Office Hours Webinar

2021 EB Year in Review: Plus What to Expect in 2022

January 11, 2022

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Newfront

Today's Topics

2021 Year in Review…

Plus What to Expect in 2022!

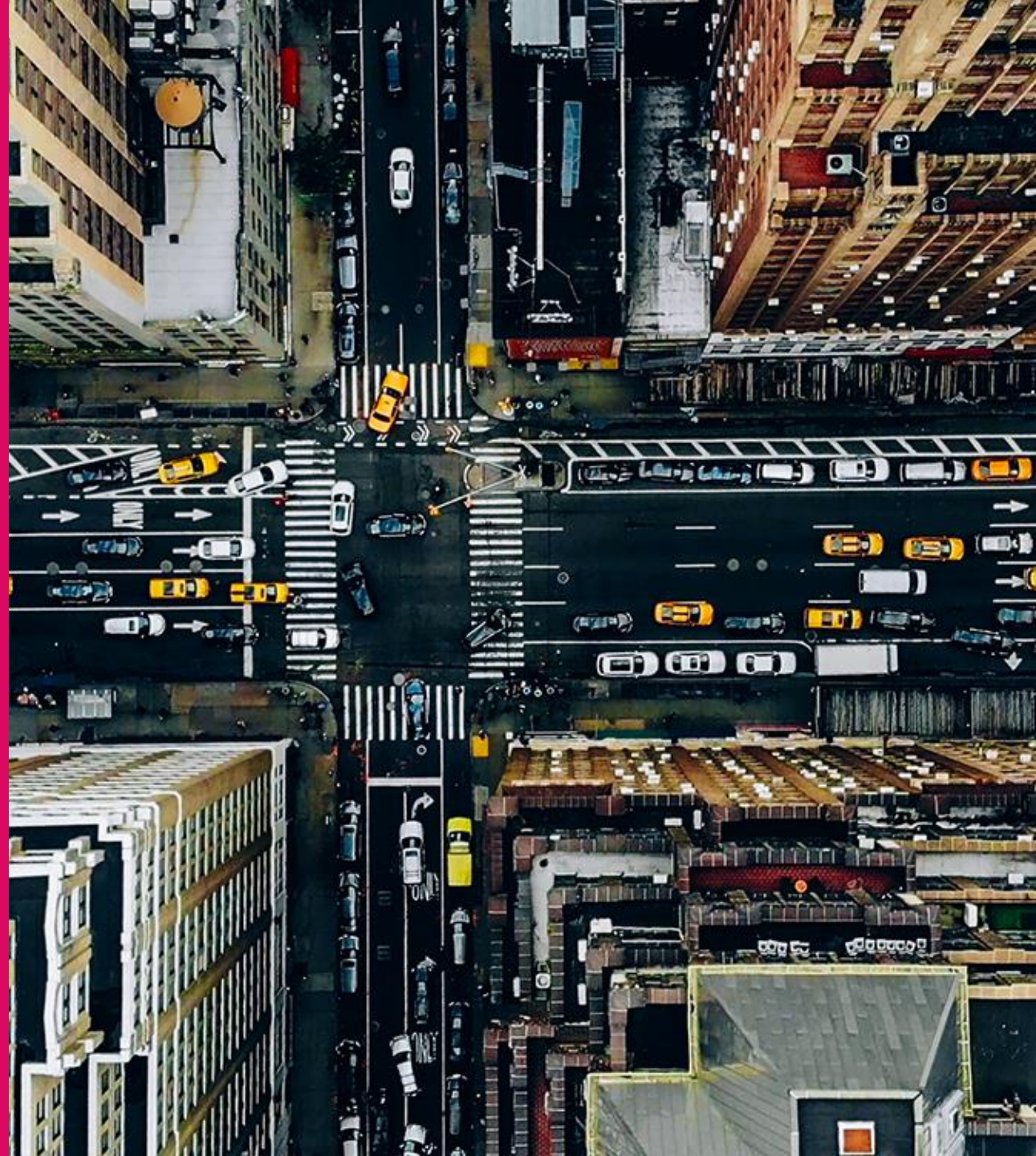
- The ACA has survived yet another U.S. Supreme Court challenge, and now we again turn back to regular order with employer mandate and reporting to address
- The CAA may not have been intended as a health bill, but it is proving to be the most significant health care reform effort since ACA (and bipartisan at that!)
- We have already seen some key temporary employee-benefits related changes from ARPA, but will we get a more permanent set from Build Back Better?
- The continuing Covid saga continues to rear its ugly head each time it seems to be mostly beat—with most of the relief provisions sunsetting should we expect more?
- HSAs continue to take small steps forward to improved eligibility access and increased utilization for eligible expenses year-by-year, and it's time to take note

Year in Review Main Topics

1	**The ACA:** With more than a decade now under its belt and surviving a trilogy of U.S. Supreme Court challenges, the ACA is now firmly ingrained—particularly the employer mandate and reporting rules
2	**The CAA:** The mega-bill begins implementation of most of its health plan-related provisions in 2022
3	**Biden Administration:** Build Back Better forecast remains foggy, but a version of the bill that passed the House has several provisions that would significantly affect employee benefits
4	**Covid Continued:** An overview of what has expired, what continues in effect, and where to next?
5	**HSAs Evolved:** Small steps forward year after year adding up to a whole greater than sum of parts

1. The ACA

Still Marching 10 Years In



ACA Trilogy Ends with Fizzle: U.S. Supreme Court Rejects Third Challenge

Full Decision: **https://www.supremecourt.gov/opinions/20pdf/19-840_6jfm.pdf**

District Court Decision Based on Individual Mandate and Severability

- At the end of 2017, the TCJA zeroed out the individual mandate as of 2019
- 20 Republican state attorneys general, as well as the federal government DOJ in part, argued that the individual mandate is no longer constitutional without the tax
- Original 2012 U.S. Supreme Court decision upheld the individual mandate as a tax
- The federal court in this case found the individual mandate is no longer constitutional as a tax now that there is no revenue mechanism
- Further found that there is no severance clause in the ACA covering the individual mandate, and looked to 2010 Congress intent finding the individual mandate to be “essential” to the ACA as a whole
- Therefore, the court struck the entire ACA because the individual mandate is inseverable

U.S. Supreme Court Held that States Have No Standing to Challenge

- After an anticlimactic trip to the Fifth Circuit Court of Appeals, Supreme Court took the case (California v. Texas)
- Supreme Court decision held that Texas (and over a dozen other states and two other individuals) do not have standing to challenge the individual mandate because they have not shown an injury tied to its enforcement
- Essentially ruled that there is no harm to base their case on because there is no longer a tax penalty
- Bottom line is the court never addressed the merits. It simply found that the states don’t have standing because no tax/penalty—meaning the ACA continues to march on after yet another court challenge fails

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
- **2022 A Penalty liability is $2,750 annualized ($229.17/month)* multiplied by all full-time employees**
  - **30 full-time employee reduction from multiplier**

  ** Projected 2022 amounts*

§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
- 2022 B Penalty liability is $4,120 annualized ($343.33/month)* multiplied by each such full-time employee who enrolls in subsidized exchange coverage (**projected 2022 amounts*)
  - Note that although the B Penalty amount is higher ($4,120 vs. $2,750), 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"
- **2022 A Penalty liability is $2,750 annualized ($229.17/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"
- **2022 B Penalty liability is $4,120 annualized ($343.33/month)** multiplied by each such full-time employee who enrolls in subsidized exchange coverage

2022 Affordability Safe Harbors: 9.61%

Full Alert: **https://www.theabdteam.com/blog/how-the-2022-aca-affordability-decrease-to-9-61-affects-employers/**

The IRS has now confirmed that the pay or play affordability safe harbors are indexed to inflation in the same manner as affordability is determined on the exchange. For 2022, the applicable percentage decreases to 9.61% (down from 9.83% in 2021).

