as combined 44-day limit

Election by Qualified Beneficiary:

- 60 days from the date of the election notice

Initial Premium Payment Deadline:

- 45 days from the COBRA election date

Subsequent Monthly Premium Deadline:

- 30-day grace period starts at beginning of coverage month

The Outbreak Period: Disregarded for Deadlines

The rules extend the plan's 44-day deadline to provide the COBRA election notice to a qualified beneficiary by disregarding the Outbreak Period

- **Example:** Terminated employee loses coverage as of April 1, 2023
- **Assume:** National Emergency period ends April 30, 2023, and therefore the Outbreak Period ends June 29, 2023
- **Result:** Employer would have until 44 days after the end of the Outbreak Period (by August 12, 2023) to provide the COBRA election notice
  - No indication yet of actual Outbreak Period end date

Outbreak Period Extended Timelines

Extension of COBRA Election Period

The Departments of Labor and the Treasury extended multiple key employee benefits deadlines **by disregarding the "Outbreak Period"** from the timeline calculation.

COBRA Election Notice: 60-Day Timeframe to Elect

Election Notice to Qualified Beneficiary:

- 44 days from loss of coverage
  - 30 days from employer to plan administrator
  - 14 days from plan administrator to qualified beneficiary
  - DOL enforces as combined 44-day limit

Election by Qualified Beneficiary:

- 60 days from the date of the election notice

Initial Premium Payment Deadline:

- 45 days from the COBRA election date

Subsequent Monthly Premium Deadline:

- 30-day grace period starts at beginning of coverage month

The Outbreak Period: Disregarded for Deadlines

The rules extend the 60-day deadline for employees/dependents to elect COBRA by disregarding the Outbreak Period

- **Example:** Reduced hour employee loses active coverage and receives COBRA election notice on April 1, 2023
- **Assume:** National Emergency period ends April 30, 2023, and therefore the Outbreak Period ends June 29, 2023
- **Result:** Employee would have until 60 days after the end of the Outbreak Period (by August 28, 2023) to make the COBRA election
  - No indication yet of actual Outbreak Period end date

Extension of COBRA Premium Payment Period

The Departments of Labor and the Treasury extended multiple key employee benefits deadlines **by disregarding the "Outbreak Period"** from the timeline calculation.

COBRA Premium Payment: 45-Day and 30-Day Deadlines

Election Notice to Qualified Beneficiary:

- 44 days from loss of coverage
  - 30 days from employer to plan administrator
  - 14 days from plan administrator to qualified beneficiary
  - DOL enforces as combined 44-day limit

Election by Qualified Beneficiary:

- 60 days from the date of the election notice

Initial Premium Payment Deadline:

- 45 days from the COBRA election date

Subsequent Monthly Premium Deadline:

- 30-day grace period starts at beginning of coverage month

The Outbreak Period: Disregarded for Deadlines

The rules extend the 45-day initial premium and 30-day grace period for subsequent premium payment deadlines by disregarding the Outbreak Period

- **Example:** Qualified beneficiary fails to make timely premium payment by the end of the 30-day grace period for March, April, May, and June 2023
- **Assume:** National Emergency period ends April 30, 2023, and therefore the Outbreak Period ends June 29, 2023
- **Result:** Employee would have until 30 days after the end of the Outbreak Period (by July 29, 2023) to make premium payment
  - No indication yet of actual Outbreak Period end date

Extension of COBRA Qualifying Event Notice

The Departments of Labor and the Treasury extended multiple key employee benefits deadlines **by disregarding the "Outbreak Period"** from the timeline calculation.

COBRA Qualifying Event Notice: 60-Day Deadline to Notify

Divorce/Legal Separation (Causing Loss of Eligibility)

- The employee or dependent is responsible for notifying the plan within 60 days of the qualifying event

Loss of Dependent Status (Age 26)

- The employee or dependent is responsible for notifying the plan within 60 days of the qualifying event

Disability Extension (to 29 Months)

- The employee is responsible (among other requirements) for notifying the plan within 60 days of the SSA disability determination

The Outbreak Period: Disregarded for Deadlines

The rules extend the 60-day employee notification deadlines by disregarding the Outbreak Period

- **Example:** Employee finalizes divorce from covered spouse effective April 1, 2022 (causing spouse to lose eligibility)
- **Assume:** National Emergency period ends April 30, 2023, and therefore the Outbreak Period ends June 29, 2023
- **Result:** The employee/spouse would have until 60 days after the Outbreak Period (until August 28, 2023) to notify the plan of the divorce qualifying event
  - No indication yet of actual Outbreak Period end date

Full Alert: Major Employee Benefits Timeframe Extensions for Covid-19 National Emergency

Extension of Additional Deadlines

The Departments of Labor and the Treasury extended multiple key employee benefits deadlines **by disregarding the "Outbreak Period"** from the timeline calculation.

