Today's webinar will begin shortly. We are waiting for attendees to log on.

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End of Year Compliance Reminders and Look Ahead Into 2022

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Agenda

- What compliance actions are still outstanding for the year, including end-of-year priorities such as ACA reporting
- Any new limits published by the Department of the Treasury
- New rules that will be coming into effect
- COVID-related changes that could be discontinued
- New affordability thresholds
- 2022 compliance calendar

2021 Cafeteria Plan and FSA Amendments

Employers who chose to adopt certain permissible amendments that applied in 2020, must execute them by end of year

- December 31, 2021 for calendar year plans; End of year ending in 2021 for non-calendar year plans
- Applies to:
  - Special mid-year enrollments
  - Extended 12-month grace periods
  - Full FSA and DCAP carryovers

Other COVID-19 Related Amendments

- May consider amending plans and plan communication regarding extended deadlines (e.g., COBRA elections and payments)
  - New guidance specifies that elections outside normal 60-day window have 1 year plus 105 days from date of notice to make initial premium payment; elections in 60-day window have 1 year plus 45 days from date of election
- Plans that permit OTC drug and menstrual care products
- HDHPs that permit pre-deductible telehealth visits; telehealth exceptions ending 12/31/21

Medicare Part D Reporting

- Disclosures to individuals should have been made by October 15
- Don’t forget reporting to CMS through online portal by March 1, 2022

ACA Reporting: More Important to Be Meticulous

- 2021 individual statements due January 31, 2022; Forms 1094/1095 due to IRS February 28, 2022 (paper) or March 31, 2022 (electronic)
- IRS announced last year that it would not be granting automatic extension for individual statements this cycle
- Also announced no longer considering good faith effort for filing errors or inaccuracies
- IRS has proposed dropping electronic filing threshold from 250 to 100 in 2022 and to 10 in 2023

Health Plan Transparency Regulations

Passed as part of ACA, No Surprises Act and CAA, 2021

Group health plan duties (DELAYED ENFORCEMENT)

- Advance explanation of benefits
- Public disclosure of in-network rates and out-of-network allowed amounts
- Rx drug pricing disclosures and reporting
- Price comparison tool
- Periodic provider directory updates (good faith standard for now)
- Expanded insurance card information (good faith standard for now)
- Treat ongoing care as in-network for 90 days following provider change to out-of-network (good faith standard for now)

Health Plan Transparency Regulations

Passed as part of ACA, No Surprises Act and CAA, 2021

- Recent guidance provides that Departments will not deem plan sponsors to be out of compliance with many transparency and disclosure provisions until final regulations issued
  - Expected to begin issuing final rulemaking in 2022
  - Rx information reporting delayed until December 27, 2022
  - No Surprises Act price comparison information delayed until January 1, 2023
  - In-network rates and out-of-network charges disclosure delayed until July 1, 2022

DOL Enforcement of Mental Health Parity

Settlements with carriers signal aggressive shift in DOL priority regarding Mental Health Parity and Addiction Equity Act (MHPAEA)

- Consolidated Appropriations Act, 2021 added new documentation requirement for comparative analysis of nonqualified treatment limitations (NQTL)
- Must provide within 30 days of participant request comparative information (and comparative analyses) on medical necessity for mental health/substance use disorder benefits and other information regarding NQTL application
- Work with carrier or TPA to perform and document comparative analyses
- Review service agreements to account for MHPAEA compliance

ACA Affordability and ESRP Amounts

- Affordability will drop to 9.61% of household income for 2022; will result in higher employer contributions
- American Rescue Plan Act (ARPA) lowered FPL cap for individuals to receive tax credits for Marketplace coverage; more likely for individual to trigger ESRP assessment
- 4980H(a) penalty increases to $2,750*; 4980H(b) penalty increases to $4,120*

* these figures are projections and subject to change when the official numbers are released

2022 HSA and HDHP Limits

Rev. Proc. 2021-25

- Individual HSA contribution limit $3,650 for individual coverage and $7,300 for family coverage
- HDHP deductible minimum $1,400 for individual coverage and $2,800 for family coverage
- Annual out-of-pocket maximum limit $7,050 for individual coverage and $14,100 for family coverage

