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Welcome

Employee benefit laws change rapidly —
UBA Partner Firms help their clients stay one step ahead
with ongoing expert compliance resources.

Please remember, employment and benefits law compliance depends on multiple factors – particularly those unique to each employer's circumstances. Numerous laws, regulations, interpretations, administrative rulings, court decisions, and other authorities must be specifically evaluated in applying the topics covered by this webinar. The webinar is intended for general-information purposes only. It is not a comprehensive or all-inclusive explanation of the topics or concepts covered by the webinar.

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Year-End Compliance Reminders And A Look Ahead To 2023

Agenda

Gain insights into 2023 and review final 2022 compliance requirements:

- Contraceptive coverage requirements and reproductive healthcare
- Prescription drug and healthcare reporting
- Critical adjusted benefit limits

Agenda

- What compliance actions are still outstanding for the year, including end-of-year priorities such as ACA reporting
- New rules that will be coming into effect
- COVID-related changes that could be discontinued
- New affordability thresholds
- 2023 compliance calendar

Agenda

Be able to answer these questions:

- What are upcoming employer responsibilities for coverage transparency?
- How are increased limits and higher fines for ACA reporting failures affecting employer and employee costs and risks?
- What legislative and litigation issues may impact employers in 2023?

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Contraceptive Coverage & Reproductive Health Care

- Many companies have faced pressure to address *Dobbs* and its ramifications. Pressures from customers, clients, employees, and media outlets have led some major U.S. companies to develop policies to address *Dobbs*.
- Other companies and firms have been careful to avoid addressing the issue and want to wait and see how the issues continue to play out.
- Each company must carefully weigh the costs and benefits to the policies.

- Add or expand travel benefits for abortion
  - Group health plan
    - Code Section 213(d) expenses
    - Certain IRS limits will apply (e.g., $50 lodging limit)
    - Only benefits those actually enrolled under plan

- Add or expand travel benefits for abortion
- Outside group health plan
  - Expenses for abortion-related travel likely deemed health care, and program likely deemed a group health plan
  - If so, ACA, ERISA, HIPAA, COBRA apply
- Health Reimbursement Arrangement (HRA)
- Employee Assistance Program (EAP)
  - Can benefit employees not enrolled in the group health plan
  - EAP properly structured to be "excepted benefits" will pass muster under Affordable Care Act (ACA)

- Work with consultants, attorneys and HR to assess current state of abortion coverage under plans and policies
  - Consider self-funding, if feasible
  - Review provider networks
- Possibly establish Abortion care HRA
  - Integrated with health plan
  - Stand-alone excepted benefits HRA (EBHRA)
- Incorporate into EAP
- Include or expand travel reimbursement under medical plan
  - Likely more viable if self-funded
- Consider taxable reimbursement policy
  - Other expenses included
  - No ERISA preemption
- Provide clear communication

- Monitor Reproductive Health Travel Fund Act
  - Would authorize grant program for next five years to help pay for travel-related costs associated with seeking reproductive care or treatment
  - Limited to NFP organizations or community-based organizations that assist individuals seeking abortions
  - Could be another resource available to companies through referral

- Non-grandfathered group health plans generally subject to covering contraceptive services as dictated by ACA
- Following *Dobbs* Departments reiterated guidance regarding ACA contraceptive coverage mandate
- Review plan documents to ensure plan language and benefits comply with latest HRSA guidelines (revised each year)
- Work with TPAs and PBMs, as necessary, to ensure proper plan administration
- Review exceptions process to be sure participants have open channel to requesting other non-HRSA services approved by FDA

ACA Reporting: More Important to Be Careful

- 2022 individual statements due by March 2, 2023; Forms 1094/1095 due to IRS February 28, 2023 (paper) or March 31, 2023 (electronic)
- IRS no longer granting automatic extension for individual statements this cycle; however, has made the automatic extension universal
- Also announced no longer considering good faith effort for filing errors or inaccuracies
- IRS has not yet adopted proposed dropping electronic filing threshold decrease (remains 250)

- Guidance released December 12, 2023, will make permanent a 30-day extension on furnishing individual statements.
- Does not change due dates for IRS filings
- Does not reinstate good-faith leniency

COVID-19 Issues

- Public Health Emergency likely (hopefully?) to end in 2023
  - HHS Secretary will declare, and Biden administration states employers will get 60-day advance notice
  - Will impact coverage of COVID-19 testing (including OTC tests)
  - Out-of-network COVID-19 vaccine coverage impacted
  - Monitor excepted benefit EAP and on-site clinics to ensure they retain excepted status if providing COVID-19 diagnosis, testing, and vaccination

- National Emergency likely (hopefully?) to end in 2023
  - President will declare
  - Monitor timing because Outbreak Period ends 60 days later and will impact COBRA, HIPAA special enrollment, etc.

- Telemedicine services under HDHP should no longer be provided pre-deductible after December 31, 2022

- Cafeteria plans that adopted changes related to carryover amounts from 2021 plan years to 2022 plan years should ensure proper amendment executed by December 31, 2022

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Health Plan Transparency Regulations

- Group health plan duties to interpret using reasonable, good faith interpretation, especially for items for which Departments plan to issue regulations
    - Advance explanation of benefits (delayed pending further regulatory guidance)
    - Public disclosure of in-network rates and out-of-network allowed amounts; machine-readable files already should be in place

- Group health plan duties to interpret using reasonable, good faith interpretation, especially for items for which Departments plan to issue regulations
    - Rx drug pricing disclosures and reporting; RxDC reports for 2020 and 2021 due to Centers for Medicare and Medicaid Services by December 27, 2022; subsequent reports will be due by next June 1 following year being reported
    - Price comparison tool; should be online by January 1, 2023, for 500 identified common covered services; Full tool disclosing ALL covered services must be online by January 1, 2024