Full Details Available Here: How the 2022 ACA Affordability Decrease to 9.61% Affects Employers

- **2022 Federal Poverty Line Safe Harbor:** 9.61% of the Federal Poverty Line
  - 2021 Federal Poverty Line (Continental U.S.): $12,880
  - 2022 Monthly Employee-Share of Premium for Lowest-Cost Plan Limit: $103.14
- **2022 Rate of Pay Safe Harbor:** 9.61% of Rate of Pay
  - Hourly Employees: 9.61% of Employee's Hourly Rate of Pay x 130
  - Salaried Employees: 9.61% of Employee's Monthly Salary
- **2022 Form W-2 Safe Harbor (Not Recommended):** 9.61% of Box 1 Wages
  - Form W-2 safe harbor provides no predictability because Box 1 unknown until January of following year
  - Box 1 does not include many forms of compensation, including 401(k) deferrals and Section 125 salary reductions for health and welfare plan coverage
  - May work if employer sets employee contribution amount at a fixed percentage of income—but most employers aren't interested in this approach

Responding to Letters From the Exchange

Full Details: **https://www.theabdteam.com/blog/when-to-appeal-covered-california-employer-notices-2/**

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 later Letter 226J)
- **Employees care:** Remove subsidy, remove need to pay it back on tax return

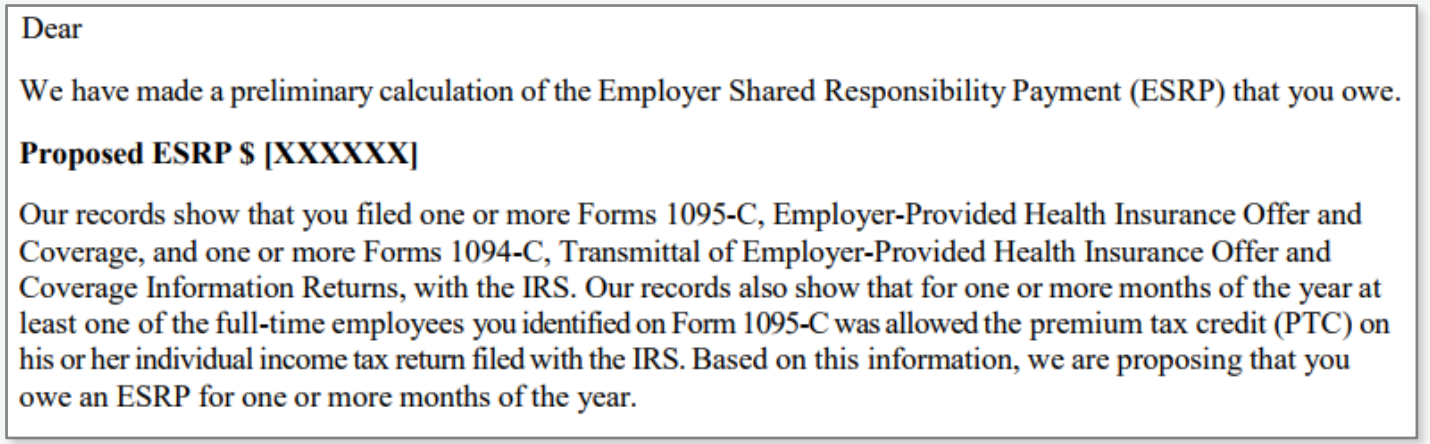
Employer Exchange Notice Approach	Employer Offered Affordable/MV MEC	Employer Did NOT Offer Affordable/MV MEC
Full-Time Employee	**Strongly Recommend Appeal** • Prevent ACA Employer Mandate §4980H Penalties • Prevent Repayment of APTC	**Do Not Appeal** • Employer will receive Letter 226J with §4980H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

ACA Employer Mandate Penalties Are Real

Full Details: **https://www.theabdteam.com/blog/responding-to-irs-letter-226j/**

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]

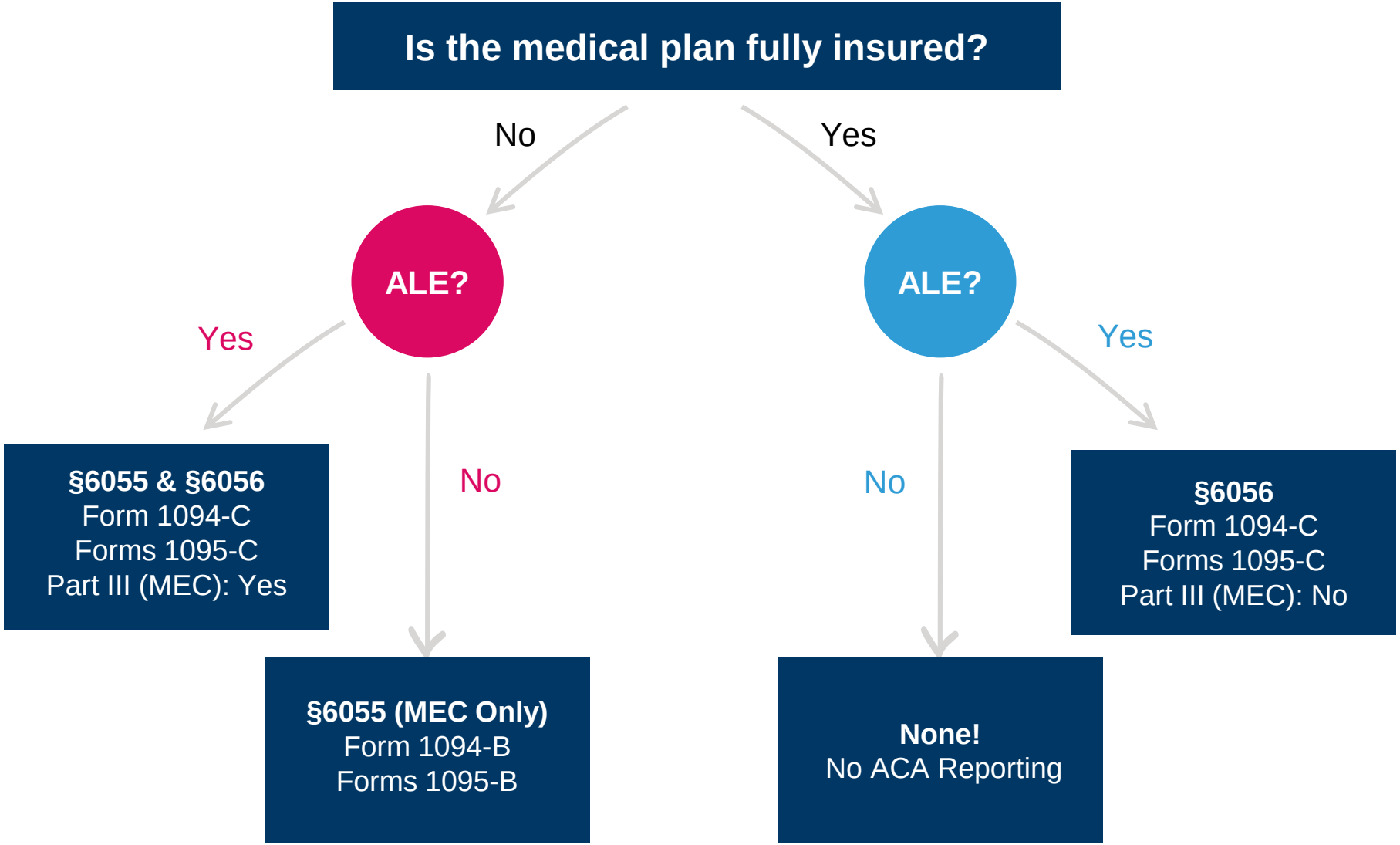
Our records show that you filed one or more Forms 1095-C, Employer-Provided Health Insurance Offer and Coverage, and one or more Forms 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns, with the IRS. Our records also show that for one or more months of the 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—End of Good Faith Safe Harbor

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

Extended Deadlines Likely Here to Stay—IRS Has Ended the Transition Relief

- The IRS proposed new regulations in November 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 remained standard
- In prior years the IRS also provided the good faith enforcement safe harbor to avoid penalties for incorrect or incomplete information (generally $280 per return)
  - **Remember:** No good-faith safe harbor for 2021 reporting at start of 2022—but likely to receive ongoing 30-day extension

2022 ACA Reporting Deadlines

Forms	Filing Method	Due Date
2021 Forms 1095-B and 1095-C	Furnish to Individuals	Standard: January 31, 2022 **IRS Extension to March 2, 2022**
2021 Forms 1094-B and 1094-C (+Copies of Forms 1095-B/1095-C)	File with IRS by Paper	February 28, 2022
2021 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, 2022

