NEWFRONT

Office Hours Webinar:

Employee Benefits
Year in Review

January 11, 2024

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Today's Topics

2023 EB Year in Review

Plus What to Expect in 2024!

- The ACA has survived a trilogy of U.S. Supreme Court challenges plus multiple repeal/replace efforts, and now (a dozen years in) we start to have some stability and can settle into a more regular routine
- 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!)
- The Covid relief provisions have all expired—what that means moving forward, plus a reminder of how to deal with the "regular" rules for special enrollment, COBRA events, etc.
- What else is new and interesting? LSAs continue to be a widely popular new offering for employees…and the most popular new questions for compliance!

Year in Reivew Main Topics:

1. **The ACA Employer Mandate & ACA Reporting:** ACA reporting season looms as the dust settles on years of transition rules finally ending and a standard routine settling in—with the new tweak this year being mandatory electronic filing
2. **The CAA:** The mega-bill's health plan-related provisions are kicking into full gear with some of the last new compliance items as we each the point of complete implementation in year 4
3. **Covid Relief Whirlwind Ends:** An endless stream of changes to plan administration rules during the pandemic era having finally wound down and now we return to those pesky "normal" rules
4. **Other News:** 2024 limits, HSA relief for telehealth extended (again!), student loan repayment assistance, state disabilty and PFL update, and what about potential Biden administration new enforcement potential for long-delayed provisions?
5. **LSAs:** The other hot supplemental benefits are LSAs desinged to cover a wide variety of non-medical "lifestyle" benefits—but not without a few compliance challenges to address

01

The ACA Employer Mandate

& The Associated ACA Reporting Requirements

The ACA's Employer Mandate "Pay or Play" §4980H Penalties for 2024

Full Alert: The Ultra Low 2024 ACA Affordability Percentage

§4980H(a)—The "A Penalty" Aka: The "Sledgehammer Penalty"	§4980H(b)—The "B Penalty" Aka: The "Tack Hammer 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
  • **2024 A Penalty liability is $2,970 annualized ($247.50/month) multiplied by all full-time employees**
  • **30 full-time employee reduction from multiplier**
	• 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; or**
	3. **Offer MEC to a full-time employee (where employer offers 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
	• 2024 B Penalty liability is $4,460 annualized ($371.67/month) multiplied by each such full-time employee who enrolls in subsidized exchange coverage
	  • Note that although the B Penalty amount is higher ($4,460 vs. $2,970), 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 for 2024

Full Alert: The Ultra Low 2024 ACA Affordability Percentage

§4980H(a)—The "A Penalty" Aka: The "Sledgehammer Penalty"	§4980H(b)—The "B Penalty" Aka: The "Tack Hammer Penalty"
Simplified Version	**Simplified Version**

• To avoid the "A Penalty" **must offer MEC to at least 95% of full-time employees and their children to age 26**
• **2024 A Penalty liability is $2,970 annualized ($247.50/month)** multiplied by all full-time employees (reduced by first 30)
	• To avoid the "B Penalty", the offer of MEC must:
	  • **Be affordable; and**
	  • **Provide minimum value (MV)**
	• **2024 B Penalty liability is $4,460 annualized ($371.67/month)** multiplied by each such full-time employee who enrolls in subsidized exchange coverage

2024 Affordability Safe Harbors: 8.39%

The employer mandate affordability safe harbors are indexed to a metric based on the rate of premium growth over the rate of CPI growth for the preceding year. For 2024, the applicable percentage decreases significantly **to 8.39%** (down from 9.12% in 2023).

Full Alert: The Ultra Low 2024 ACA Affordability Percentage

- **2024 Federal Poverty Line Safe Harbor:** 8.39% of the Federal Poverty Line
  - Prior-Year Federal Poverty Line (Contiguous 48 States): $14,580
  - 2024 Monthly Employee-Share of Premium for Lowest-Cost (Minimum Value) Plan Limit: **$101.93**
  - *Action Item: Always use this approach where the employer offers plan option at a cost that does not exceed $101.93/month*
- **2024 Rate of Pay Safe Harbor:** 8.39% of Rate of Pay
  - Hourly Employees: 8.39% of Employee's Hourly Rate of Pay x 130 Hours (regardless of actual hours of service)
  - Salaried Employees: 8.39% of Employee's Monthly Salary
  - *Action Item: Use this approach where the employer's cheapest (minimum value) plan option costs employees more than $101.93/month*
- **2024 Form W-2 Safe Harbor (Not Recommended):** 8.39% of Box 1 Wages
  - Disadvantage #1: Retrospective Determination—Form W-2 safe harbor provides no predictability because Box 1 unknown until January of following year (i.e., employer will not know until January 2025 whether it met the Form W-2 safe harbor for 2024)
  - Disadvantage #2: Disregarded Compensation—Box 1 does not include many forms of compensation, including 401(k) deferrals and Section 125 salary reductions for health and welfare plan coverage
  - Disadvantage #3: Fixed Premium—The employee-share of the premium must remain consistent as an amount or percentage for the full plan year, which means employers cannot make mid-year adjustments to address lower-than-anticipated Box 1 amounts

Responding to Letters From the Exchange

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

Employer Exchange Notices Are the First Bite at the Apple!

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

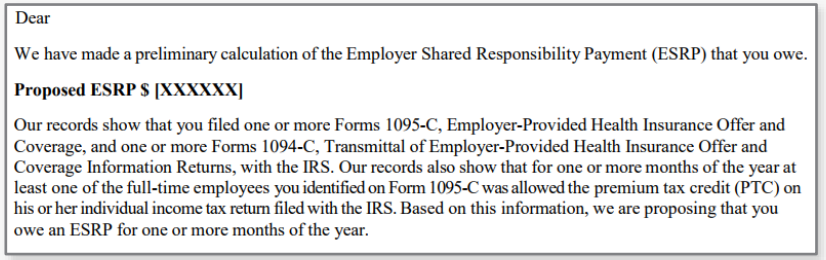
Employer Exchange Notice Approach	Employer Offered Affordable/MV MEC	Employer Did NOT Offer Affordable/MV MEC
Full-time Employee	**Strongly Recommend Appeal** • Prevent ACA Employer Mandate §4980H Penalties • Prevent Repayment of APTC	**Do Not Appeal** • Employer will receive Letter 226J with §4980H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