PCORI Fees

- Health care reform created a nonprofit corporation, the Patient-Centered Outcomes Research Institute, to support clinical effectiveness research, funded in part by fees paid by certain health insurers and applicable sponsors of self-insured health plans
  - Fees apply to plan years ending after October 1, 2012 and before October 1, 2019 (i.e., for seven full plan years); Was to have sunset, but brought back by SECURE Act in 2019
- Filing Due Dates and Applicable Rates

Plan Ending Date	Due By	Fee per Covered Life
Jan–Sep 2021	Jul 31, 2022	$2.66
Oct–Dec 2021	Jul 31, 2022	TBD

Looking Ahead – Infrastructure Bill

Ways and Means Committee Approves Health & Welfare Provisions

- Proposes new ACA affordability percentage of 8.5% and not indexed for inflation in future years
- Proposes to make permanent the ARPA temporary expansion of Dependent Care Assistance Program (DCAP) annual limits to $10,500

Timing of Reporting & Notices

- Form 5500
  - Plan sponsors must generally file the return on the last day of the seventh month after their plan year ends (July 31 for a calendar-year plan)
- Summary Annual Report (SAR)
  - Within nine months from the close of the plan year (no later than September 30 for calendar year plans), or 2 months after due date for filing Form 5500 if an extension is obtained.
- SPD
  - Automatically to participants within 90 days of becoming covered by the plan; to all participants every 5 years
- Medicare Part D Disclosures
  - Must be provided to Medicare Part D eligible employees prior to the annual coordinated election period of October 15 through December 7 each year, for each employee upon initial eligibility prior to their initial enrollment period, and upon request
- HIPAA Notice Of Privacy Practices
  - To new enrollees at time of enrollment, within 60 days of a material change, and a reminder every three years and provided online if the plan maintains a website for participants to review information about the plan
  - Best practice is to distribute at open enrollment

Timing of Reporting & Notices

- Wellness Program Disclosures
  - EEOC regulations require information privacy disclosures for any plan utilizing a medical inquiry such as an HRA
  - HIPAA wellness program regulations require that activity-only and outcome-based wellness programs provide a "reasonable alternative standard" (or waiver of standard)
  - Reasonable alternative standard (or possibility of waiver) must be disclosed in all plan materials describing the wellness program terms (SPD, open enrollment materials, etc.)
    - Include contact information for obtaining the alternative and a statement that recommendations of an individual's personal physician will be accommodated
    - Sample language on DOL website

Electronic Distribution Rules

Employees with Work-related Computer Access

- Electronic materials must be prepared and delivered in accordance with applicable requirements. (e.g., timing and format requirements for SPDs as outlined under ERISA)
- A notice must be provided to each recipient, at the time that the electronic document is furnished, detailing the significance of the document
    - Notice must advise the participant of their rights to have the opportunity, at their work site, to access documents furnished electronically and to request and receive (free of charge) paper copies of any documents received electronically
- The employer must take appropriate measures to ensure the electronic distribution will result in actual receipt of information by the participants (i.e. return-receipt)
- If the disclosure includes personal information relating to an individual's accounts and benefits, the plan must take reasonable and appropriate steps to safeguard the confidentiality of the information

Electronic Distribution Rules

Non-Employees or Employees with Non-work Related Computer Access (additional requirements)

- A pre-consent statement must be furnished (may be provided electronically) explaining:
  - The types of documents that will be provided electronically;
  - The individual's right to withdraw consent at any time without charge;
  - The procedures for withdrawing consent and updating information;
  - The right to request a paper version and its cost (if any); and
  - The hardware and software requirements needed to access the electronic document
- Affirmative consent for electronic distribution must be obtained
  - If the documents are to be provided via the Internet, the affirmative consent must be given in a manner that reasonably demonstrates the individual's ability to access the information in electronic form, and the individual must have provided an address for the receipt of electronically distributed documents
- If system hardware or software requirements change, a revised statement must be provided and renewed consent from each individual must be obtained
- The employer must keep track of individual electronic delivery addresses, individual consents and the actual receipt of e-mailed documents by recipients