The Plan's Benefit Claim Filing Deadline (Including Run-Out Periods)

- The rules extend the ERISA plan's deadline to file a benefit claim under the plan's claims procedures by disregarding the Outbreak Period
  - Claim filing deadline is **set by the plan's terms**
  - Applies to the health FSA run-out period (ERISA plan) but not the dependent care FSA run-out period (non-ERISA plan)

ERISA Adverse Benefit Determination Appeal Deadline

- The rules extend the ERISA deadline to file an appeal of the plan's adverse benefit determination by disregarding the Outbreak Period
  - **180-day** timeframe to appeal an adverse benefit determination under a group health plan or disability plan
  - **60-day** timeframe to appeal an adverse benefit determination under any other type of ERISA plan

ERISA External Review Deadlines

- The rules extend the ERISA deadline to file an external review request or provide additional information to perfect a request by disregarding the Outbreak Period
  - **Four-month** timeframe to request external review upon receipt of adverse benefit determination involving medical judgment or rescission of coverage
  - **Same four-month timeframe** (or, if later, 48 hours following receipt of notification of incomplete request) to perfect request for external review upon incomplete notice

Temporary CARES Act Telehealth Relaxation: Extended Through 2024

Full Alert: CAA 2023 Includes Two-Year Extension of HSA Telehealth Relief

HSA Eligibility Preserved

HDHPs can provide first dollar coverage for telehealth or other remote care services

- Means that individuals covered under a HDHP that waive the deductible for telehealth services or other remote care can maintain HSA eligibility
- Includes non-preventive telehealth/remote care

CARES Act/CAA 2022 Relief: Originally applied for plan years beginning on or before December 31, 2021

- CAA 2022 extension applied from April – December 2022

CAA 2023: Extension of relief makes it available through 2024

- Extension applies to plan years beginning after December 31, 2022 and before January 1, 2025
- Includes 2023 and 2024 for calendar plan year HDHPs
- For plan years beginning on or after January 1, 2025, no relief is available (absent a new act of Congress to again extend relief)

Practical Considerations - Plan Design Issues

First-dollar telehealth relief is an optional plan provision

- HDHPs are not required to offer free telehealth care
- The relief simply permits it without causing loss of HSA eligibility

Fully Insured Plan

- Up to the insurance carrier to make the determination of whether to add first-dollar telehealth/remote care

Self-Insured Plan

- Employers can work with TPA and stop-loss provider to make this plan design decision

Mind the gap

- Was an unfortunate gap from January 2022 through March 2022 with no telehealth relief in place for calendar plan years
- There is another unfortunate gap for non-calendar plan years from January 2023 until start of first plan year beginning in 2023

Telemedicine That is Part of the HDHP: Not Disqualifying Coverage

- In this case, the employee's costs related to the telemedicine services are subject to the same HDHP cost-sharing rules as non-telemedicine services
- In other words, the HDHP deductible applies to telemedicine in the same manner as in-person services
- Preventive care or EAP/Wellness/Disease Management services are not required to be subject to the deductible (same as in-person services)

Telemedicine That is Not Part of the HDHP: May Be Disqualifying Coverage

- Separate telemedicine plans that are not subject to the HDHP deductible—therefore another exception must apply to the telemedicine benefit to avoid blocking HSA eligibility
- Main exemptions that could apply are:
  1. **Preventive Services:** Telemedicine limited to preventive services only; or
  2. **EAP/Wellness/Disease Management:** Telemedicine that does not provide "significant benefits in the nature of medical care or treatment"

"Significant Benefits" Standard Difficult to Apply to Telemedicine

- Best examples come from HIPAA/ACA excepted benefit regulations preamble:
- **For example**, "an EAP that provides only limited, short-term outpatient counseling for substance use disorder services (without covering inpatient, residential, partial residential or intensive outpatient care) without requiring prior authorization or review for medical necessity does not provide significant benefits in the nature of medical care. At the same time, a program that provides disease management services (such as laboratory testing, counseling, and prescription drugs) for individuals with chronic conditions, such as diabetes, does provide significant benefits in the nature of medical care."