ACA Employer Mandate Penalties are Real

Full Alert: 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

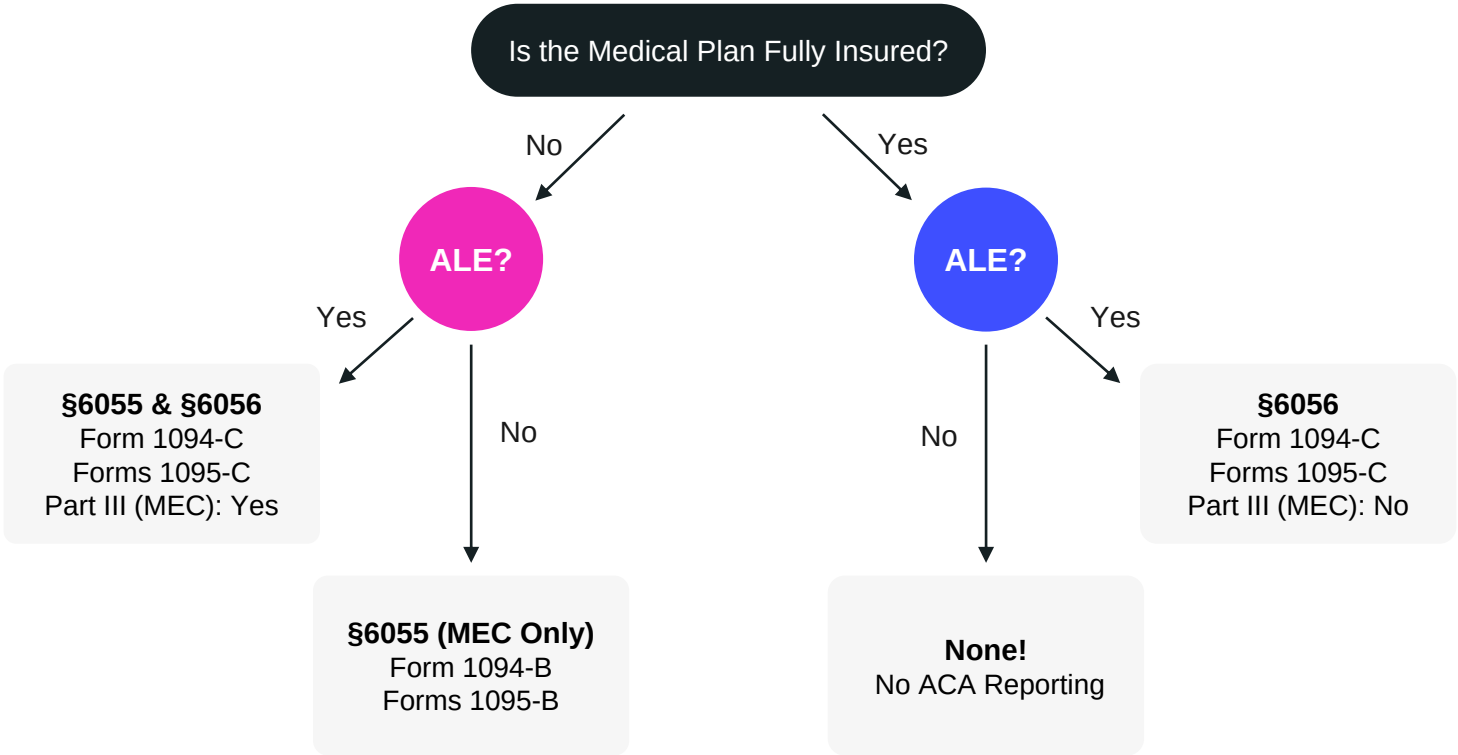
We have made a preliminary calculation of the Employer Shared Responsibility Payment (ESRP) that you owe.

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.

ACA Reporting: Which Employers Must Report?

Full Alert: ACA Reporting Deadlines and Compliance Requirements in 2024



ACA Reporting Deadlines

Extension Stays, No More Good Faith Safe Harbor

Full Alert: ACA Reporting Deadlines and Compliance Requirements in 2024

Extended Deadline Is Here to Stay

- The IRS has finalized new regulations to make the 30-day extension permanent!
- 30-day extension applies only to the deadline for providing the forms to individuals
- Deadlines to file with the IRS remain standard
- In prior years the IRS also provided the good faith enforcement safe harbor to avoid penalties for incorrect or incomplete information (generally $310 per return)
- In prior years, IRS allowed employers filing fewer than 250 returns to file by paper
- **Remember:** No good-faith safe harbor available anymore—standard penalty scheme applies for incorrect information
- **Remember:** No option to file by paper anymore—going forward all employers must file electronically

2024 ACA Reporting Deadlines for ALEs

Forms	Filing Method	Due Date
2023 Forms 1095-C	**Furnish to Individuals**	**March 1, 2024** (Note: Deadline is March 2 in Non-Leap Year)
2023 Forms 1094-C (+Copies of Forms 1095-C)	**Electronically File with IRS**	**April 1, 2024** (Note: March 31 is a Sunday in 2024)

Due Dates: 30-Day Extension to Furnish, No Longer Option to File by Paper

Full Alert: ACA Reporting Deadlines and Compliance Requirements in 2024

Form 1095-C: To Employees	Forms 1094-C and 1095-C to the IRS: Electronic Only
• Must be furnished by **March 1, 2024** • Standard deadline is January 31, but the new IRS final regulations make the 30-day extension from previous years permanently available going forward (great news!) • Unfortunate downside is they have also confirmed that the good faith enforcement safe harbor for incorrect/incomplete forms is no longer available • Note: 2024 is a leap year—in a non-leap year, the 30-day extension makes the deadline March 2	• Must be filed electronically by **April 1, 2024** • Employers must file electronically if filing 10 or more returns (including ACA reporting, Form W-2, and 1099, etc.) starting in 2024—includes virtually all employers • Previous ability to file by paper where under 250 ACA form return threshold is now eliminated • More details: IRS Requires Electronic ACA Filing in 2024 • Note: Standard deadline is March 31, but March 31, 2024 is a Sunday

Furnishing the Form 1095-C to Employees: Electronic Delivery Barriers

Full Alert: Furnishing Forms 1095-C to Employees Electronically

Option 1: Standard Paper Mailing (or Hand Delivery)	Option 2: Electronic Delivery
• The general rule is that the Form 1095-C must be furnished on paper by mail (or hand delivered) • The form must be properly addressed and mailed on or before the due date • May truncate SSNs by replacing the first five digits with asterisks (*) or Xs (but truncation not allowed on forms filed with IRS) • If mailed, must be sent to the employee's last known permanent address (or if no permanent address is known, to the employee's temporary address)	• Employers **must obtain affirmative consent** to furnish the Form 1095-C electronically • The consent **must relate specifically** to receiving the Form 1095-C electronically • Individuals may consent on paper or electronically—if consent is on paper, the individual must confirm consent electronically • Electronic distribution after proper consent is permitted by email or by informing the individual how to access the statement on a website • Note: This is different than the standard ERISA electronic disclosure rules—requires specific Form 1095-C authorization!

ACA Individual Mandate Tax Penalty (Effectively) Repealed

Full Alert: Tax Cuts and Jobs Act Individual Mandate Tax Penalty Elimination

Tax Cuts and Jobs Act (TCJA) Removed Tax Penalty

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

Individual Mandate ACA vs. TCJA	ACA:2018 Last Year Individual Mandate In Effect	TCJA: 2019 and Beyond Individual Mandate Tax Penalty Removed
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

Ongoing Relief for Carriers & Non-ALEs

Full Alert: ACA Reporting Deadlines and Compliance Requirements in 2024

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

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

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

- The ACA employer mandate remains fully in effect, therefore employers still must furnish and file the Forms 1095-C.
- **Employers sponsoring a self-insured medical plan still must complete Part III of the Form 1095-C for any full-time employee.**
  - Still required even though that information in Part III is related to the §6055 reporting requirements.
- California, New Jersey, Rhode Island, and D.C. have state-based individual mandates that rely on the Form 1095-B (fully insured plan) and Part III of the Form 1095-C (self-insured plan) information.
  - May eventually need to develop a state form like the Massachusetts Form MA 1099-HC) for this purpose.
- *Note:* Non-ALEs sponsoring a self-insured health plan (e.g., level funded employers under 50 full-time employees) can take advantage of this §6055 furnishing relief—**however, they are still required to file the Form 1094-B and 1095-B with the IRS**

ACA Reporting Penalties

Full Alert: ACA Reporting Deadlines and Compliance Requirements in 2024

Same Penalties as Apply for Forms W-2 (Penalty Amounts for Forms Furnished/Filed in 2024)

General penalty is **$620** for each incorrect return (**$310** for return furnished to individual, **$310** for return filed with the IRS).