ACA Reporting Due Dates

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

Form 1095-C: To Employees

- Must be furnished by **March 2** of the following year
- Standard deadline is January 31, but was delayed 30 days for previous years of ACA reporting
- Just before Thanksgiving, the IRS proposed regulations to extend the deadline by 30 days after January 31 permanently, great news
- Downside is they also confirmed the end of the good faith enforcement safe harbor for incorrect/incomplete forms

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 move threshold to 100 returns in the future

Ongoing ACA Reporting Relief for Carriers (Not Employers)

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

IRS Provides "Section 6055 Furnishing Relief" for Insurance Carriers

- 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 no longer has a clear reporting purpose under IRC §6055.
- **IRS therefore stated it will not assess penalties on insurance carriers for failure to furnish Forms 1095-B to individuals under two conditions:**
  1. The insurance carrier 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 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, Vermont, 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

ACA Reporting Penalties

Full Details: **https://www.theabdteam.com/blog/aca-reporting-penalties/**

Same Penalties as Apply for Forms W-2

General penalty is $560 for each incorrect return ($280 for return furnished to individual, $280 for return filed with the IRS).

- Total fine not to exceed $3,426,000.
- Penalty reduced to $50 if the corrected return is filed within 30 days after the required filing date—total fine max reduced to $571,000.
- Penalty reduced to $110 if corrected by August 1 of the year in which the filing due—total fine max reduced to $1,713,000.
- For full details, see: ACA Reporting Penalties

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 previously stated it was unlikely they would provide the good faith safe harbor for 2021 reporting at the start of 2022—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: **https://www.theabdteam.com/blog/aca-pcori-fee-increases-to-2-66-for-2020-calendar-year-plans/**

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

- 2019 was originally to be the final year 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 must file for and pay the PCORI fee (the insurance carrier files/pays for fully insured plans)

PCORI Fees	July 31, 2021 Form 720 PCORI Filing	July 31, 2022 Form 720 PCORI Filing
Plan Year Ends January 1 – September 30	• Applicable Rate: $2.54 per covered individual	• Applicable Rate: $2.66 per covered individual
Plan Year Ends October 1 – December 31	• Applicable Rate: $2.66 per covered individual	• Applicable Rate: $2.79 per covered individual

The Cadillac Tax Fully Repealed!

Full Alert: **https://www.theabdteam.com/blog/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:** CBO and 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 an enormous victory for employer-sponsored coverage
- 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: **https://www.theabdteam.com/blog/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

Full Alert: https://www.theabdteam.com/blog/2022-health-fsa-limit-increased-to-2850/

2022 Health FSA Limit Increased to $2,850—Carryover Limit Up to $570

Salary Reduction Contribution Limit:

$2,850 for Plan Year Beginning On or After 1/1/2022

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 2022
- Means that for plan years beginning on or after January 1, 2022, the health FSA salary reduction contribution limit increases to $2,850

Carryover Limit:

$570 for 2022-2023 (CAA Full Carryover Expires)

IRS Announces Indexing of 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
- Sets the carryover limit at $570 for 2022 to 2023 carryovers (20% of $2,850)
- 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

ACA Individual Mandate Tax Penalty (Effectively) Repealed

Full Alert: https://www.theabdteam.com/blog/final-tax-cuts-jobs-act-bill-passes-congress-2/

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

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

The Individual Mandate is Dead, Long Live the (State) Individual Mandate

Full Alert: https://www.theabdteam.com/blog/california-enacts-individual-mandate-and-paid-family-leave-expansion-2/

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 $750/adult and $375/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
- 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

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 Details 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
  - Delayed enforcement provides until 12/27/22 to report on both 2020 and 2021 information (originally would have required 2020 data by 12/27/21)

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

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: https://www.theabdteam.com/blog/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: https://www.theabdteam.com/blog/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

The New/Modified CAA Patient Protections: No Surprises Act

Full Alert: https://www.theabdteam.com/blog/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: https://www.theabdteam.com/blog/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 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: https://www.theabdteam.com/blog/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 process similar to the one described above in #2 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: **https://www.theabdteam.com/blog/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: https://www.theabdteam.com/blog/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.

The New/Modified CAA Patient Protections: No Surprises Act

Full Alert: https://www.theabdteam.com/blog/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.”

CAA Annual Prescription Drug Reporting (Delayed)

Full Alert: https://www.cms.gov/newsroom/fact-sheets/prescription-drug-and-health-care-spending-interim-final-rule-request-comments

New Annual Reporting on Pharmacy Benefits and Drug Costs

- Reporting is designed to "as a means to promote competition and bring down overall health care costs"
- Content of annual Rx reporting:
  - 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.

Initial Reporting Deadline Delayed

- Regulations issued in November 2021 confirm that plans and carriers are not required to report on 2020 and 2021 until December 27, 2022

CAA Mental Health Parity Comparative Analysis

Full Details: **https://www.theabdteam.com/blog/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 a 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

- 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.
- This requirement to submit such documentation upon request took effect February 10, 2021 (45 days after enactment of the CAA).

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

Full Details: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-49.pdf

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)

Tax-Free Student Loan Reimbursement Extended by CAA

Full Alert: https://www.theabdteam.com/blog/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

Build Back Better and Other Priorities into 2022

Fully Insured Nondiscrimination Rules Delayed Until…?

Full Alert: https://www.theabdteam.com/blog/cadillac-tax-fully-repealed/

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 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

Price Transparency Revolution Looms in 2022 and 2023

President Biden to Continue Implementation of CAA and Trump Administration Rules

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.

Public Disclosures:

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 (likely as of December 2022)

Plan Participant Disclosures:

Effective January 1, 2023

Real-Time and Accurate Cost-Sharing Information

- Personalized out-of-pocket cost information
- Underlying negotiated rates for all items/services
- Includes prescription drugs
- Made available via an internet-based self-service tool
- First 500 shoppable services will be available for plan years that begin on or after January 1, 2023
- Remainder of the items and services will be required for plan years that begin on or after January 1, 2024
- ACA/CAA rules conflict on grandfathered plan exemption
- Insurance carriers directly subject for fully insured plans
- Employers will contract with TPAs/PBMs to satisfy for self-insured plans (expressly permitted by the rules)

Will SBC Enforcement Finally Ramp Up?

Full Alert: https://www.theabdteam.com/blog/providing-sbcs-to-employees/

New SBC Template In Effect as of 2021

- Includes 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

What to Expect When You're Expecting Build Back Better (BBB)

Full House Bill: https://www.congress.gov/bill/117th-congress/house-bill/5376

Passed the House on 11/19/21

Remember—very likely to be changed significantly by the Senate, may not even make it to reconciliation

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

The Paid Family and Medical Leave Predicament

House version includes, Senate appears very likely to remove

- Four weeks of PFML included in House BBB bill with a 1/1/24 effective date (and no federal preemption)
- Benefit set at 90% of pay for those earning less than $290/week, 73% up to $620/week, 53% up to $1,192/week
- Administered by Social Security Administration, more generous state program, or employer voluntary plan
- CBO score shows $205.5 billion cost over 10 years ($500 billion estimate under initial 12-week proposal)

Realistic Outlook

- Don't get too caught up in House bill provisions, Senate version (if any) much more likely to be basis for final bill

4. Covid Cont’d

Most Relief Phases Out, New Forms Yet to Come?