- Plans should receive disclosures from service providers and ask for explanation from any who fail to provide
- Periodic provider directory updates; awaiting regulations (good faith standard)
- Expanded insurance card information; awaiting regulations (good faith standard)
- Treat ongoing care as in-network for 90 days following provider change to out-of-network; awaiting regulations (good faith standard for now)

- DOL Enforcement of Mental Health Parity
  Settlements with carriers continue to reflect DOL aggressiveness regarding Mental Health Parity and Addiction Equity Act (MHPAEA)

- Consolidated Appropriations Act, 2021 added new documentation requirement for comparative analysis of nonquantitative treatment limitations (NQTL)
  - Must provide within 30 days of participant or Department request
  - Work with carrier or TPA to perform and document
  - Review service agreements to account for MHPAEA compliance

ACA Affordability and ESRP Amounts

- Affordability will drop to 9.12% of household income for 2023; will result in higher employer contributions
- 4980H(a) penalty $2,880; 4980H(b) penalty $4,320

2023 HSA and HDHP Limits Rev. Proc. 2022-24

- Individual HSA contribution limit $3,850 for individual coverage and $7,750 for family coverage
- HDHP deductible minimum $1,500 for individual coverage and $3,000 for family coverage
- Annual out-of-pocket maximum limit $7,500 for individual coverage and $15,000 for family coverage

2023 HFSA Limits Rev. Proc 2022-38

- Can contribute up to $3,050 to health FSA
- Permissible carryover raised to $610
- Qualified transportation and parking fringe benefit increased to $300/month

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 2022	July 31, 2023	$2.79
Oct-Dec 2022	July 31, 2023	$3.00

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

Wellness Issues

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

Employees with Work-related Computer Access

- 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

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

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

- 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

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

- 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
- Nine 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

- 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

Non-discrimination 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

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

Respect for Marriage Act

- Law passed in December will be signed by President Biden December 13, 2023
- Doesn't guarantee same-sex marriage will remain legal in all states; codifies that states must recognize same-sex marriages where legally entered (even if Supreme Court overturns *Obergefell)*
- Self-funded plans could continue to exclude benefits, but legal challenges likely
- Doesn't change anything relating to benefits provided to domestic partners

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, 2023

2023 Compliance

January 31	Employers that issued 250 or more W-2 in 2022 must include health plan cost information on 2023 W-2
February 28	Forms 1094-C and 1095-C, or Forms 1094-B and 1095-B, as applicable, filed with IRS (paper filers)
March 1	Calendar year plans report creditable status of Rx drug coverage to CMS through its online portal (60 days from beginning of plan year for non-calendar year plans)
March 2	ACA individual statements furnished to full-time employees
March 31	Forms 1094-C and 1095-C, or Forms 1094-B and 1095-B, as applicable, filed with IRS (electronic filers)
June 1	RxDC reporting to CMS for 2022 prescription drug and health care spending

July 31	PCORI fee forms and payments due to IRS
July 31	Large calendar year group health plans file Form 5500; non-calendar year plans file no later than last day of 7th month following end of plan year
September 30	Plans eligible for MLR refund should receive by September 30; regardless of when received, plans must use or distribute funds within three months of receipt
September 30	Large calendar year group health plans that file Form 5500 must provide participants with summary annual report (SAR); non-calendar year plans provide no later than last day of 9th month following end of plan year
October 14	Employers sponsoring group health plans including Rx drug coverage must provide notice to affected individuals before October 15

Also remember annual obligations under ACA, WHCRA, CHIP
Required disclosure of SPD and SMM

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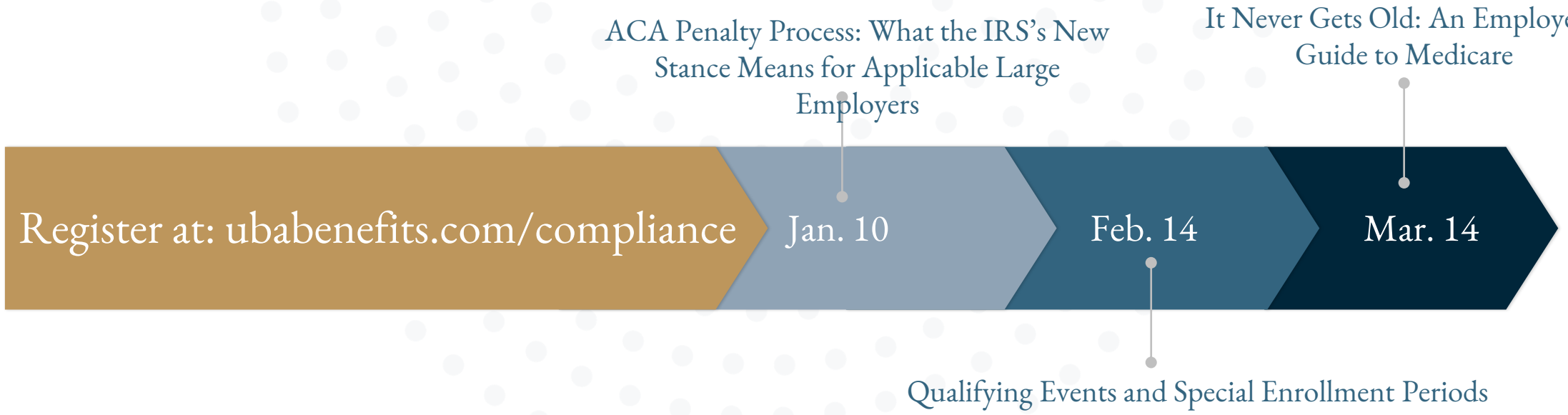

Thank You