- Total fine not to exceed $3,783,000.
- Penalty reduced to **$60** if the corrected return is filed **within 30 days** after the required filing date—total fine max reduced to $630,500.
- Penalty reduced to **$120** if corrected by **August 1** of the year in which the filing due—total fine max reduced to $1,891,500.

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

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

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

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

Full Alert: ACA Reporting Deadlines and Compliance Requirements in 2024

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 $850/adult and $425/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
- Note that some states have not provided the same 30-day extension available from IRS for furnishing Form 1095-C
- What happens if §6055 reporting is eliminated? States would devise their own forms, likely modelled after the Form 1099-HC in Massachusetts

02

The CAA

Reaching Full Implementation in 2024

CAA Effective Dates Timeline

February 10, 2021

- **Mental Health Parity Comparative Analysis Documentation**

First Plan Year 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 pending final regulations
- **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

July 1, 2022

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

CAA Effective Dates Timeline

December 27, 2022

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

First Plan Year on or After January 1, 2023

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

December 31, 2023

- **Gag Clause Prohibition Compliance Attestation**
  - Covers the period from date of CAA enactment (December 27, 2020) through the date of the attestation

First Plan Year on or After January 1, 2024

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

The New/Modified CAA Patient Protections: No Surprises Act

Full Alert: The ACA and CAA Patient Protections

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Preventing Surprise Medical Bills: Emergency Services

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 details: The CAA Patient Protections

The New/Modified CAA Patient Protections: No Surprises Act

Full Alert: The ACA and CAA Patient Protections

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Preventing Surprise Medical Bills: Non-Emergency Services

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 amounts exceeding the cost-sharing owed by the participant; and
5. By counting the cost-sharing payments toward any in-network deductible and out-of-pocket maximum in the same manner as if the services were provided in-network

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

The New/Modified CAA Patient Protections: No Surprises Act

Full Alert: The New CAA Surprise Billing Notice

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

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

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

The New/Modified CAA Patient Protections: No Surprises Act

Full Alert: The New CAA Surprise Billing Notice

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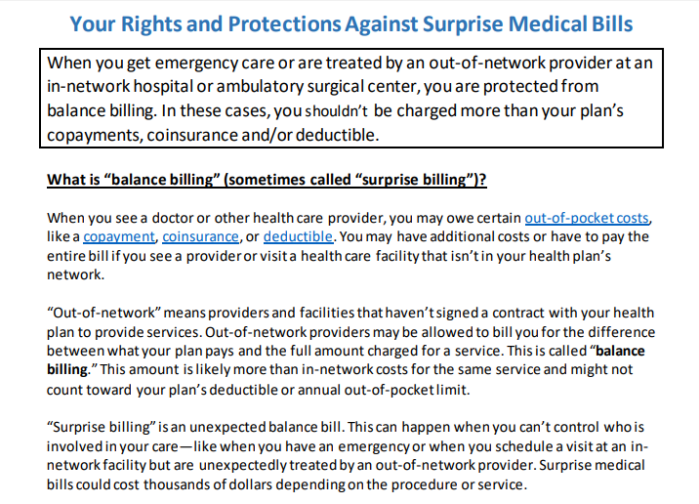
Preventing Surprise Medical Bills (added by CAA—No Surprises Act)

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

- Available via CMS website, use "Version 2"
- Full details: The CAA Surprise Billing Notice



Your Rights and Protections Against Surprise Medical Bills

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

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

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

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

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

The New/Modified CAA Patient Protections: No Surprises Act

Full Alert: The ACA and CAA Patient Protections

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Preventing Surprise Medical Bills: Air Amublance Services

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

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

- The plan has 30 days after receiving the bill for the out-of-network air ambulance services to respond to the provider with the initial notice of payment or denial
- There can be no balance billing charged to the participant in the process
- An independent dispute resolution will apply where the parties cannot agree to the appropriate out-of-network rate
- Plans will have a two-part, Tri-Agency reporting requirement to provide claims data related to air ambulance services (reporting requirement delayed indefinitely pending final regulations)
- Full details: The CAA Patient Protections

The New/Modified CAA Patient Protections: No Surprises Act

Full Alert: The ACA and CAA Patient Protections

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Continuity of Care

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

The New/Modified CAA Patient Protections: No Surprises Act

Full Alert: The ACA and CAA Patient Protections

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Continuity of Care

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.

CAA Prescription Drug Data Collection Reporting (RxDC)

Full Alert: RxDC Reporting Considerations for Employers

New Annual Reporting on Pharmacy Benefits and Drug Costs	Reports Due Annually by June 1 for Prior Year

• **Reporting is designed "as a means to promote competition and bring down overall health care costs" by collecting:**
  • General information regarding the plan or coverage;
  • Enrollment and premium information, including average monthly premiums paid by employees versus employers;
  • Total health care spending, broken down by type of cost (hospital care; primary care; specialty care; prescription drugs; and other medical costs, including wellness services), including prescription drug spending by enrollees versus employers and issuers;
  • The 50 most frequently dispensed brand prescription drugs;
  • The 50 costliest prescription drugs by total annual spending;
  • The 50 prescription drugs with the greatest increase in plan or coverage expenditures from the previous year;
  • Prescription drug rebates, fees, and other remuneration paid by drug manufacturers to the plan or issuer in each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates; and
  • The impact of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs.
	• FAQ guidance issued 12/23/22 extended grace period for initial 2020/2021 reporting from 12/27/22 through 1/31/23
	  • Guidance also announced a good faith efforts standard for enforcement for this initial reporting submission
	• Going forward the due date is June 1 annually to report on prior calendar year
	  • June 1, 2023 reported on 2022 calendar year
	  • June 1, 2024 reports on 2023 calendar year
	  • No good faith efforts standards or extensions apply
	• Employers rely on their insurance carrier or TPA/PBM to submit the Prescription Drug Data Collection (RxDC) Report
	  • For self-insured plans, the obligation lies with the employer, but the rules permit (and expect) employers to delegate to TPA/PBM
	• Full details: RxDC Reporting Considerations for Employers

CAA Mental Health Parity Comparative Analysis

Full Alert: The CAA Mental Health Parity Comparative Analysis Requirement

MHPAEA Overview

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

CAA Imposes New MHPAEA Documentation Requirement

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

Comparative Analysis Disclosure

- 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
- July 2023 Tri-Agency MHPAEA Report to Congress reported EBSA issued 25 letters requesting comparative analyses for 69 NQTLs from Nov. 2021 – July 2022
- New proposed regulations would require self-insured plan sponsors to certify they have received the comparative analysis and found it to be in compliance
- Full details: The CAA Mental Health Parity Comparative Analysis Requirement

CAA Gag Clause Prohibition Compliance Attestation

Full Alert: The CAA Gag Clause Prohibition Attestation Requirement

Prohibited Gag Clauses Under CAA

To increase transparency by removing gag clauses on price and quality information, CAA prohibits plans from entering into agreements with health care providers, network, TPA, or other service providers that have restrictions on relasing certaion information:

1. Provider-specific cost or qualify of care information or data through a consumer engagement tool or any other means;
2. Electronic de-identified claims and encounter information or data for individuals upon request and consistent with HIPAA, GINA, and the ADA;
3. The ability to share information or data in 1) and 2) above (or to direct information be shared) with a HIPAA business associate, consistent with HIPAA, GINA, and the ADA.