Full Alert: Free Covid-19 Testing Coverage Mandate for All Group Health Plans

FFCRA Coverage Mandates

Mandate took effect as of March 18, 2020 and remains in effect until the end of the declared national emergency period.

Applies to ALL Employer-Sponsored Major Medical Group Health Plans

- Fully insured
- Self-insured
- Grandfathered

Prohibits ANY Form of Cost-Sharing for COVID-19 Testing

- No deductibles, copays, coinsurance, or any other form of cost-sharing
- Applies where the testing is medically appropriate for the individual, as determined by the attending health care provider
- Includes out-of-network providers and non-traditional care settings such as drive-through screening and testing sites
- Does not include general workplace health and safety (e.g., “return to work” programs) testing

Coverages COVID-19 Testing and Interaction with Health Care Provider

- In vitro diagnostic testing (e.g., nasal swab)
- All items and services related to office visit, telehealth session, urgent care visit, or emergency room visit for COVID-19 diagnostics that result in an order for, or administration of a COVID-19 diagnostic test
- Must relate to the test or the evaluation of the individual to determine the need for the test
- Includes testing for other causes of respiratory illness (e.g., influenza) if recommended by a health provider and medically appropriate to determine the need for COVID-19 testing

Full Alert: How the CARES Act Affects Employee Benefits

CARES Act Coverage Mandates

The CARES Act expanded upon the existing FFCRA testing coverage mandate with important additions—including vaccine coverage.

Sets Rules Around Provider Reimbursement

- Must reimburse at rate negotiated before the public health emergency declared
- If no negotiated rate, must reimburse at amount posted by provider on the provider's website
- New obligation for providers to post cost of COVID-19 testing on public website

Preventive and Vaccine Costs Included

- Mandate expanded to include free coverage of preventive services or vaccines for COVID-19 as such items and services become available
- To qualify, the items, services, or immunizations designed to prevent or mitigate COVID-19 must be recommended by the USPSTF or CDC
- Coverage mandates take effect 15 business days after the recommendation

How Long Do Mandates Last?

- From March 18, 2020 (FFCRA enactment date) through the end of the public health emergency related to COVID-19
- Public health emergency period is determined by the Secretary of HHS and extended in 90-day increments
- Will extend to at least January 11, 2023 (based on latest extension here)

COVID Testing/Vaccine Coverage Mandate: Free OTC Tests

Full Alert: **Health Plans Must Cover OTC Covid Tests Without Cost-Sharing**

Full Details: **The FSA/HRA/HSA Double-Dipping Prohibition and OTC Covid Tests**

Eight Free Tests Per Month for Each Covered Individual

Expanded Mandate Includes Rapid OTC At-Home Testing

- Covered individuals who purchase OTC at-home Covid rapid diagnostic tests can seek reimbursement from their group health plan (self-insured and fully insured) from 1/15/22 through remainder of the public health emergency
- Plans typically also offer direct coverage of OTC tests where participants don't have to pay up front and submit receipt
- Still does not include workplace screening testing (i.e., mandate does not apply for return-to-work screening testing)

OTC Test Permitted Plan Coverage Limits

- Capped at 8 tests per covered individual per month (e.g., covered family of four could receive 32 free tests/month)
- Plans that offer direct coverage of OTC tests (i.e., no up-front cost and reimbursement post-purchase required) can cap the amount they will reimburse for each test at $12 per test
- Where tests are sold in packages containing more than one test, the caps apply for each test within the package

The Double-Dipping Prohibition

- The OTC testing mandate has created a rare situation where employees are submitting expenses for reimbursement to the major medical plan (in almost all other cases the plan directly pays the provider with no reimbursement to the participant)
- IRS rules are clear that OTC tests are a qualifying medical expense for FSA/HRA/HSA purposes
- However, you can't use FSA/HRA/HSA to reimburse expenses that are covered by the health plan
- FSA/HRA/HSA can be used here only in rare situations where employee has test expenses not covered by the health plan