Covid Relief Provisions Expiring After 2021

Sunsetting Provisions Absent New Acts of Congress or Regulatory Guidance to Extend

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 years 2022 to a new plan year starting in calendar year 2023, carryover limit will be $570 (dependent care FSA will no longer permit carryovers)
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

Covid Relief Provisions Expiring After 2021

Sunsetting Provisions Absent New Acts of Congress or Regulatory Guidance to Extend

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	**First-Dollar Telehealth Permitted for HSA Eligibility:** Applied to plan years beginning on or before December 31, 2021 • For plan years beginning on or after 1/1/22, non-preventive telehealth must be subject to HDHP deductible to preserve employees' HSA eligibility
10	**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 2022

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

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 request 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

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 3/31/22 and wants to use HIPAA special enrollment event to enroll child in health plan
- **Assume:** National Emergency period ends April 30, 2022, and therefore the Outbreak Period ends June 29, 2022
- **Result:** Employee would have until 30 days after the end of the Outbreak Period (by July 29, 2022) to enroll
  - No indication yet of actual Outbreak Period end date

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, 2022
- **Assume:** National Emergency period ends April 30, 2022, and therefore the Outbreak Period ends June 29, 2022
- **Result:** Employer would have until 44 days after the end of the Outbreak Period (by August 12, 2022) 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, 2022
- **Assume:** National Emergency period ends April 30, 2022, and therefore the Outbreak Period ends June 29, 2022
- **Result:** Employee would have until 60 days after the end of the Outbreak Period (by August 28, 2022) 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 2022
- **Assume:** National Emergency period ends April 30, 2022, and therefore the Outbreak Period ends June 29, 2022
- **Result:** Employee would have until 30 days after the end of the Outbreak Period (by July 29, 2022) to make premium payment
  - No indication yet of actual Outbreak Period end date

Outbreak Period Extended Timelines

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, 2022, and therefore the Outbreak Period ends June 29, 2022
- **Result:** The employee/spouse would have until 60 days after the Outbreak Period (until August 28, 2022) to notify the plan of the divorce qualifying event
  - No indication yet of actual Outbreak Period end date

Outbreak Period Extended Timelines

Full Alert: https://www.theabdteam.com/blog/major-employee-benefits-timeframe-extensions-announced-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

COVID Bill Major FSA Relief for 2021 & 2022 – Consolidated Appropriations Act, 2021

Full Alert: **https://www.theabdteam.com/blog/top-10-issues-resolved-in-irs-fsa-relief-guidance/**

Optional: Full FSA Carryovers from 2020-2021 and 2021-2022 Plan Years!

- Applies to both the health FSA and the dependent care FSA
- Allows the cafeteria plan to permit carryovers of the full unused balance from plan years ending in 2020 and 2021 into the subsequent plan years ending in 2021 and 2022, respectively
  - Requires cafeteria plan amendment no later than the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective
  - For calendar plan year, amendment would have to be adopted by 12/31/21 for full carryovers from 2020 to 2021

Example:
Calendar Plan Year with Full FSA Carryovers

- Employee elected to contribute $2,750 to the health FSA and $5,000 to the dependent care FSA for the 2020 calendar plan year
- Employee only had $1,500 in health expenses and $3,500 in daycare care expenses in 2020 because of inability to access services during pandemic
- Employer amends its cafeteria plan no later than December 31, 2021 to permit full carryovers from 2020 to 2021 (by 12/31/22 for 2021 to 2022)

Result

Employee can carry over the full remaining balances ($1,250 health FSA, $1,500 dependent care FSA) into the 2021 calendar plan year

- Under normal rules, the health FSA carryover would have been capped at $550 and the dependent care FSA could not have a carryover (i.e., forfeitures!)
- *Beware of HSA eligibility issues!*
- Employer needs to coordinate the implementation, communication, and amendment with the FSA TPA

Health FSA Carryover and HSA Eligibility

General Purpose Health FSA Carryover is a Potential Problem!

- Employees who want to move to an HDHP for year two, but have general purpose health FSA amounts remaining in their account from year one subject to the standard $550 **or expanded full** carryover, have an HSA eligibility issue
- If the employee carries over any amount as general purpose health FSA balance into year two, the carryover will block HSA eligibility for all of year two

Two Main Ways to Avoid the Carryover HSA Eligibility Issue

New IRS Notice 2021-15 reiterates the IRS issued guidance in 2014 permitting two approaches to maintain HSA eligibility:

1. **Automatic Conversion of Carryover Balance to Limited Purpose:** Structure the plan to automatically convert the general purpose carryover amount to limited purpose where the employee is moving to an HDHP (preferred approach where available)
2. **Election to Forfeit Carryover Balance:** Allow the employee to waive the general purpose carryover balance and have it forfeit to the plan (fallback approach for plans that do not offer limited purpose option)

Example

- Manny moves from standard HMO in 2021 to HDHP in 2022
- He has $10 remaining of general purpose health FSA balance from 2021 that will carry over into the 2022 calendar plan year

Result

- Manny's employer's plan utilizes the first approach above to automatically convert general purpose carryover to limited purpose where employee moves to HDHP
- The limited purpose health FSA carryover will not block 2022 HSA eligibility!

COVID Bill Major FSA Relief for 2021 & 2022 – Consolidated Appropriations Act, 2021

Full Alert: **https://www.theabdteam.com/blog/top-10-issues-resolved-in-irs-fsa-relief-guidance/**

Optional: 12-Month Grace Periods Following 2020 and 2021 Plan Years!

- Applies to both the health FSA and the dependent care FSA
- Allows the cafeteria plan to permit a 12-month grace period after the end of plan years ending in 2020 and 2021
  - Exception from the general rule that permits a grace period of only up to 2 ½ months
  - Requires cafeteria plan amendment no later than the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective
  - For calendar plan year, amendment would have to be adopted by 12/31/21 for grace period from 2020 to 2021

Example:
Calendar Plan Year with 12-Month FSA Grace Period

- Employee elected to contribute $2,750 to the health FSA and $5,000 to the dependent care FSA for the 2020 calendar plan year
- Employee only had $1,500 in health expenses and $3,500 in daycare care expenses in 2020 because of inability to access services during pandemic
- Employer will amend its cafeteria plan no later than December 31, 2021 to permit 12-month grace period in 2021 for 2020 plan year (and '22 for '21 plan year)

Result

Employee will have access to the remaining balances ($1,250 health FSA, $1,500 dependent care FSA) in all of 2021 during 12-month grace period

- Under normal rules, the grace period would end March 15, which could cause additional forfeitures
- *Beware of HSA eligibility issues!*
- Employer needs to coordinate the implementation, communication, and amendment with the FSA TPA

Health FSA Grace Period and HSA Eligibility

General Purpose Health FSA Balance Available in Grace Period is a Potential Problem!

- Employees who want to move to an HDHP for year two, but have general purpose health FSA amounts subject to the 2½-month **or extended 12-month** grace period, have an HSA eligibility issue
- General rule is that the employee will not be HSA eligible until month four in year two (i.e., April for a calendar plan year) because the grace period will be disqualifying coverage for the first three months
- With the extended 12-month grace period, the employee will have disqualifying coverage for the **entire** subsequent plan year!

Three Main Ways to Avoid the Grace Period HSA Eligibility Issue

New IRS Notice 2021-15 adds the same approach two approaches as carryover to maintain HSA eligibility:

1. **Automatic Conversion of Grace Period Balance to Limited Purpose:** Structure the plan to automatically convert the general purpose grace period amount to limited purpose where the employee is moving to an HDHP (preferred approach)
2. **Election to Forfeit Grace Period Balance:** Allow the employee to waive the general purpose grace period balance and have it forfeit to the plan (fallback approach for plans that do not offer limited purpose option)
3. **Spend Down the Account Balance to Zero By End of Plan Year:** The employee spends down the health FSA to zero by the last day of the plan year on a cash basis (meaning the account balance is actually zeroed out through reimbursements)

Example

- Manny moves from standard HMO in 2021 to HDHP in 2022 with $10 remaining of general purpose health FSA balance from 2021 that be available in the extended 12-month grace period for 2022

Result

- Manny's employer's plan utilizes the first approach to automatically convert general purpose carryover to limited purpose where employee moves to HDHP—so the grace period will not block HSA eligibility in 2022

COVID Bill Major §125 Relief for 2021 – Consolidated Appropriations Act, 2021

Full Alert: https://www.theabdteam.com/blog/top-10-issues-resolved-in-irs-fsa-relief-guidance/

Optional: Mid-Year Health Plan Enrollment for Waived Employees

- Employers can amend their Section 125 cafeteria plan to allow employees who originally waived health plan coverage to make a new election for employer-sponsored health coverage on a prospective basis
- Must have insurance carrier confirmation (or stop-loss provider if self-insured) to proceed with this approach
  - Applies only to plan years ending in 2021 (the 2021 plan year for calendar plan years)
  - Requires cafeteria plan amendment be adopted no later than the last day for the first calendar year beginning after the end of the plan year in which the amendment is effective (December 31, 2022 for calendar plan years)