CAA Imposes New Gag Clause Prohibition Comlpiance Attestation Requirement (GCPCA)

- The CAA includes an annual attestation requirement for plans to certify their compliance with the gag clause prohibition. This is referred to as the annual Gag Clause Prohibition Compliance Attestation, or “GCPCA”.

Satisfying the GCPCA

- For fully insured plans, the employer and carrier are both repsonsible, but FAQ gudiance confirms both will be treated as satisfying if carrier submits
- For self-insured plans, the employer may satisfy the attestation requirement by entering into a written agreement with the for TPA to complete
- Attestation is due by December 31 annually (first was due in 2023), completed at the Gag Clause Prohibition Compliance Attestation website
- Full details: The CAA Gag Clause Prohibition Attestation Requirement

Price Transparency Revolution Underway with ACA and CAA

Full Alert: The CAA Machine-Readable File Posting

Machine-Readable Files (MRF):
Enforced as of July 1, 2022

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:** Previously delayed pending implementation of broader CAA Rx reporting rules—new guidance states there is no meaningful difference with CAA, so now will be required with new guidance expected to address reliance on prior relief

Employer Issues:
The Public Group Health Plan Website Conundrum

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

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

Price Transparency Revolution Underway with ACA and CAA

Full Alert: The TiC Participant-Level Disclosures

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

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

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

Staggered Availability:
Final Phase of Tool Available in 2024

First Plan Year Beginning On or After January 1, 2023

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

First Plan Year Beginning On or After January 1, 2024

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

Employers Will Rely On Insurance Carrier or TPA

- Rules provide that employer can enter into a written agreement for carrier/TPA to maintain this internet-based tool
- Potential $100/day penalties apply for non-compliance
- Full details: The TiC Participant-Level Disclosures

03

Covid Relief Ends

Returing to Regular Order

The Outbreak Period Condcludes

After More Than Three Years, The Pandemic Extensions Come to an End

Multiple key employee benefits deadlines were **disregarded for the "Outbreak Period"** from March 1, 2020 through July 10, 2023

Full Alert: Covid Emergency Period Ends May 11

The National Emergency Period
March 1, 2020 to May 11, 2023

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 also issued emergency declarations for every state, territory, and possession in the U.S.
- Collectively, this was referred to as the "National Emergency"
- President Biden continued the period of National Emergency until May 11, 2023

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

The Outbreak Period
National Emergency + 60 Days (July 10, 2023)

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

- Meant the Outbreak Period began March 1, 2020 and ended 60 days after the announced end of the National Emergency period
  - Ran through July 10, 2023

EBSA Disaster Relief Notice 2021-01 capped the maximum period disregarded at <u>one year</u> per event

- Outbreak Period therefore ended **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 (7/10/23)

Expired:
Outbreak Period Extensions

Why It Matters

- The standard deadlines apply again in the same manner as they did before the pandemic
- Employers and employees had gotten used to extensions available to address missed deadlines—those are no longer available!
- Employers need to return to enforcing standard deadlines to avoid multiple issues associated with making exceptions

Full Alert: Covid Emergency Period Ends May 11

1. **Outbreak Period: HIPAA Special Enrollment Periods (SEP)**
   Applied until the earlier of a) July 10, 2023, or b) one-year of relief after event
   - The rules extended the 30-day and 60-day HIPAA SEP period by disregarding the Outbreak Period

2. **Outbreak Period: COBRA Election Notice**
   Applied until the earlier of a) July 10, 2023, or b) one-year of relief after event
   - The rules extended the 44-day deadline for employer to provide, and 60-day deadline for employee to elect

3. **Outbreak Period: COBRA Premium Payment Period**
   Applied until the earlier of a) July 10, 2023, or b) one-year of relief after event
   - The rules extended the 45-day deadline for initial premium, 30-day grace period for subsequent premiums

4. **Outbreak Period: Employee Qualifying Event Notice**
   Applied until the earlier of a) July 10, 2023, or b) one-year of relief after event
   - The rules extended the 60-day deadline to notify of divorce, child reaching age 26, and disability extension

5. **Outbreak Period: ERISA Plan Run-Out Period**
   Applied until the earlier of a) July 10, 2023, or b) one-year of relief after event
   - The rules extended any ERISA plan (including health FSA) run-out period deadline set by the plan terms

Expired:
Outbreak Period Extensions

Why It Matters

- The standard deadlines apply again in the same manner as they did before the pandemic
- Employers and employees had gotten used to extensions available to address missed deadlines—those are no longer available!
- Employers need to return to enforcing standard deadlines to avoid multiple issues associated with making exceptions

Full Alert: Covid Emergency Period Ends May 11

6

Outbreak Period: ERISA Adverse Benefit Determination Appeal Deadline

Applied until the earlier of a) July 10, 2023, or b) one-year of relief after event

- The rules extended the 60-day and 180-day appeal period by disregarding the Outbreak Period

7

Outbreak Period: ERISA External Review Deadlines

Applied until the earlier of a) July 10, 2023, or b) one-year of relief after event

- The rules extended the four-month period to request an external review by disregarding the Outbreak Period

Addressing Employee Late Enrollment Exception Requests Post-Outbreak Period:

- Mid-Year Enrollment Requests Outside of Permitted Election Change Event Window
- Employee Requests to Extend COBRA Election and/or Premium Payment Window

1. Section 125 Cafeteria Plan Rules
2. Insurance Carrier Policy (or Stop-Loss Provider) Limitations
3. ERISA Plan Precedent Concerns

Late Mid-Year Enrollment: Exception Requests

Full Alert: Mid-Year Enrollment Requests Outside of Permitted Election Change Event Window

Three Main Reasons Why Exceptions Are Not Recommended

1

2

3

Reason #1: The Section 125 Cafeteria Plan Rules

Failure to adhere to the permitted election change event rules set forth in Treas. Reg. §1.125-4 can **cause the entire cafeteria plan to lose its tax-advantaged status**

- This would result in all elections becoming taxable to all employees
- Could permit employee to pay after-tax outside the cafeteria plan, but still issues #2 and #3

Late Mid-Year Enrollment: Exception Requests

Full Alert: Mid-Year Enrollment Requests Outside of Permitted Election Change Event Window

Three Main Reasons Why Exceptions Are Not Recommended

1

2

3

Reason #2: Insurance Carrier Policy (or Stop-Loss Provider) Limitations

Insurance carriers (and stop-loss providers) generally will pay claims only for employees and dependents who are eligible and properly enrolled

- Carriers generally will permit employees to enroll only at open enrollment, upon new hire/newly eligible status, and within 30 days of experiencing a permitted election change event
- **If a carrier discovers that an employee was allowed to enroll in any other situation, the carrier would be within its right to deny paying all claims for that employee/dependent**
- **That would make the employer responsible for self-funding all claims (worst-case scenario!)**
- Crucial that carrier (or stop-loss provider for self-insured) agree to any exception for mid-year enrollment if employer makes exception