Covid Vaccine Premium Incentives and Surcharges

Full Details: **Covid Vaccine Premium Incentive and Surcharges**

Four Main Compliance Considerations

- **No Employer Role in Vaccine Administration:** Employers should not administer the vaccine by directly providing it to employees either through its own workforce or agents (e.g., third-party vendors) acting on the employer's behalf. Employees should receive the Covid vaccine from a pharmacy, public health department, or any other health care provider in the community not tied to the employer to avoid strict limitations on the incentive or surcharge under the ADA and GINA
- **HIPAA/ACA Wellness Program Rules Apply:** These rules limit the Covid vaccine incentive or surcharge to 30% of the total cost of the coverage. They treat this as an "activity-only" health-contingent wellness program that requires the employer to offer reasonable alternative standards (including notice of availability) for employees to receive the incentive or avoid the surcharge for any individual for whom it is a) unreasonably difficult to receive the vaccine due to a medical condition, or b) medically inadvisable to receive the vaccine
- **Incentive/Surcharge Affects ACA Affordability:** The employer's lowest-cost plan option cost is determined without regard to any discount the employee may have received for being vaccinated, and including the amount of the surcharge the employee may have avoided by being vaccinated. This can cause employers to inadvertently move out of the automatic passing grade offered through the federal poverty line affordability safe harbor (and the associated streamlined reporting through the qualifying offer method). It may also cause the offer of coverage to fail to meet the rate of pay safe affordability safe harbor, potentially triggering unexpected "B Penalties"
- **Religious Accommodations:** Where employees express that a sincerely held religious belief, practice, or observance prevents them from getting a Covid vaccine, Title VII of the Civil Rights Act requires the employer to provide a reasonable accommodation unless it would pose an undue hardship. Employee notifications of a religious objection may require consultation with employment counsel to determine the appropriate accommodation

ARPA COBRA Subsidy: April – September 2021 (Expired)

Full Alert: IRS Issues ARPA COBRA Subsidy Guidance

Six Months of Fully Subsidized COBRA (Expired)

Included among the $1.9 trillion American Rescue Plan Act passed in March 2021

- Applied only to COBRA qualifying events that were a loss of coverage due to an involuntary termination of employment or reduction in hours
- Applied to all family members and all group health plan benefits (medical, dental, vision, HRA, EAP) other than the health FSA

Applied for coverage period from April 1, 2021 – September 30, 2021

- Full APRA subsidy left no balance payable by the employee or other qualified beneficiary (i.e., $0 premium charged)
- Employer was reimbursed for the cost of maintaining COBRA coverage through a premium assistance credit on Form 941 against share of Medicare tax

Eligibility for APRA COBRA Subsidies

- Employees self-certified as to whether they qualified in the model forms prepared by the DOL
- Employers could rely on employee's attestations unless they had actual knowledge it was incorrect
  - Must keep record of certification or any other evidence

Involuntary Termination of Employment Defined

- "[A] severance from employment due to the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services."

End of ARPA COBRA Subsidy

- Subsidies ended as of the earliest date the individual:
  - Was eligible for other group medical coverage/Medicare;
  - Lost eligibility for COBRA (e.g., exhausted COBRA); or
  - Reached the end of the last coverage period beginning on or before September 30, 2021

ARPA Dependent Care FSA Increase – $10,500 Applied for 2021 Calendar Year Only

Full Alert: IRS Issues Dependent Care FSA Increase Guidance

2021 Calendar Year $10,500 Limit

As with the standard rules, the limit was reduced to half of that amount ($5,250) for married individuals filing separately

- Increased limit added by ARPA automatically sunsetted at the end of 2021 calendar year
- **The dependent care FSA limit has reverted back to $5,000 for the 2022 calendar year forward**
- House version of BBB (did not pass Senate) would have made increase permanent and indexed

Section 125 Cafeteria Plan Retroactive Amendment

- Employer must have adopted the amendment no later than the last day of the plan year in which the amendment is effective; and
- Plan must have operated consistently with the terms of the amendment for the full retroactive period

The Standard $5,000 Dependent Care FSA Limit

- Congress did not index the limit when established in 1986
- 35 years later, the limit would be roughly $12,800 if §129 limit was indexed to standard CPI inflation
  - First Lady Michelle Obama had requested increase from IRS—but IRS confirmed only Congress can: https://www.irs.gov/pub/irs-wd/16-0058.pdf