Non-discrimination Testing

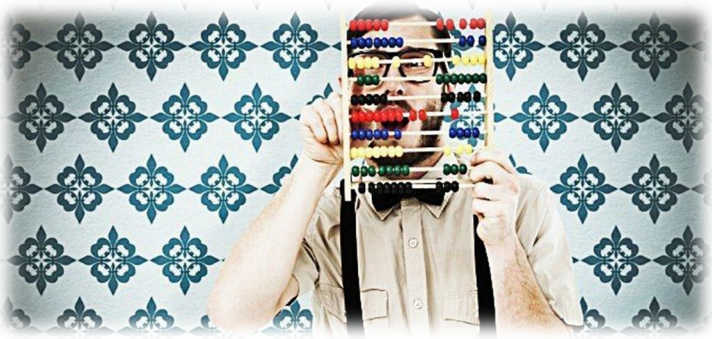
- Required for all employers for both a cafeteria plan and its component benefit plans
- Controlled Group Testing
- Aggregate pre-tax benefits and test them together
- 9 different nondiscrimination tests are possible depending on the structure of the arrangement and the component benefits available
- All applicable tests must be satisfied for a cafeteria plan to be in compliance with the nondiscrimination rules

Non-discrimination Testing

- Cafeteria plans and all component benefits must not unduly favor Highly Compensated Individuals (HCIs), Highly Compensated Employees (HCEs) and/or Key Employees with respect to either eligibility to participate or benefits offered and selected
  - Annual testing required
  - HCI, HCE and Key Employee defined differently for different component benefits offered under a cafeteria plan
  - Using the wrong definition of HCI, HCE and Key Employee for any particular test could result in incorrect results

Nondiscrimination Tests for Cafeteria Plans

- Eligibility Test – ensures that enough non-highly compensated individuals (non-HCIs) are eligible to benefit or elect to participate in the plan
- Contributions and Benefits Test – ensures that the benefits do not discriminate in favor of HCIs and that HCIs do not select more nontaxable benefits than non-HCIs
- Key Employee Concentration Test – ensures that benefits provided to Key Employees do not exceed 25% of the benefits provided to all employees



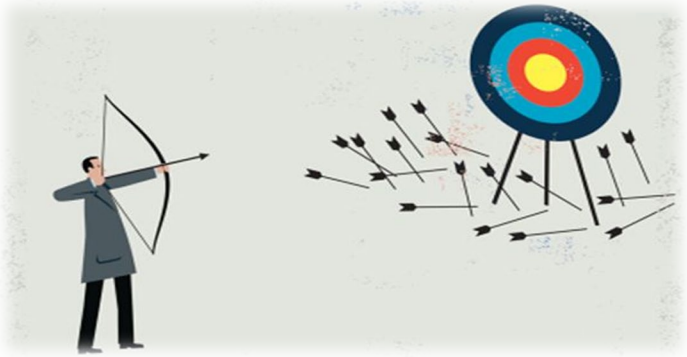
Consequences of Failure of Cafeteria Plan Nondiscrimination Tests

Consequences for Employees

- HCIs and/or Key Employees participating in a discriminatory cafeteria plan will have imputed income equal to the taxable benefit amount that the employee could have elected to receive for the plan year even if the employee elected to receive all nontaxable (qualified) benefits
- HCPs and Key Employees will be taxed on the amount of salary reductions plus any cash-out amounts or other taxable benefits received under the plan
- Amounts are treated as taxable income for purposes of wage reporting on form W-2 and for purposes of income tax, FICA and FUTA withholding
- Non-HCPs and non-Key Employees are not affected

Consequences for Employers

- The plan does not cease to be a qualified plan (tax-favored status) due to failing nondiscrimination testing
- May be subject to additional taxes (underpaid state/federal tax, payroll taxes, etc.)
- May have to reissue W-2s - HCIs, HCEs, and Key Employees may have to file amended tax returns
- May be subject to interest and penalties on top of additional taxes



Review Plan Contracts

- Stop-Loss Agreements
  - Any new or changed provisions (e.g., coverage ceilings or other limitations on coverage)?
  - Ensure terms of Plan and stop-loss policy are consistent (or that the Plan's terms are incorporated by reference) so that all claims covered under the Plan are covered by the stop-loss carrier
- Business Associate Agreements (BAAs)
  - Verify Business Associate compliance and ensure HITECH Act provisions are in BAA
  - Review timeline for BA to notify the plan of a breach and confirm that the plan has sufficient time to meet notice and reporting obligations under HIPAA
  - Review indemnification and liability limits
  - Review choice of law

Questions?

HRCI –

SHRM –

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Thank You

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