Late Mid-Year Enrollment: Exception Requests

Full Alert: Mid-Year Enrollment Requests Outside of Permitted Election Change Event Window

Three Main Reasons Why Exceptions Are Not Recommended

1

2

3

Reason #3 ERISA Plan Precedent Concerns

- ERISA requires that employers administer the plan in accordance with the terms of the written plan document
  - Plan document will not permit employees to make election changes unless they experience a permitted election change event and make the election within the required timeframe (typically 30 days)
  - If the employer makes an exception, the employer has interpreted the plan's terms to permit the exception, and this interpretation must be applied consistently for all similarly situated employees
- **This means that exceptions create an ERISA plan precedent requiring the plan to permit election changes for all employees in similar circumstances**
  - Employees denied ability to change their election in similar circumstances would have a potential claim for ERISA breach of fiduciary duty or claim for benefits

Late Mid-Year Enrollment: Exception Requests

Full Alert: Mid-Year Enrollment Requests Outside of Permitted Election Change Event Window

Three Main Reasons Why Exceptions Are Not Recommended

1

2

3

*

Summary

- For these three reasons, employers should generally avoid making mid-year enrollment exceptions outside of a permitted election change event
  - The issues associated with making an exception in most cases far outweigh the typical hardship case presented by the employee requesting the late enrollment
- There may be some very rare situations where employers consider making a mid-year enrollment exception despite the inherent plan risks
  - In these situations, employers will need to take employee contributions on an after-tax basis, ensure the insurance carrier (or stop-loss provider) approves the enrollment, and understand they must apply the exception consistently for similarly situated employees based on the applicable scope of the ERISA plan precedent

COBRA Election/Payment Exceptions

Full Alert: Employee Requests to Extend COBRA Election and/or Premium Payment Window

Former Employees Frequently Ask for COBRA Exceptions

There are two major issues with making an exception to permit late a COBRA election or premium payment:

1

Insurance Carrier Policy Limitations

&

2

The ERISA Plan Precedent

COBRA Election/Payment Exception

Full Alert: Employee Requests to Extend COBRA Election and/or Premium Payment Window

Reason 1: Insurance Carrier Policy Limitations

- Insurance carriers (and stop-loss providers) generally will pay claims only for employees and dependents who are eligible and properly enrolled
- Policies generally permit coverage for individuals through COBRA only if the individuals meet all of the conditions to receive COBRA coverage—including timely election and payment
  - COBRA has inherent adverse selection risks for carriers
  - These heightened concerns are magnified even further by extending election or payment deadlines
  - **If a carrier (or stop-loss provider) discovers that the employer permitted an employee to maintain COBRA coverage despite missing the applicable election or payment deadline, the carrier would be within its right to deny paying all claims for that individual from the date the issue arose**
  - **That would make the employer responsible for self-funding the COBRA claims (worst-case scenario!)**
  - Crucial that carrier agree to any late election/payment exception if employer wants to make exception
  - Carrier is well within its right to deny the coverage

COBRA Election/Payment Exceptions

Full Alert: Employee Requests to Extend COBRA Election and/or Premium Payment Window

Reason 2: ERISA Plan Precedent	Summary
ERISA requires that employers administer the plan in accordance with the terms of the written plan document • Plan document will not permit employees to maintain COBRA coverage unless they timely elect COBRA and make the required premium payments within the applicable deadlines • If the employer makes an exception, the employer has interpreted the plan's terms to permit the exception, and this interpretation must be applied consistently for all similarly situated employees **This means that exceptions create an ERISA plan precedent requiring the plan to permit the late election or payment for all qualified beneficiaries in similar circumstances** • A qualified beneficiary denied ability to make a late COBRA election or payment in similar circumstances would have a potential claim for ERISA breach of fiduciary duty or claim for benefits • This can create a very difficult plan precedent to manage	• For these reasons, we recommend not making COBRA election/payment exceptions • Where an individual is incapacitated, exceptions are appropriate with carrier approval

End of Free Covid Testing/Vaccine Mandate

Full Alert: Covid Emergency Period Ends May 11

FFCRA/CARES Act Free Testing/Vaccine Mandates Ended as of May 11, 2023

- FFCRA required that all employer-sponsored group health plans—including fully insured, self-insured, and grandfathered plans—cover Covid testing expenses without any cost-sharing during the Public Health Emergency (PHE)
- The CARES Act expanded the mandate to include out-of-network tests and added free coverage for Covid vaccines
- The mandate then expanded again as of January 15, 2022 to include up to eight over-the-counter (OTC) Covid tests/individual/month
- With the end of the PHE on May 11, 2023, these free coverage mandates no longer apply

What Free Coverage Remains?

- Non-grandfathered health plans are subject to the ACA preventive services mandate
- In-network Covid vaccines are still covered as a free preventive service under the ACA mandate
- Unlike the FFCRA/CARES Act provisions, the ACA mandate does not cover out-of-network vaccines
- Note that some states continue to impose Covid testing/vaccine/coverage mandates on fully insured plans sitused in the state
- For example, California's state insurance mandate continued to require that fully insured policies provide free in-network and out-of-network Covid testing/vaccine/treatment coverage through November 11, 2023 (and continuing indefinitely for in-network coverage)

HSA Eligiblity: Covid Testing and Treatment

Full Alert: IRS Covid Guidance Regarding HDHPs and HSA Eligibility

General Rule: Minimum Annual HDHP Deductible Required	**Last Year of Covid Relief:** **HDHP Status and HSA Eligibility Preserved for First-Dollar Coverage**
1. Employee-Only Coverage: • **2023: $1,500** • **2024: $1,600** **2. Family Coverage:** • **2023: $3,000** • **2024: $3,200**	• 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.”
• 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	• IRS Notice 2023-37 provides that this relief will remain available for plan years ending on or before December 31, 2024 • **Accordingly, this Covid relief will expire for the 2025 plan year—HDHPs will have to impose the standard deductible**

04

Other News

The Health FSA Contribution & Carryover Limits

Full Alert: 2024 Health FSA Limit Increased to $3,200

Salary Contributoin Limit:
$3,200 for Plan Years Beginning On or After 1/1/2024

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 year
- The cost-of-living increases in 2023 were sufficient to boost the 2024 limit by three $50 increments ($150 total)
- Means that for plan years beginning on or after January 1, 2024, the health FSA salary reduction contribution limit is $3,200

Historical FSA Limits:

2024: $3,200	2021: $2,750
2023: $3,050	2020: $2,750
2022: $2,850	2019: $2,700

Carryover Limit:
$640 for PY Starting in 2024 to PY Starting in 2025

IRS Now Indexes the Carryover Limit

- Executive Order 13877 in June 2019 directed the IRS to increase the $500 carryover limit
- The IRS announced in Notice 2020-33 that it was increasing the carryover limit to an amount equal to 20% of the maximum health FSA salary reduction contribution
- The carryover limit for plan years starting in 2023 to plan years starting in 2024 was at $610 (20% of $3,050)
- The carryover limit for plan years starting in 2024 to plan years starting in 2025 is now set at $640 (20% of $3,200)
- Reminder: CAA FSA relief provisions permitted full carryovers for both the health FSA and the dependent care FSA for plan years ending in 2020 and 2021 into the subsequent plan years ending in 2021 and 2022, respectively. That provision has now sunset.