Effect of CAA Carryover and Extended Grace Period

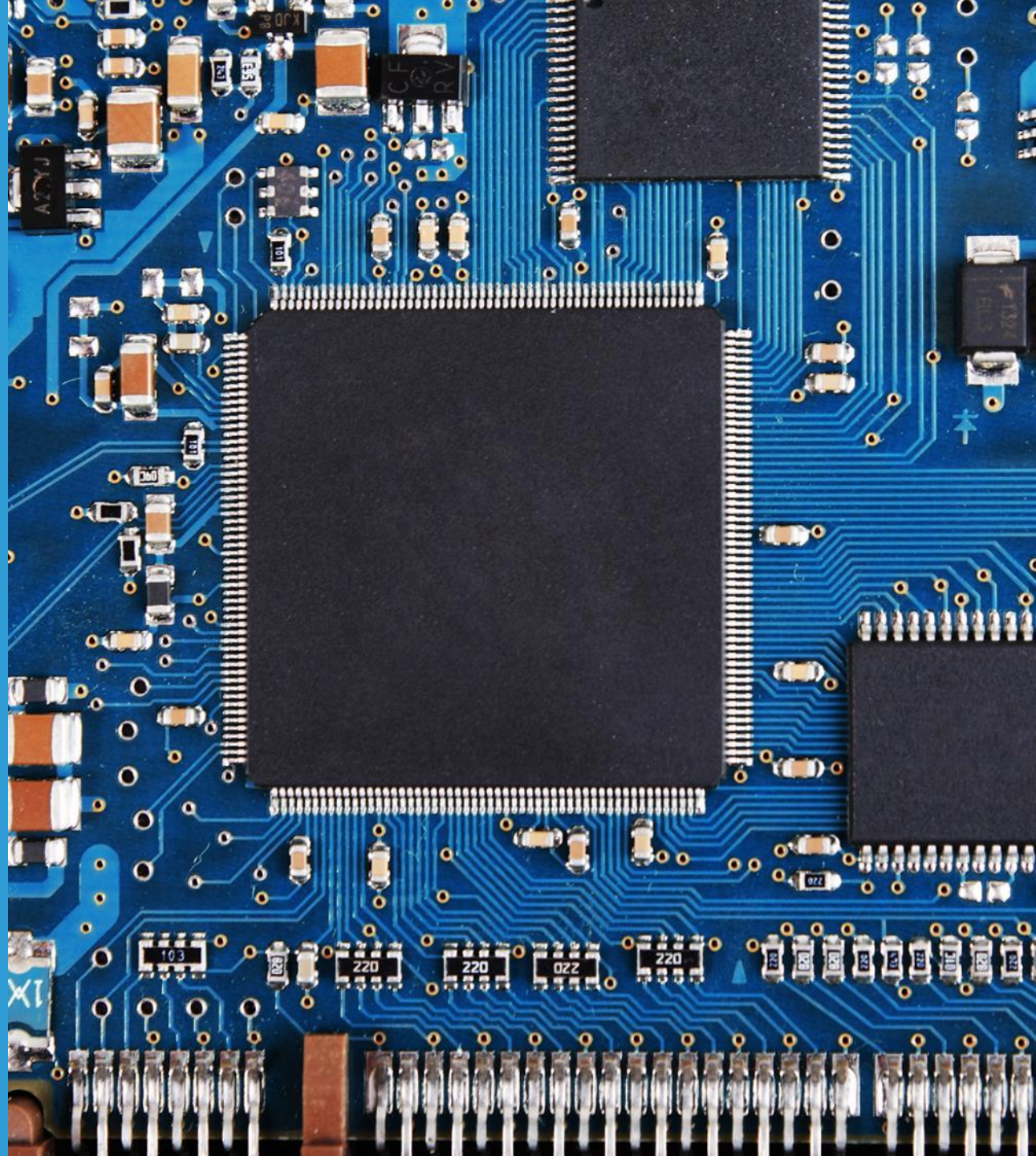
- Unused amounts carried over or available during an extended grace period pursuant to CAA are disregarded in determining the limit for the following year
  - CAA carryover/extended grace period amounts also do not affect the subsequent income exclusion amount

Non-Calendar Plan Year Dependent Care FSA Issues

- Because §129 limit always runs based on the calendar year, there are additional complications for a dependent care FSA with a non-calendar plan year
  - Amounts in excess of $5,000 in CY 2022 not attributable to CAA FSA relief will be taxable income

5. Dobbs v. Jackson

The Post-Roe Landscape



Full Alert: Compliance Considerations for Employer Reimbursement of Abortion-Related Expenses

Employers Consider Options to Provide Abortion-Related Travel Assistance

Abortion Becomes a State-by-State Issue

- U.S. Supreme Court's *Dobbs* decision held that the Constitution does not confer a right to abortion
- Overruled the existing framework under *Roe* and *Casey* that established nationwide right to obtain an abortion and forbid states from adopting any restriction on abortion access that imposed an "undue burden" on a woman's right to have an abortion prior to the point at which a fetus was thought to achieve "viability" (i.e., ability to so survive outside the womb)
- Since *Dobbs*, many states now ban abortion either entirely or at a certain point in the pregnancy