Example: Waived Employee Enrolled Mid-Year in 2021

- Employee waived coverage at open enrollment for 2021 calendar plan year coverage
- Employer confirms with insurance carriers and/or stop-loss providers that they will permit mid-year enrollment without a permitted election change event
- Employer will amend its cafeteria plan to adopt the CAA §125 relief no later than December 31, 2022

Result

Within parameters established by the insurance carriers and/or stop-loss providers, the employee could in the 2021 plan year enroll in health plan mid-year without experiencing a permitted election change event

- Employee could pay employee-share of the premium on a pre-tax basis under Section 125

COVID Bill Major §125 Relief for 2021 – Consolidated Appropriations Act, 2021

Full Alert: **https://www.theabdteam.com/blog/top-10-issues-resolved-in-irs-fsa-relief-guidance/**

Optional: Mid-Year Plan Option Change or to Add Dependents

- Employers can amend their Section 125 cafeteria plan to allow employees to change their health plan option or enroll dependents on a prospective basis
- Must have insurance carrier confirmation (or stop-loss provider if self-insured) to proceed with this approach
  - Applies only to plan years ending in 2021 (the 2021 plan year for calendar plan years)
  - Requires cafeteria plan amendment be adopted no later than the last day for the first calendar year beginning after the end of the plan year in which the amendment is effective (December 31, 2022 for calendar plan years)

Example: Move from PPO to HMO Mid-Year in 2021

- Employee enrolled in employee-only PPO coverage at open enrollment for 2021 calendar plan year
- Employer confirms with insurance carriers and/or stop-loss providers that they will permit mid-year enrollment changes without a permitted election change event
- Employer will amend its cafeteria plan to adopt the CAA §125 relief no later than December 31, 2022

Result

Within parameters established by the insurance carriers and/or stop-loss providers, the employee could in the 2021 plan year change to family HMO coverage mid-year without experiencing a permitted election change event

- Employee could pay employee-share of the premium on a pre-tax basis under Section 125

Full Alert: https://www.theabdteam.com/blog/top-10-issues-resolved-in-irs-fsa-relief-guidance/

Optional: Mid-Year Dropping of Health Plan Coverage

- Employers can amend their Section 125 cafeteria plan to allow employees to revoke their health plan election on a prospective basis
- Employee must attest in writing that the employee is enrolled (or will immediately enroll) in other health coverage not sponsored by the employer
  - Applies only to plan years ending in 2021 (the 2021 plan year for calendar plan years)
  - Requires cafeteria plan amendment be adopted no later than the last day for the first calendar year beginning after the end of the plan year in which the amendment is effective (December 31, 2022 for calendar plan years)

Written Attestation Template from IRS – Can Rely Upon Absent Actual Knowledge it is False

Name: _____ (and other identifying information requested by the employer for administrative purposes).

I attest that I am enrolled in, or immediately will enroll in, one of the following types of coverage: (1) employer-sponsored health coverage through the employer of my spouse or parent; (2) individual health insurance coverage enrolled in through the Health Insurance Marketplace (also known as the Health Insurance Exchange); (3) Medicaid; (4) Medicare; (5) TRICARE; (6) Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA); or (7) other coverage that provides comprehensive health benefits (for example, health insurance purchased directly from an insurance company or health insurance provided through a student health plan).

Signature: _____

COVID Bill Major §125 Relief for 2021 – Consolidated Appropriations Act, 2021

Full Alert: https://www.theabdteam.com/blog/top-10-issues-resolved-in-irs-fsa-relief-guidance/

Optional: Mid-Year Health FSA Election Changes

- Employers can amend their Section 125 cafeteria plan to allow employees to revoke, decrease, make, or increase a health FSA election on a prospective basis
- Allows employees to change their health FSA election mid-year for any reason
  - Applies only to plan years ending in 2021 (the 2021 plan year for calendar plan years)
  - Requires cafeteria plan amendment be adopted no later than the last day for the first calendar year beginning after the end of the plan year in which the amendment is effective (December 31, 2022 for calendar plan years)

Example: Health FSA Election to Enroll Mid-Year

- Employee elected to waive the health FSA at 2021 calendar plan year open enrollment
- Employee now wants to enroll because of ability to access elective surgery services following the end of most COVID-19 pandemic closures
- Employer will amend its cafeteria plan to adopt the CAA FSA relief no later than December 31, 2022

Result

In the 2021 plan year, employee can enroll in the health FSA mid-year without experiencing a permitted election change event

- Employee's election to waive is not irrevocable because of these relaxed rules adopted by employer
- Employer needs to coordinate implementation, administration, and communication with TPA

COVID Bill Major §125 Relief for 2021 – Consolidated Appropriations Act, 2021

Full Alert: https://www.theabdteam.com/blog/top-10-issues-resolved-in-irs-fsa-relief-guidance/

Optional: Mid-Year Dependent Care FSA Election Changes

- Employers can amend their Section 125 cafeteria plan to allow employees to revoke, decrease, make, or increase a dependent care FSA election on a prospective basis
- Allows employees to change their dependent FSA election mid-year for any reason
  - Applies only to plan years ending in 2021 (the 2021 plan year for calendar plan years)
  - Requires cafeteria plan amendment be adopted no later than the last day for the first calendar year beginning after the end of the plan year in which the amendment is effective (December 31, 2022 for calendar plan years)

Example: Dependent Care FSA Enrollment Mid-Year

- Employee elected to waive the dependent care FSA at 2021 calendar plan year open enrollment
- Employee now wants to enroll because of ability to access childcare services following the end of most COVID-19 pandemic closures
- Employer will amend its cafeteria plan to adopt the CAA FSA relief no later than December 31, 2022

Result

In the 2021 plan year, employee can enroll in the dependent care FSA mid-year without experiencing a permitted election change event

- Employee's election to waive is not irrevocable because of these relaxed rules adopted by employer
- Employer needs to coordinate implementation, administration, and communication with TPA

Full Alert: https://www.theabdteam.com/blog/top-10-issues-resolved-in-irs-fsa-relief-guidance/

Additional Optional 2021 CAA FSA Relief Provisions

Health FSA Spend Down

- The cafeteria plan may permit employees who terminate participation mid-year during calendar year 2020 or 2021 to continue to incur reimbursable claims for the remainder of the plan year in which participation ceased
  - Essentially mirrors the optional spend down provision that is always available for the dependent care FSA
  - Beware of HSA eligibility issues—the spend down causes employees to have disqualifying coverage for the remainder of the plan year

Plan Amendments May be Retroactive

- Employers wishing to offer any of the Consolidated Appropriations Act, 2021 FSA relief provisions must amend the cafeteria plan to incorporate the changes
  - The amendment may be retroactive as long as it is adopted no later than the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective
  - For example, employers with a calendar year cafeteria plan that adopted the full carryover provision from the 2021 plan year into 2022, or the extended 12-month grace period provision into 2022, must amend the cafeteria plan by 12/31/22 to reflect the change
  - Plan must be operated consistent with the terms of the amendment during the full retroactive period
  - Work closely with FSA TPA to ensure any amendment is consistent with their administrative capabilities and communication

Full Alert: https://www.theabdteam.com/blog/president-signs-bill-free-covid-19-testing-coverage-mandate-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: https://www.theabdteam.com/blog/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 16, 2022 (based on latest extension here)

Full Details: https://www.whitehouse.gov/briefing-room/statements-releases/2021/12/02/fact-sheet-president-biden-announces-new-actions-to-protect-americans-against-the-delta-and-omicron-variants-as-we-battle-covid-19-this-winter/

What's New for 2022?

The Biden Administration released a nine-point action plan on 12/2/21 for combating the spread of Covid, particularly in light of the rise of Delta and emerging threats posed by Omicron

Expands Mandate to Include Rapid OTC At-Home Testing

- Individuals who purchase OTC at-home Covid rapid diagnostic tests will be able to seek reimbursement from their group health plan (self-insured and fully insured) during the public health emergency
- Departments to issue guidance by 1/15/22 with more details
- Still does not include workplace screening testing (i.e., mandate does not apply for return-to-work screening testing)

Additional Funding Allocated

- An additional $2 billion to accelerate the production of rapid tests
- Additional $1 billion to procure at-home tests
- Currently eight tests available on the market today

What is Different Now?