HSA and HDHP 2024 Limits

The annual statutory maximum HSA contribution limits are for all contributions combined (employer and employee). These amounts are subject to cost-of-living adjustments each year based on chained CPI (modified by TCJA).

Full Alert: Significant HSA Contribution Limit Increase for 2024

	2023	**2024**
Annual Contribution Limit	Individual Coverage: $3,850 Family Coverage: $7,750 Age 55+ Catch-Up: $1,000	**Individual Coverage: $4,150** **Family Coverage: $8,300** **Age 55+ Catch-Up: $1,000**
Minimum Annual Deductible	Individual Coverage: $1,500 Family Coverage: $3,000	**Individual Coverage: $1,600** **Family Coverage: $3,200**
Annual Out-of-Pocket Maximum	Individual Coverage: $7,500 Family Coverage: $15,000	**Individual Coverage: $8,050** **Family Coverage: $16,100**

2024 Employee Benefit Limits

Full Alert: 2024 Health and Welfare Employee Benefit Amounts

Employee benefit limit	2023	2024
HSA Individual	**$3,850**	**$4,150**
HSA Family	**$7,750**	**$8,300**
HSA Catch-Up (55+)	**$1,000**	**$1,000**
HDHP Maximum Out-of-Pocket	**$7,500 / $15,000**	**$8,050 / $16,100**
HDHP Minimum Deductible	**$1,500 / $3,000**	**$1,600 / $3,200**
Health FSA Salary Reduction Contribution	**$3,050**	**$3,200**
Health FSA Carryover to Following Year	**$610**	**$640**
Dependent Care FSA	**$5,000 ($2,500 married filing separately)**	**$5,000 ($2,500 married filing separately)**
Highly Compensated Employee	**$135,000**	**$150,000**
Mass Transit/Vanpooling	**$300/month**	**$315/month**
Qualified Parking	**$300/month**	**$315/month**
401(k) Elective Deferral	**$22,500**	**$23,000**
401(k) Catch-Up (50+)	**$7,500**	**$7,500**
FICA Wage Base (SS Only)	**$160,200**	**$168,600**
ACA Employer Mandate Penalties	**A Penalty: $2,880, B Penalty: $4,320**	**A Penalty: $2,970, B Penalty: $4,460**
ACA Employer Mandate Affordability	**9.12%**	**8.39%**
ACA Federal Poverty Level Safe Harbor	**$103.28/month**	**$101.93/month**
Adoption Assistance	**$15,950**	**$16,810**

CARES Act HSA Relief: Extended Through 2024

Last Year of First-Dollar HDHP Telehealth Relief Extended Two Years by CAA 2023

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

HSA Eligibility Preserved

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

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

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

- CAA 2022 extension applied from April – December 2022

CAA 2023: Extension of relief makes it available through 2024

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

Practical Considerations – Plan Design Issues

First-dollar telehealth relief is an optional plan provision

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

Fully Insured Plan

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

Self-Insured Plan

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

Mind the gap

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

PCORI Fee for Self-Insured Plans

Full Alert: ACA PCORI Fee Due in July via IRS Form 720

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

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

PCORI Fees	July 31, 2023 Form 720 PCORI Filing	July 31, 2024 Form 720 PCORI Filing
Plan Year Ends January 1–September 30	Applicable Rate: • $2.79 per covered individual	Applicable Rate: • $3.00 per covered individual
Plan Year Ends October 1–December 31 (Including Calendar Plan Years)	Applicable Rate: • $3.00 per covered individual	Applicable Rate: • $3.22 per covered individual

Qualified Educational Assistance Program (§127)

CARES Act Added Student Loan Repayment, 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.

Full Alert: Employer Tax-Free Student Loan Repayment Available Through 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 for inflation given increases in costs (that fixed amount dates back to 1979!)

IRS Fixes the ACA "Family Glitch"

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

The ACA Family Glitch

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

The Family Glitch "Fix"

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

The Cafeteria Plan "Fix"

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

Fully Insured Nondiscrimination Rules Delayed Until…?

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

ACA Added Fully Insured Nondiscrimination Rules

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

Will Biden Administration Finally Implement/Enforce?

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

Will SBC Enforcement Finally Ramp Up?

Full Alert: Providing SBCs to Employees

The Neverending Story: Good Faith Enforcement Safe Harbor

SBC Penalty Provisions

- An employer that willfully fails to provide SBCs in accordance with the SBC rules is subject to a penalty of up to $1,362 (indexed) per failure
  - Failure with respect to each employee or dependent constitutes a separate offense
  - If the employee has a family of four, the penalty could be up to $5,448!
- Failures may also trigger the standard $100/day ACA excise tax liability under IRC §4980D
- Failures may also be considered a breach of fiduciary duty under ERISA

Temporary Good Faith Standard Appears to Still Apply

- 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"
- Although it raised eyebrows that the good faith standard went unaddressed in the most recent 2015 SBC regulations, no further guidance has wound down this long-lasting safe harbor

Will Biden Administration Enforce SBC Rules?

- During Trump Administration, there was an executive order to avoid penalties and enforcement where possible that likely prevented enforcement of SBC fines
- The Biden Administration has long since returned to normal ACA implementation and enforcement mode
- Given the change in administration and long runway for employers to adjust, it seems appropriate at this point to see an end to the SBC good faith standard

Build Back Better: Biden Admin Priorities

It’s Not Passing in This Congress, But Lays out Framework of Priorities Moving Forward

Eventually signed into law in a very different form as the Inflation Reduction Act

BBB Bill (Only Passed House) Would Have Affected Benefits in Multiple Ways

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

Realistic Outlook

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

State Paid Family Leave Law Updates

Full Alerts: State Paid Family Leave Law Updates | CA SDI Payroll Tax Cap Eliminated in 2024

States with New PFL Programs:
More States Continue to Add PFL Mandates Each Year

Colorado
- PFML contributions began 1/1/23, and benefits begin 1/1/24
- 12 week maximum, up to four additional weeks for pregnancy

Maine
- PFML program contributions begin January 2025
- Paid leaves begin May 2026

Minnesota
- PFML program contributions and benefits effective January 2026

Voluntary PFL Insurance Products
- A number of states have passed laws authorizing the creation of a PFL insurance product
- Unlike state mandated programs (such as the ones above), these products are voluntary
- Alabama (August 2023), Arkansas (February 2023), Florida (May 2023), New Hampshire (January 2023), Tennessee (January 2024), Texas (September 2023), Vermont (July 2023), Virginia (April 2022)

California SDI/PFL Changes for 2024/2025:
Payroll Cap Eliminated and More!

Wage Ceiling Removed Starting 2024
- SB 951 removes the SDI/PFL contribution wage ceiling as of 2024 (cap was $153,164 in 2023)
- Means that all wages paid will be subject to the SDI/PFL 1.1% (2024) payroll tax
- Will have a significant impact on high wage earners
- For example, an employee earning $500,000 in 2024 will pay $5,500 SDI/PFL payroll tax (vs. $1,378 in 2023)
- CA EDD changed its position in 9/14/23 “Guidelines for Voluntary Plan Employers Retaining the Wage Ceiling” document by stating that employers with a VDI alternative may in some cases by able to keep the wage ceiling

Increased Benefits in 2025
- 2024 Benefit Levels: 60% or 70% (depending on income)
- 2025 Benefit Levels: 63% or 90% (depending on income)

San Francisco Health Care Security Ordinance (HCSO): 2024 Health Expenditure Rates

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.