Some Health Plans Address the Issue

- In some cases, employers' major medical plans will provide abortion-related travel assistance coverage for employees or dependents who need to travel a significant distance to access abortion services
- For fully insured plans, employers will need to review options (if any) provided by insurance carrier to address
  - Generally won't be an option for carrier to provide assistance if policy is sitused in a state that does not permit (or significantly restricts) abortions because of state legal barriers
- For self-insured plans, employers have more flexibility in plan design and specific benefit offerings
  - Still need to determine what options available in consultation with TPA and stop-loss provider

Many Employers are Addressing the Issue Through Specialty HRAs

- Specialty HRAs are designed to cover a specific type of health expense that typically is not adequately covered by the major medical plan, while satisfying all the applicable group health plan laws that apply (ERISA, COBRA, HIPAA, ACA, etc.)
- HRAs are defined contribution, account-based plans that can solve for the group health plan compliance burdens associated with covering these additional employee medical expenses

Specialty Health Reimbursement Arrangements (HRAs): What and Why?

Employers often want to reimburse employees' medical expenses in areas where the major medical plan is commonly viewed as insufficient by many employees.

Why is the Specialty HRA Needed?

- Employers cannot reimburse a §213(d) medical expense outside of a group health plan
- Reimbursement of a medical expense creates a group health plan (GHP) that has to comply with the full array of group health plan laws
- GHP laws that apply include ERISA, COBRA, HIPAA, ACA, §105(h), HSA eligibility, PCORI
- Whether the employer formally recognizes it or not, employers would effectively create a new group health plan anytime they reimbursed a medical expenses without formal plan documentation
- IRS Publication 502 provides a useful summary of expenses that qualify as a §213(d) medical expense
- HRAs are defined contribution, account-based plans that can solve for these GHP compliance burdens

What is a Specialty HRA?

- Specialty HRAs are designed to cover a specific (or multiple types of specific) health expense that is typically not adequately covered by the medical plan
- Commonly designed to cover infertility, mental health, gender reassignment surgery, abortion, medical travel costs, and/or autism expenses
- HRAs must be exclusively employer-funded
- Typically there will be an annual and lifetime limit placed on the benefit (e.g., $10,000/$25,000)
- The HRA is a group health plan subject to ERISA that needs a plan document and SPD
- Employers will want to work with a third-party administrator (TPA) to manage the HRA operations and ensure compliance with the multiple group health plan laws that apply and prepare plan document/SPD

The Friday the 13th Guidance (September 13, 2013)

IRS Notice 2013-54; DOL Technical Release 2013-03

- The beginning of a long series of (particularly IRS) guidance confirming the ACA prohibition of HRA coverage that is not "integrated" with a group health plan
- Guidance highlights that integration is not possible through individual policies, that would create an "Employer Payment Plan" or a "Non-Integrated HRA"

The IRS ACA Potluck Guidance (2015)

IRS Notice 2015-17; IRS Notice 2015-87

- Additional guidance reiterating the IRS prohibition of Employer Payment Plans and Non-Integrated HRAs
- Confirmed that even taxable reimbursements are prohibited, and that integration rules apply to employees, spouses and dependents

Penalties

IRC §4980D

- Employers offering an Employer Payment Plan or Non-Integrated HRA for employer reimbursement of individual policies violates the ACA market reform rules
- Penalty is $100/day/employee excise taxes—resulting in potential penalties of $36,500 per employee per year
- *Note: Individual Coverage HRAs (ICHRAs) meeting several conditions are a new exception to this general rule*

Full Details: **The ACA Integration Rules for Specialty HRAs**

The ACA HRA Integration Rules

MV Integration Requirements (Applicable to Specialty HRAs)

1. Employer offers major medical that provides minimum value (MV) to the employee
2. Employee covered by HRA is also enrolled in a group major medical plan that provides MV—whether through that employer or a spouse/domestic partner (DP)/parent
3. HRA is available only to employees enrolled in a group major medical plan that provides MV—whether through that employer or a spouse/DP/parent
4. Employee is permitted to permanently opt-out of HRA at least annually and upon termination

Non-MV Integration Requirements (Not Applicable to Specialty HRAs)