- Previously, at-home testing was covered by the mandate only when the test was ordered by an attending health care provider who had determined that the test was medically appropriate for the individual
- Not clear what limitations will apply under the guidance to ensure there are reasonable safeguards on amount purchased by plan participants
- Also not clear whether tests will be covered at purchase or only upon submitting receipt to plan for reimbursement

Covid Vaccine Premium Incentives and Surcharges

Full Details: https://www.theabdteam.com/blog/covid-vaccine-premium-incentives-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

Full Alert: https://www.theabdteam.com/blog/irs-issues-long-awaited-arpa-cobra-subsidy-guidance/

Six Months of Fully Subsidized COBRA

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

- 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 COBRA Subsidy: April – September 2021

Full Alert: https://www.theabdteam.com/blog/irs-issues-long-awaited-arpa-cobra-subsidy-guidance/

The DOL Model Notices	• ARPA General Notice and COBRA Continuation Coverage Election Notice:
	  • Distributed to all qualified beneficiaries with qualifying events from April – September 2021
	• COBRA Notice in Connection with Extended Election Periods:
	  • Distributed by May 31, 2021 to those currently in COBRA or within the 18-month max period
	• Notice of Expiration of Period of Premium Assistance:
	  • Distributed 15 – 45 days before ARPA COBRA subsidies expired or end of 18-month max period

Examples of What Qualifies as Involuntary Termination of Employment	• Qualifies as Involuntary Termination of Employment:
	  • Employee terminates for good reason due to employer action causing a material negative change
	  • Retirement where employee intended to continue work but had knowledge of pending termination
	  • Resignation as result of the employer's material change in geographic location
	  • Employee-initiated termination in response to involuntary material reduction in hours
	  • Employer's decision not to renew an employee's contract if employee was willing/able to continue
	• Does Not Qualify as Involuntary Termination of Employment
	  • Termination due to general concerns about workplace safety (e.g., exposure to Covid-19)
	  • Termination because a child is unable to attend school or access childcare due to Covid-19

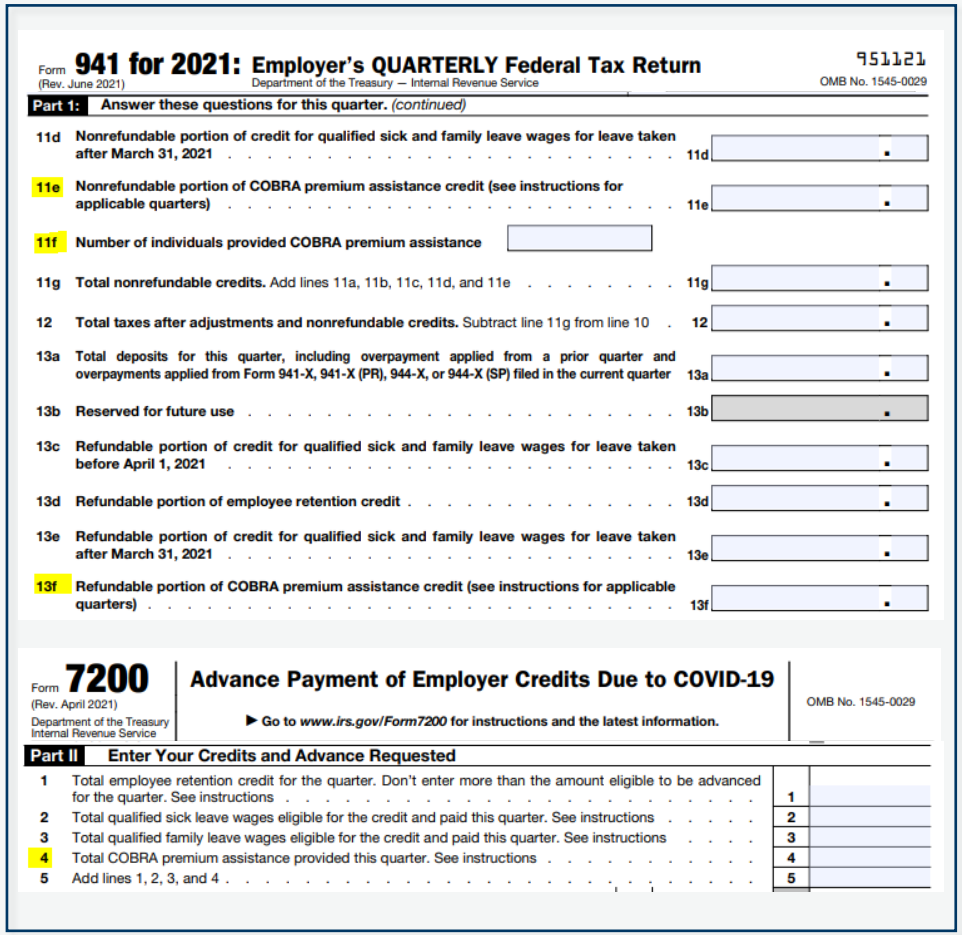
Interaction with Employer COBRA Subsidies	• ARPA COBRA subsidy is available only for the amount not subsidized by the employer • If employer fully subsidizes premium, no ARPA COBRA subsidy or tax credit available • If employer partially subsidizes, the ARPA subsidy and tax credit applies to the remainder • Separate taxable severance benefits do not affect ARPA subsidy or tax credit

ARPA COBRA Subsidy: April – September 2021

Full Alert: https://www.theabdteam.com/blog/irs-issues-long-awaited-arpa-cobra-subsidy-guidance/

The COBRA Premium Assistance Credit

- The credit for a quarter was the total amount of premiums not paid by the APRA subsidy-eligible individuals receiving the ARPA subsidy in that quarter
- Employer was the "premium payee" eligible for the credit unless the plan was subject to state mini-COBRA instead of federal COBRA (e.g., Cal-COBRA)
- Employer claimed the premium assistance credit by reporting it on the appropriate lines of quarterly Form 941
- Credit applied against employer share of Medicare portion of FICA payroll tax
- Employers could claim advance if anticipated credit exceeded available reduction in deposits via Form 7200
- Employers must retain records to substantiate eligibility for the credit and provide them to the IRS upon request



Form **941 for 2021:** Employer's QUARTERLY Federal Tax Return
(Rev. June 2021) Department of the Treasury — Internal Revenue Service
951121 OMB No. 1545-0029

Part 1: Answer these questions for this quarter. *(continued)*

11d	Nonrefundable portion of credit for qualified sick and family leave wages for leave taken after March 31, 2021	11d
11e	Nonrefundable portion of COBRA premium assistance credit (see instructions for applicable quarters)	11e
11f	Number of individuals provided COBRA premium assistance	
11g	Total nonrefundable credits. Add lines 11a, 11b, 11c, 11d, and 11e	11g
12	Total taxes after adjustments and nonrefundable credits. Subtract line 11g from line 10	12
13a	Total deposits for this quarter, including overpayment applied from a prior quarter and overpayments applied from Form 941-X, 941-X (PR), 944-X, or 944-X (SP) filed in the current quarter	13a
13b	Reserved for future use	13b
13c	Refundable portion of credit for qualified sick and family leave wages for leave taken before April 1, 2021	13c
13d	Refundable portion of employee retention credit	13d
13e	Refundable portion of credit for qualified sick and family leave wages for leave taken after March 31, 2021	13e
13f	Refundable portion of COBRA premium assistance credit (see instructions for applicable quarters)	13f

Form **7200** (Rev. April 2021)
Department of the Treasury Internal Revenue Service

Advance Payment of Employer Credits Due to COVID-19

▶ Go to *www.irs.gov/Form7200* for instructions and the latest information.