Full Alert: 2024 San Francisco HCSO Expenditure Rates Released

Employer Size	2023 Rate	2024 Rate	172 Hours/Month 2024 Maximum
Large: **100+ Employees** (Worldwide)	$3.40/hour payable	$3.51/hour payable	$603.72/month $1,811.16/quarter
Medium: **Business w/ 20-99** **Nonprofit w/ 50-99** (Worldwide)	$2.27/hour payable	$2.34/hour payable	$402.48/month $1,207.44/quarter
Small: **Business w/ 0-19** **Nonprofit w/ 0-49** (Worldwide)	*Exempt*	*Exempt*	*Exempt*

San Francisco Paid Parental Leave Ordinance (PPLO): 2024 Maximum Benefits

The maximum PPLO benefit is based off the maximum weekly PFL benefit at $1,620 in 2024.
Calculation Excel spreadsheet (resources): https://sf.gov/information/paid-parental-leave-ordinance

	2024 Maximum Weekly Benefits	2024 Maximum Total Benefits
California PFL Payment Amount	Maximum Weekly PFL Benefit $1,620 ($153,164* / 52 x 55%)	Maximum PFL Benefit x 8 $12,960
San Francisco PPL Payment Amount	Maximum Weekly PPLO Amount **$1,080** ($1,620 / 60% - $1,620)	Maximum PPLO Amount x 8 **$8,640**
Maximum Total Payment Amount (PFL+PPL)	$2,700 Per Week of New Child Bonding Leave	$21,600 Per 8-Weeks of New Child Bonding Leave

**Note:* As of 2024, there is no more payroll tax cap for CA SDI/PFL. For more details: California SDI/PFL Payroll Tax Eliminated in 2024

05

Lifestyle Spending Accounts

Popular New Taxable “Wellness” Fund Benefit

What is a Lifestyle Spending Account?

Full Alert: Lifestyle Spending Account (LSA) Compliance Considerations

Lifestyle Spending Accounts (LSAs) are an increasingly popular employer-funded arrangement for employers to reimburse common and beneficial expenses incurred by employees during ordinary life.

- *Designs vary considerably because of their flexibility, but a typical approach is to offer roughly $500-$2,000 annually for physical, emotional, and financial wellness costs. Unused amounts may forfeit or carry over.*

Physical Wellness Examples:	Emotional Wellness Examples:	Financial Wellness Examples:
• Athletic equipment and accessories • Exercise equipment • Gym, health club, spa, and fitness studio memberships • Recreational sport expenses such as rock climbing, martial arts, tennis, race or league entry fees • Fitness class expenses such as yoga, pilates, cycling • Sport lesson expenses such as golf, swimming, tennis, dance • Personal trainers, fitness trackers • Nutritional supplements • Ski, snowboard, golf, passes	• Meditation classes • Non-medical counseling services such as marital counseling, life coaching, parental skill counseling, executive coaching • Retreats such as leadership and spiritual retreats • Personal development classes such as art and cooking • Pet care such as walkers, day care, grooming • Camping such as equipment and fees • Park passes • Licenses such as fishing, hunting	• Home purchase costs such as down payment, closing costs • Financial advisor and planning services • Financial seminars and classes • Estate planning costs • Credit counseling • Vacation funding • Charitable donations

General Rule: Compensation Taxable (Unless Exclusion Applies)

Full Alert: Lifestyle Spending Account (LSA) Compliance Considerations

LSAs are not designed to take advantage of any Code section that would permit employers to exclude the benefit from employees' income. LSAs are specifically designed to avoid tax-advantaged limitations.

Fringe Benefits Taxable Where No Exclusion Applies	**Taxation of Fringe Benefits** IRS Guidance
General Rule: • Gross income means all income from whatever source derived ("income realized in any form") • The fair market value of any fringe benefit offered to employees must be included in the employee's taxable income unless a specific exclusion applies • IRC §61 specifically refers to "compensation for services, including fringe benefits, and similar items" • LSAs are designed to include benefits for which no exclusion applies to avoid the complications, limitations, and compliance burdens associated with tax-advantaged accounts • Means that LSAs are a taxable fringe benefit	**Treas. Reg. §1.61-21(a)(1):** *(1) In general. Section 61(a)(1) provides that, except as otherwise provided in subtitle A of the Internal Revenue Code of 1986, gross income includes compensation for services, including fees, commissions, fringe benefits, and similar items.* **IRS Publication 15-B** *Are Fringe Benefits Taxable?* *Any fringe benefit you provide is taxable and must be included in the recipient's pay unless the law specifically excludes it.* **IRS Publication 5137** *Fringe benefits that do not meet any statutory requirements for exclusion are fully taxable. Although there are special rules and elections for certain benefits, in general, employers report taxable fringe benefits as wages on Form W-2 for the year in which the employee received them.*

LSA Taxation: Competing Theories on Proper Approach

Full Alert: Lifestyle Spending Account (LSA) Compliance Considerations

LSAs are Not Tax-Advantaged!
They are purposefully designed not to be a tax-advantaged account to avoid the strict limitations associated with those arrangements. Employees do not enjoy an exclusion from income with respect to LSA benefits as they would for other account-based offerings such as FSAs, HSAs, HRAs, commuter benefits, educational assistance, etc.

Common Approach to Taxation
Benefits Taxable Upon Reimbursement

Most employers take the position that LSA benefits are taxable to employees upon reimbursement

- Under this standard approach, the employer includes in the employee's gross income (and subject to withholding and payroll taxes) the amount of each LSA reimbursement
- Any amount made available to the employee but not reimbursed is not included in the employee's taxable income
- Excess amounts may be carried over or forfeited per plan design
- Although employers almost always follow this approach in practice, it's not clear the IRS agrees with this industry standard

Constructive Receipt Approach to Taxation
Value of Amount Made Available is Taxable

There is an argument that employers should include in employees' taxable income the value of the LSA amount made available to employees for reimbursement regardless of the amount reimbursed to the employee

- This approach is based on the doctrine of "constructive receipt" (Treas. Reg. §1.451-2(a))
- Basic principle is that you cannot "turn your back on taxable income" to escape income taxes
- Means employees are treated as in constructive receipt of the value of the full LSA amount made available and it is taxable income regardless of utilization

Key Areas for LSAs to Avoid

LSAs are Designed to Avoid Compliance Issues Associated with Tax-Advantaged Accounts

Full Alert: Lifestyle Spending Account (LSA) Compliance Considerations

1
Medical Benefits

2
Other Tax-Advantaged Benefits

Medical Benefits

- Reimbursement of §213(d) health expenses creates a group health plan
- That would trigger the full array of group health plan laws (ERISA, COBRA, HIPAA, ACA, HSA eligibility, §105(h), etc.)
- Employers therefore should avoid covering any medical expense under the LSA

Other Tax-Advantaged Benefits

- It generally does not make sense to include in an LSA any expense that could otherwise be provided on a tax-free basis outside the LSA
- Inclusion of a potentially tax-advantaged benefit in the LSA would make the expense taxable