1. Employer offers major medical to the employee
2. Employee covered by the HRA is also enrolled in group major medical—whether through that employer or a spouse/DP/parent
3. HRA is available only to employees enrolled in a group major medical plan—whether through that employer or a spouse/DP/parent
4. HRA reimburses only cost-sharing amounts under the major medical and/or non-essential health benefits
5. Employee is permitted to permanently opt-out of HRA at least annually and upon termination

Full Details: **The ACA Integration Rules for Specialty HRAs**

Summary of the ACA HRA Integration Rules

Non-Integrated HRA Prohibition

- Employers offering an HRA have to meet the "integration" requirements stemming from the Friday the 13th Guidance
- Those rules generally require that the employee and any covered dependent be enrolled in an employer-sponsored major medical group health plan that provides minimum value
- Most important piece is that HRAs cannot not be integrated with individual market coverage
- *Note: Individual Coverage HRAs (ICHRAs) meeting several conditions are a new exception to this general rule*

Why Prohibited?

- Non-integrated HRAs cannot satisfy the ACA market reform requirements for group health plans

1. Does not comply with the ACA prohibition of annual limits on the dollar amount of essential health benefits; and
2. Does not satisfy the ACA requirement to provide certain preventive services without imposing any cost-sharing requirements for the services

- Potential Penalties: $100/day/employee excise tax under §4980D ($36,500/employee/year!)

Abortion-Related HRAs: Common Expenses

Full Alert: Compliance Considerations for Employer Reimbursement of Abortion-Related Expenses

Common Medical Expenses Reimbursed by HRA on Tax-Free Basis

- Legal abortion procedure costs
- Transportation:
  - To a new region or within the region
  - Must be primarily for, and essential to, medical care
  - Bus, taxi, train, airplane, rental car, Uber/Lyft used to go to and from the point of medical treatment
  - If using own car, IRS sets mileage rate at 22 cents/mile
- Lodging:
  - Up to $50/night limit
  - Up to $100/night if traveling with another person
  - Must be primarily for, and essential to, medical care
  - Medical care must be provided by a doctor in a licensed hospital or a medical facility related to, or equivalent of, a licensed hospital
  - Cannot be any significant element of pleasure/vacation/recreation
- Meals:
  - Included if provided at hospital or similar medical institution where individual is receiving medical care

Common Non-Medical Expenses Reimbursed Outside HRA on Taxable Basis

- Lodging expenses in excess of $50/individual/night
- Mileage reimbursement for car usage in excess of 22 cents/mile
- Relocation expenses (no longer excludible from income after TCJA)
- Any other form of compensation provided to employees to assist in the abortion procedure/travel process that does not qualify as medical

Addressing Non-Medical Expenses

- An HRA can only reimburse §213(d) medical expenses
- Non-medical expenses must be a) reimbursed outside the HRA, and b) on a taxable basis to the employee
- Although these expenses cannot be reimbursed tax-free by an HRA, employers may still provide reimbursement for these non-medical expenses on a taxable basis through a broadly-defined abortion assistance program
- Employers may present this as one integrated arrangement, but keep in mind the technical distinction here for non-medical reimbursements

Preserving HSA Eligibility: Post-Deductible HRAs

Full Details: Post-Deductible Specialty HRAs Preserve HSA Eligibility

HRAs Will Generally Block HSA Eligibility

- HRAs that are not specially designed as HSA-compatible are disqualifying coverage for any individual covered by a High Deductible Health Plan (HDHP)

Post-Deductible HRAs Are Not Disqualifying Coverage

- To avoid the HRA blocking employee's HSA eligibility, the HRA needs to be structured as post-deductible
- This requires that the HRA not permit any reimbursements (i.e., not pay any benefits) until the employee has reached the statutory minimum deductible (2023: $1,500 individual/$3,000 family) in expenses covered by the HDHP

Example

- Mookie's employer offers a specialty HRA for infertility services—he is covered under the family HDHP
- The HDHP does not cover any infertility expenses

Result

- If Mookie is eligible for reimbursement under the infertility HRA, he's blocked from being HSA eligible
- The employer has two ways of avoiding this issue:
  1. Exclude employees covered by the HDHP from eligibility under the HRA; or
  2. Make the HRA post-deductible for anyone covered by the HDHP
- #2 requires that Mookie incur at least $3,000 in expenses covered by the HDHP before the HRA can pay