OMB No. 1545-0029

Part II Enter Your Credits and Advance Requested

1	Total employee retention credit for the quarter. Don't enter more than the amount eligible to be advanced for the quarter. See instructions	1
2	Total qualified sick leave wages eligible for the credit and paid this quarter. See instructions	2
3	Total qualified family leave wages eligible for the credit and paid this quarter. See instructions	3
4	Total COBRA premium assistance provided this quarter. See instructions	4
5	Add lines 1, 2, 3, and 4	5

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

Full Alert: https://www.theabdteam.com/blog/irs-issues-2021-dependent-care-fsa-increase-guidance-and-2022-hsa-limits/

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**
- House version of BBB would make increase permanent and index for inflation

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 $12,000 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

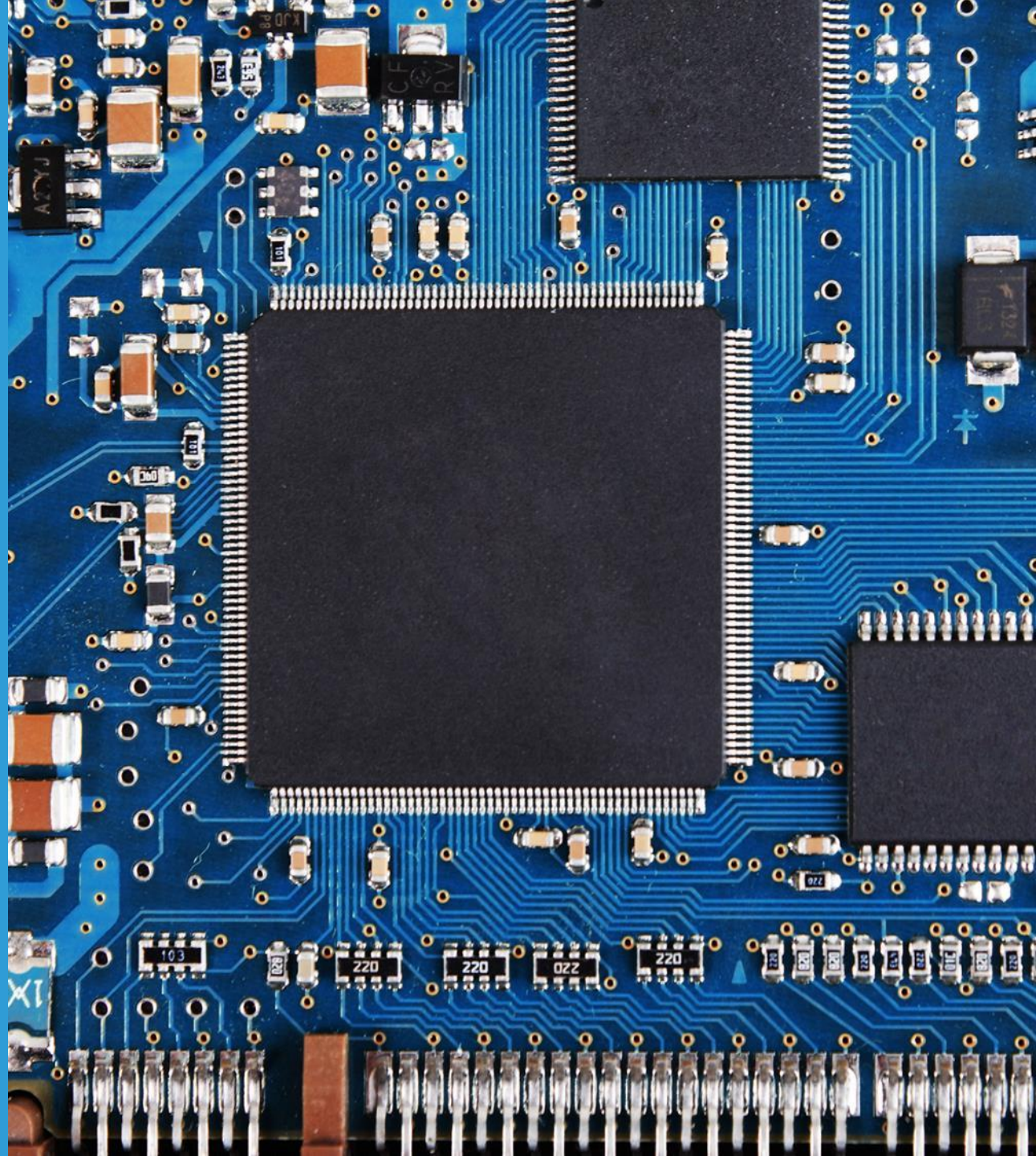
- Unused amounts carried over or available during an extended grace period pursuant to CAA are disregarded in determining the limit for the following year
  - CAA carryover/extended grace period amounts also do not affect the subsequent income exclusion amount

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. HSAs

Continuing to Evolve



New HDHP Preventive Services Permitted

Full Alert: https://www.theabdteam.com/blog/irs-expands-definition-of-preventive-care-for-hdhps/

IRS Expands List of First-Dollar Preventive Care to Chronic Conditions

- President Trump issued an executive order in June 2019 directing the IRS to issue guidance expanding the list of HDHP preventive services
- In July 2019, the IRS issued Notice 2019-45 to add certain medical services and items, including prescription drugs, relating to preventing exacerbation of a chronic condition (or the development of an associated secondary condition)
  - The Notice highlights that the Treasury Department and IRS are aware that cost barriers for care related to chronic conditions can result in some individuals failing to seek or utilize effective and necessary care that would prevent exacerbation of the chronic conditions

Reminder - Preventive Care Not Subject to Minimum Deductible

- HDHPs may (and typically do) provide first-dollar coverage for preventive care
  - These items and services are not subject to the minimum statutory deductible of $1,400 for single coverage and $2,800 for family coverage
- "Preventive care" already included:
  - Periodic health evaluations, including annual physicals
  - Routine prenatal and well-child care
  - Child and adult immunizations
  - Tobacco cessation programs
  - Obesity weight-loss programs
  - Screening services (long list in IRS Notice 2004-23)
  - All ACA preventive services required to be provided without cost sharing for non-grandfathered health plans
  - New for 2020: Items and services related to exacerbation of a chronic condition

New HDHP Preventive Services Permitted

Full Alert: https://www.theabdteam.com/blog/irs-expands-definition-of-preventive-care-for-hdhps/

Reminder - New (and Old) Preventive Services are Not Required

- The new guidance simply permits HDHPs to offer these new chronic condition-related preventive services as first-dollar coverage (i.e., not subject to the deductible)
- Each plan is taking a different approach to if/when it will adopt these optional new services
- Check your plan terms for more details!

The New Chronic Condition Preventive Services (IRS Notice 2019-45)

Preventive Care for Specialized Conditions	For Individuals Diagnosed with
ACE Inhibitors / Beta Blockers	Congestive Heart Failure and/or Coronary Artery Disease
Inhaled Corticosteroids / Peak Flow Meter	Asthma
Insulin and Other Glucose Lowering Agents / Glucometer / Retinopathy Screening / Hemoglobin A1c Testing / Statins	Diabetes
LDL Testing / Statins	Heart Disease
Anti-Resorptive Therapy	Osteoporosis and/or Osteopenia
INR Testing	Liver Disease and/or Bleeding Disorders
SSRIs	Depression
Blood Pressure Monitor	Hypertension

Covid Testing and Treatment

Full Alert: https://theabdteam.com/blog/irs-and-dol-issue-new-covid-19-guidance-regarding-hdhp-and-hsa-eligibility/

General Rule:

Minimum Annual HDHP Deductible Required

1. **Employee-Only Coverage:**
   - **2021: $1,400**
   - **2022: $1,400**
2. **Family Coverage:**
   - **2021: $2,800**
   - **2022: $2,800**

- Family coverage includes any plan other than employee-only (e.g., employee plus spouse, employee plus child, employee plus family)
- Preventive services typically not subject to the deductible
- Embedded deductible in family coverage must be at least the minimum annual family deductible

Covid Relief: HDHP Status and HSA Eligibility Preserved for First-Dollar Coverage

- IRS Notice 2020-15 was the first piece of IRS guidance related to Covid!
- Provides that HDHPs will not fail to maintain HDHP status if they provide medical care services and items purchased related to testing for and treatment of Covid prior to satisfaction of the applicable minimum deductible
- Means all individuals covered by plans providing first-dollar (i.e., not subject to the deductible) coverage for testing and treatment of Covid can maintain HSA eligibility
- Designed by the IRS to “eliminate potential administrative and financial barriers to testing for and treatment of COVID-19.”