Key Areas for LSAs to Avoid: Medical Benefits

Full Alert: Lifestyle Spending Account (LSA) Compliance Considerations

Avoid Inadvertently Creating a Group Health Plan

Carefully Monitor the Benefits to Avoid §213(d) Expenses

- LSAs are intended to be a taxable, non-group health plan benefit
- Failure to exclude such medical expenses would cause onerous group health plan laws such as ERISA, COBRA, HIPAA, ACA, etc. to apply
- Avoid expenses such as smoking cessation, mental health therapy, acupuncture, and chiropractic treatment that are §213(d) expenses
- Such expenses could be included in a separate medical wellness program arrangement designed to comply with applicable group health plan laws
- Look to IRS Publication 502 for a useful summary of §213(d) expenses

"Dual Purpose" Expenses Can Be Included

- Dual purposes expenses are generally non-medical but can be considered medical where incurred upon the advice of a medical practitioner to treat a specified medical condition
- These are expenses that a health FSA will reimburse only if the employee provides a letter of medical necessity from a treating physician
- Examples include gym membership, massage, nutritionist expenses, exercise equipment, health club, smartwatch, fitness tracker, personal trainer
- No issue with an LSA including dual purpose expenses that are overwhelmingly non-medical as long as the LSA does not condition the benefit on the employee's medical status (no Rx/letter of medical necessity required)

Common Expenses To Avoid

- Smoking cessation programs and products
- Acupuncture
- Mental health therapy
- Chiropractic treatment
- Abortion
- IVF and other infertility treatments
- Treatment for alcoholism and drug addiction
- Laser eye surgery
- Hearing aids
- Medical travel costs (including abortion-related travel)

Areas for LSAs to Avoid: Other Tax-Advantaged Benefits

Full Alert: Lifestyle Spending Account (LSA) Compliance Considerations

If it Ain't Broke…Don't "Fix" it by Adding it to an LSA

LSA Causes Loss of Tax-Advantaged Status

- Employers have broad flexibility to include virtually any non-medical expense as reimbursable by the LSA
- However, the LSA is intended not to be tax-advantaged to avoid all the restrictions placed on tax-free arrangements
- It generally does not make sense for employers to include in an LSA any expense that could otherwise be provided on a tax-free basis by the employer outside the LSA
- Inclusion in the LSA has the effect of providing a taxable benefit that could have otherwise been provided as non-taxable

Examples of Potentially Tax-Advantaged Expenses to Exclude

- Dependent care expenses (§125/§129 dependent care FSA)
- Student loan reimbursement (§127 educational assistance)
- Tuition assistance (§127 or §132 educational assistance)
- Commuter benefits (§132 transit pass/vanpool, parking)
- Identity theft protection (IRS guidance excluding from income)
- Adoption expenses (§139 adoption assistance plan)

Is There an Argument to Include These Expenses?

- Some employers have a strong desire to make the LSA a one-stop catchall benefit for all expenses, even if it causes the benefits to be taxable
- While including medical expenses is clearly problematic because of group health plan laws, these non-medical expenses don't have that issue
- Employers could in theory gross up employees for the tax liability and provide essentially the same benefit, but that is far more costly and unnecessary

LSA Summary: Advantages and Disadvantages

Full Alert: Lifestyle Spending Account (LSA) Compliance Considerations

Advantages of the LSA: Simplicity and Flexibility

Fewer Rules:

- Very few compliance issues associated with LSAs because they are not tax-advantaged or subject to GHP laws

Flexibility:

- Employers can include virtually any non-medical expense as eligible for reimbursement

No Limits:

- There are no limits on the amount of employer funds made available for reimbursement

No Formal Documentation:

- Employers can use simple communications to describe LSAs

Low Cost:

- Most FSA TPAs will administer LSAs for a relatively low fee

Corporate Culture:

- Can be customized to fit specific wellness and culture goals

Quick Win:

- Novelty of LSAs can create employee excitement/morale boost

Disadvantages of the LSA: Taxes and Avoiding Certain Expenses

Taxable:

- LSAs are (purposefully) not tax-advantaged, and therefore employees will be taxed on the LSA unlike other account-based arrangements with which employees are familiar

Competing Taxation Theories:

- Employers face different approaches for how to tax LSAs, with no guidance confirming the standard taxable benefit approach

Excluding Medical Expenses:

- Employers need to exclude §213(d) medical expenses from the LSA to avoid inadvertently triggering vast array of GHP laws

Excluding Other Tax-Advantaged Expenses:

- Employers should exclude other potentially tax-advantaged benefits to utilize the exemption from income in a separate vehicle designed to take advantage of tax-free opportunity

Exclusively Employer-Funded:

- There is no point to having an employee funded LSA because there is no tax advantage, so LSAs are exclusively paid for by the employer and therefore add cost to their budget

WRAP-UP

Takeaways

Year in Review – Top Five Summary

Remember: This is just a short thumbnail sketch of the boundless issues we face in employee benefits compliance for health and welfare plans. For all the latest alerts, guides, and FAQs throughout the year: https://www.newfront.com/blog/category/compliance

1 ACA Employer Mandate & Reporting

- The §4980H penalties continue to increase each year. Make sure to offer affordable coverage to all full-time employees to avoid potential liability
- The affordability threshold drops to its lowest level ever in 2024 to 8.39%--avoid the hassle by offering coverage at or below $101.93/month

Key New Point for 2024

- Electronic filing is no longer optional for mid-sized employers in 2024—all employers subject to ACA reporting need to find a vendor to complete their filing

2 CAA Reaches Full Implementation in 2024

- The slow build each year since enactment has reached a crescendo in 2024 as the last items take full effect
- Employers with fully insured plans can largely rely on their insurance carrier to address most of the CAA requirements
- Employers with self-insured plans (including level funded) need to coordinate with the TPA to determine what aspects they will assume on the plan's behalf

Key New Point for 2024

- The participant-level transparency in coverage internet-based tool for cost-sharing liability moves from first 500 to all items/services

3 Covid Relief Ends & Regular Order Returns

- The Outbreak Period provided extensions to nearly all major employee benefit deadlines for over three years
- During that three-year period, employers, administrators, and participants largely became used to relief
- There is no room for complacency going forward—all parties must meet their deadlines now

Key New Point for 2024

- Free Covid testing also ended in 2023, but free in-network vaccines will continue indefinitely under the ACA

4 The Other News

- 2024 annual limits include significant increases to correspond with high inflation
- HDHPs continue to have telehealth relief through 2024
- PCORI fees increase to $3.22 for the July 2024 filing
- States continue to pile on the new paid family leave laws—but even CA is making big news by removing the wage ceiling
- The ACA family glitch fix allows more access to Exchange subsidies—and a new life event

Key New Point for 2024

- The Biden Administration still has multiple opportunities to complete the last few stitches in the ACA patchwork with the regulatory agencies in 2024

5 LSAs Present New Compliance Considerations

- What is an LSA? It's the way for employers to offer all those benefits they always wanted to but couldn't through tax-advantaged accounts
- An employer-funded taxable arrangement to reimburse various physical, financial, and emotional wellness expenses
- Make sure not to include medical expenses in an LSA—it is not designed to comply with ERISA, COBRA, HIPAA, ACA, etc.
- Best practice is generally to exclude other non-medical tax-advantaged items too because those benefits can be provided tax-free through the proper arrangement

Key New Point for 2024

- The right "quick win" new benefit for your organization in 2024?

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EB Year in Review

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Thank you

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