Annual Limits

2023 Inflation Adjustments

2023 Employee Benefit Limits

Employee Benefit Limit	2022	2023
HSA Individual	$3,650	**$3,850**
HSA Family	$7,300	**$7,750**
HSA Catch-Up (55+)	$1,000	**$1,000**
HDHP Maximum Out-of-Pocket	$7,050 / $14,100	**$7,500 / $15,000**
HDHP Minimum Deductible	$1,400 / $2,800	**$1,500 / $3,000**
Health FSA Salary Reduction Contribution	$2,850	**$3,050**
Health FSA Carryover to Following Year	$570	**$610**
Dependent Care FSA	$5,000 ($2,500 married filing separately)	**$5,000 ($2,500 married filing separately)**
Highly Compensated Employee	$135,000	**$140,000**
Mass Transit/Vanpooling	$280/month	**$300/month**
Qualified Parking	$280/month	**$300/month**
401(k) Elective Deferral	$20,500	**$22,500**
401(k) Catch-Up (50+)	$6,500	**$7,500**
FICA Wage Base (SS Only)	$147,000	**$155,100**
ACA Employer Mandate Penalties	A Penalty: $2,750, B Penalty: $4,120	**A Penalty: $2,880, B Penalty: $4,320**
ACA Employer Mandate Affordability	9.61%	**9.12%**
ACA Federal Poverty Level Safe Harbor	$103.14/month	**$103.28/month**
Adoption Assistance	$14,890	**$15,950**

The San Francisco Health Care Security Ordinance (HCSO): 2023 Rates

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Full Alert: 2023 San Francisco HCSO Expenditure Rates Released

The HCSO generally requires employers with 20 or more employees (50 or more for non-profits) to make a minimum level of health care expenditures for employees performing at least eight hours of work per week in San Francisco.

Employer Size	2022 Rate	2023 Rate	172 Hours/Month 2022 Maximum
Large: **100+ Employees** (Worldwide)	$3.30/hour payable	$3.40/hour payable	$584.80/month $1,754.40/quarter
Medium: **Business w/ 20-99** **Nonprofit w/ 50-99** (Worldwide)	$2.20/hour payable	$2.27/hour payable	$390.44/month $1,171.32/quarter
Small: **Business w/ 0-19** **Nonprofit w/ 0-49** (Worldwide)	Exempt	Exempt	Exempt

The San Francisco Paid Parental Leave Ordinance (PPLO): 2023 Maximums

The maximum benefit is based off the PFL cap at an annual salary of $153,164 in 2023.

Calculation Excel Spreadsheet (Resources): https://sf.gov/information/understanding-paid-parental-leave-ordinance

	2023 Maximum Weekly Benefits	2023 Maximum Total Benefits
California PFL Payment Amount	Maximum Weekly PFL Benefit $1,620 ($153,164 / 52 x 55%)	Maximum PFL Benefit x 8 $12,960
San Francisco PPL Payment Amount	Maximum Weekly PPLO Amount $1,080 ($1,620 / 60% - $1,620)	Maximum PPLO Amount x 8 $8,640
Maximum Total Payment Amount (PFL+PPL)	$2,700 Per Week of New Child Bonding Leave	$21,600 Per 8-Weeks of New Child Bonding Leave

Wrap-Up

Takeaways

2022 Year In Review: Key Points

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1 The ACA	• The ACA continues to march on, after a trifecta of Supreme Court challenges • Elimination of the ACA individual mandate tax penalty, Cadillac tax, insurance premium tax are major changes to the original law • But don't forget the employer mandate and ACA reporting are still going strong—with reporting due soon!
2 The CAA	• The CAA includes several significant changes for group health plans, mostly starting in 2022 and 2023 • Most of the CAA provisions are items that will be addressed directly by insurance carriers or indirectly by TPAs, but employers should understand the new landscape
3 Biden	• Inflation Reduction Act was not a major bill from an employee benefits perspective • Build Back Better would have had a major effect on employee benefits, but it is now off the table • More standard ACA enforcement approach could result in some dormant provisions being revived by the regulators
4 Covid	• Many of the Covid-related relief provisions have expired and returned us to regular order • However, some key provisions remain in effect, including the Outbreak Period extensions for multiple of the foundational employee benefit law timeframes, and the free Covid testing (including OTC tests) mandate • Future variants always present the potential for new forms of relief in the future
5 Dobbs	• The Post-Roe era is filled with many challenges for employers as they navigate a wide variety of state laws that now restrict or prohibit abortion • Employers seeking to offer abortion-related travel assistance should first look to the health plan, then consider supplementing the health plan through a specialty HRA administered by a TPA that can address compliance issues

Content Disclaimer
2022 Year in Review

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Thank You!

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