Temporary CARES Act Telehealth Relaxation (Through 2021 Plan Year)

Full Alert: https://www.theabdteam.com/blog/how-the-cares-act-affects-employee-benefits/

First-Dollar HDHP Telehealth Permitted (Expired for Calendar Plan Years)

CARES Act Changes - HSA Eligibility Preserved

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

- Meant that individuals covered under a HDHP that waived the deductible for telehealth services or other remote care could maintain HSA eligibility
- Included non-preventive telehealth/remote care

Applied for plan years beginning on or before December 31, 2021

- For a calendar plan year, the relief has already expired (applied for 2020 and 2021 plan years)

Industry push to extend or make permanent the relief

- Large coalition of groups sent letters to congressional leaders requesting extension
- Two bills in congress with bipartisan cosponsors have been introduced, but do not seem likely to pass (S.1704 and H.R.5981)

Practical Considerations - Plan Design Issues

These were optional provisions

- HDHPs were not required to offer free telehealth and remote care
- These rules simply permitted it without causing loss of HSA eligibility

Fully Insured Plan

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

Self-Insured Plan

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

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."

Permanent CARES Act HSA Improvements

Full Alert: https://www.theabdteam.com/blog/how-the-cares-act-affects-employee-benefits/

Changes to Eligible HSA/FSA/HRA Expenses

The CARES Act paired a longstanding Republican priority with a longstanding Democrat priority for a bipartisan combo of changes to the list of eligible medical expenses for an HSA/FSA/HRA.

OTC Medicines and Drugs - No Rx Required

CARES Act eliminated the requirement for a prescription to reimburse an over-the-counter medicine or drug

- Prior rule from the ACA restricted eligible account-based plan expenses to only OTC medicines and drugs (other than insulin) provided pursuant to a prescription
- No Rx required anymore for OTC medicines and drugs to qualify as eligible HSA/FSA/HRA expense
- Was effective for expenses incurred on or after January 1, 2020

Menstrual Care Products - Now Eligible Expenses

CARES Act adds menstrual care products to qualifying expenses

- Previously excluded as an item for general health
  - §213(d) applies only to expenses incurred for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body
- **Now HSA/FSA/HRA can reimburse these products tax-free**
- Includes tampons, pads, liners, cups, sponges, or similar products
- Was effective for expenses incurred on or after January 1, 2020

Getting Better Every Year!

HSA Expense and Eligibility Enhancements Added in 2021

Full Alert: **https://www.theabdteam.com/blog/caa-surprise-billing-rules-preserve-hsa-eligibility/**

After remaining relatively stable for an extended period since the HSA inception point, HSAs have been experiencing a whirlwind of enhancements in recent years. Although none of the changes by themselves are revolutionary, the modifications are significant in the aggregate by increasing reimbursable expenses and eliminating unnecessary barriers to eligibility. In 2021, Congress and the IRS added two new items to the growing list of improvements.

Personal Protective Equipment (PPE)

IRS Announcement 2021-7 notified taxpayers that amounts paid for PPE now qualify as medical care expenses under §213(d)

- Includes PPE such as masks, hand sanitizer, and sanitizing wipes for the primary purpose of preventing the spread of Covid
- Inclusion in definition of §213(d) medical expense makes PPE eligible to be paid or reimbursed under a health FSA, HRA, or HSA
- PPE eligible expense inclusion was made effective for expenses incurred on or after January 1, 2020

No Surprises Act HSA Eligibility Preservation

CAA adds two provisions to ensure the new surprise billing patient protections do not affect HSA eligibility

1. HSA Eligibility Not Affected by Surprise Billing Payments
   - Individuals will not fail to be HSA-eligible merely because they receive surprise billing benefits required by the CAA No Surprises Act provisions
2. HDHP Status Not Affected by Surprise Billing Protection Payments
   - Plans will not lose HDHP status merely because they provide surprise billing benefits required by the CAA's No Surprises Act patient protection provisions
   - Both effective for plan years beginning on or after 1/1/22

Annual Limits

2022 Inflation Adjustments

2022 Employee Benefit Limits

Employee Benefit Limit	2021	2022
HSA Individual	$3,600	**$3,650**
HSA Family	$7,200	**$7,300**
HSA Catch-Up (55+)	$1,000	**$1,000**
HDHP Maximum Out-of-Pocket	$7,000 / $14,000	**$7,050 / $14,100**
HDHP Minimum Deductible	$1,400 / $2,800	**$1,400 / $2,800**
Health FSA Salary Reduction Contribution	$2,750	**$2,850**
Health FSA Carryover to Following Year	$550 (CAA FSA relief unlimited available)	**$570**
Dependent Care FSA	$10,500 ($5,250 married filing separately)	**$5,000 ($2,500 married filing separately)**
Highly Compensated Employee	$130,000	**$135,000**
Mass Transit/Vanpooling	$270/month	**$280/month**
Qualified Parking	$270/month	**$280/month**
401(k) Elective Deferral	$19,500	**$20,500**
401(k) Catch-Up (50+)	$6,500	**$6,500**
FICA Wage Base (SS Only)	$142,800	**$147,000**
ACA Employer Mandate Penalties	A Penalty: $2,700, B Penalty: $4,060	**A Penalty: $2,750*, B Penalty: $4,120***
ACA Employer Mandate Affordability	9.83%	**9.61%**
ACA Federal Poverty Level Safe Harbor	$104.52/month	**$103.14/month**
Adoption Assistance	$14,440	**$14,890**

*projected

The San Francisco Health Care Security Ordinance (HCSO): 2022 Rates

Full Webinar: **Newfront Office Hours Webinar—The San Francisco Health Care Security Ordinance (HCSO)**

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	2021 Rate	2022 Rate	172 Hours/Month 2022 Maximum
Large: **100+ Employees** (Worldwide)	$3.18/hour payable	$3.30/hour payable	$567.60/month $1,702.80/quarter
Medium: **Business w/ 20-99** **Nonprofit w/ 50-99** (Worldwide)	$2.12/hour payable	$2.20/hour payable	$378.40/month $1,135.20/quarter
Small: **Business w/ 0-19** **Nonprofit w/ 0-49** (Worldwide)	Exempt	Exempt	Exempt

The San Francisco Paid Parental Leave Ordinance (PPLO): 2022 Maximums

Full Webinar: **Newfront Office Hours Webinar—The San Francisco Paid Parental Leave Ordinance (PPLO)**

The maximum benefit is based of the PFL cap at an annual salary of $145,600 in 2022.

Calculation Instructions and Worksheets: https://sfgov.org/olse/paid-parental-leave-calculations

Calculation Excel Spreadsheet: https://sfgov.org/olse/paid-parental-leave-ordinance

	2022 Maximum Weekly Benefits	2022 Maximum Total Benefits
California PFL Payment Amount	Maximum Weekly PFL Benefit $1,540 ($145,600 / 52 x 55%)	Maximum PFL Benefit x 8 $12,320
San Francisco PPL Payment Amount	Maximum Weekly PPLO Amount $1,027 ($1,540 / 60% - $1,540)	Maximum PPLO Amount x 8 $8,216
Maximum Total Payment Amount (PFL+PPL)	$2,567 Per Week of New Child Bonding Leave	$20,536 Per 8-Weeks of New Child Bonding Leave

Wrap-Up

Takeaways

2022 Year In Review: Key Points

1 The ACA	• The ACA continues to march on, despite yet another Supreme Court challenge • 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!
2 The CAA	• The CAA includes several significant changes for group health plans, mostly starting in 2022 • 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	• Build Back Better incoming? Will there be other major legislative attempts before the midterms? • 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 phased out as of the end of 2021 • However, some key provisions remain in effect, including the Outbreak Period extensions for multiple of the foundational employee benefit law timeframes • Omicron and future variants always present the potential for new forms of relief in the future
5 HSAs	• The ACA repeal/replace efforts to revolutionize the use of HSAs failed five years ago, but there have been several significant evolutionary steps towards improving them in the interim • Major legislative changes to HSAs are unlikely during Biden Administration, but small steps forward continue to be possibilities as throw-ins on large bills or relief provisions for new Covid issues

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2021 Year in Review

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Thank You!

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