McGriff
EMPLOYEE BENEFIT SOLUTIONS

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Your Employee Benefits Newsletter

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Tax Time is Approaching!

As spring blooms and fresh energy fills the air, April 15 looms on the horizon. While tax time is top of mind for many, McGriff is here to prune your compliance risk by ensuring you're not caught off guard by the multitude of important employee benefits deadlines. Together, let's navigate this season with confidence to ensure your benefits landscape is primed for success in the months ahead.

Upcoming Compliance Deadlines

June 1

Reporting on Pharmacy Benefits and Drug Costs

Plan sponsors must report information about prescription drugs and health care spending to the Centers for Medicare & Medicaid Services (CMS) each year. Data for the 2023 reference (calendar) year is due by June 1, 2024. This reporting is required for fully insured and self-funded group health plans of all sizes. The McGriff Compliance Team's updated reference guide provides employers with practical steps to help them comply with reporting obligations.

July 31

PCORI Fee Deadline

If an employer sponsors a self-insured health plan, including a level-funded plan or an employer-sponsored HRA, the ACA requires the employer to submit the annual Participant-Centered Outcomes Research Institute (PCORI) Trust Fund Fee. Plan sponsors must report and pay the PCORI fee using IRS Form 720.

July 31

Form 5500 Filing Deadline (Calendar Year Plans)

Generally, a Form 5500 must be filed no later than the last day of the seventh month after the end of the plan year for ERISA pension and welfare benefit plans. For calendar-year plans, the deadline is July 31. With few exceptions, an employer must file a 5500 if any of its ERISA benefit plans had 100 or more covered participants on the first day of the plan year.

Avoiding Ableism and Promoting Inclusion in Wellness

If you search the term “wellness” under stock photos, you’ll likely see healthy, glowing, fit people out running, hiking, performing yoga poses on rocks, and some pictures of fruit. While these images are what we expect to see and can be great for advertising, they represent an idea of wellness that does not feel accessible to all.

While ableism is a complex, broadly defined topic, in the context of wellness it refers to the beliefs, stigma, and stereotypes concerning people who do not fit the mainstream view of “healthy” – and the belief that the difference between good health and something less than that is always a matter of individual choice.

We also see ableism in programs that fail to accommodate for people with genetic and socioeconomic factors that can make performing and achieving certain health metrics very difficult or impossible.

The incorrect assumption that good health and well-being is always the result of personal choices and motivation can lead to “internalized ableism,” which is the shame experienced by those who believe their health challenges stem from their own perceived laziness, lack of motivation, or other flaws.

Internalized ableism can also lead to much unsolicited advice on how to defeat an illness or injury, when in fact the person might be dealing with a situation that can’t be “fixed” or resolved in their own strength. This can lead to a lack of engagement in wellness programs when people feel as if they won’t be successful or “fit in.”

While our choices and behaviors can greatly influence our health, when designing and promoting wellness programs we must be careful to suspend judgments and instead focus on health as a continuum that will look different for everyone. For example, a ketogenic diet might work well for some people, but for others they might have different needs and achieve better results with a more moderate approach.

Healthy recipes are great, but if people are working long shifts, caring for children, and exhausted, providing discounts on meal kits and healthy food on-site can be more effective to bridge the gap. Conditions such as hypertension, high cholesterol, and arthritis can be the result of genetics, not necessarily personal choices.

Through more inclusion and offering more ways for employees to make a program work for them, you can promote positive engagement with wellness programs. Instead of feeling like they’re being monitored, employees will begin to feel inspired.

Katie O'Neill, DC, BS
McGriff Clinical Wellness Practice Leader

Tax Time Reminders for FSAs and HSAs

Tax season is a great time to remind employees about their tax savings potential with their FSA and HSA plans. Many may have already noticed they have more spendable income (net income) because they've lowered their taxable income by making pre-tax payroll contributions.

We've put together some helpful tips and reminders that we hope will come in handy during tax season when asked about contribution limits and rollovers. This year's tax filing deadline for 2023 taxes is April 15.

IRS LIMIT	2024	2023
FSA Contribution Limit	$3,200 Individual	$3,050 Individual
Maximum Carryover Amount of Used FSA Amounts *(Section 3.16 of Rev. Proc.2023-34)*	$640	$610
HSA Contribution Limit	$4,150 Individual ($8,300 for family coverage)	$3,850 Individual ($7,750 for family coverage)

Important FSA Reminders

- Payroll contributions to an FSA are made before taxes are deducted.
- These days most employers select one of two IRS provisions to help their employees use up their unspent FSA funds to avoid the anxious feeling associated with the phrase "use-it-or-lose-it." Employers should repeatedly remind their employees about their plan's provision option, if it applies, to avoid frustration and give their employees time to spend funds on eligible health care items and supplies. Keep reading for great suggestions.
  - **Provision 1 grants employees a carryover allowance:**
    The 2023 carryover allowance is $610. This means all unspent funds in the employee's FSA account over $610 are automatically forfeited to the employer.
  - Provision 2 grants more time to use the unspent funds. The extended time is generally about 2.5 months but can vary depending on state laws.

Important HSA Reminders:

- Remind all enrollees: anyone with an HSA plan can also opt to make additional post-tax HSA contributions (up to the IRS contribution limit) to reduce their tax bill. Employees have until the IRS deadline to max out.
- Employees 55 and older can make an additional annual catch-up contribution and save even more on their taxes while investing for future medical expenses.

Quick Refresher on The Triple Tax Advantage

HSA plans come with what's known as a "Triple Tax Advantage" because employees get tax-free contributions, investment growth and withdrawals.

Tax-free Contributions

Payroll contributions to an HSA are made before taxes are deducted. Unlike the FSA account, there is no risk of loss to the employee. All money in the account remains in the HSA and simply rolls forward each year, building up with no use-it-or-lose-it rule.

Tax-free Growth

Any interest or earnings on your HSA account balance are tax free. This means over time, invested HSA dollars can add up to even more money available for future medical needs.

Tax-free Withdrawals[1]

Unlike a 401(k) or an IRA plan, when you make a withdrawal from your HSA account to pay for qualified health expenses, there is no tax!

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Ideas to USE Up Unspent FSA Dollars Before April 15th!

- Contact lens solution and eye drops
- Stock up on menstrual products
- Refresh and restock your first aid supplies and OTC Pain Relief, Antacids, Allergy Meds
- Replace foot care supplies (cushions, pads, creams, anti-fungal medications)
- Stock up on acne medication
- Pregnancy products (ovulation monitor, pregnancy testing kits, prenatal vitamins)
- Baby care Items like: petroleum jelly, diaper rash ointment, thermometers, pediatric electrolyte solutions)
- Condoms and contraceptive devices
- Smoking cessation products (nicotine patches, gum and lozenges, inhalers)

References

1. About Triple Tax Advantages: You can receive federal tax-free distributions from your HSA to pay or be reimbursed for qualified medical expenses after you establish the HSA. If you receive distributions for other reasons, the amount you withdraw will be subject to federal income tax and may be subject to an additional 20% tax. Any interest or earnings on the assets in the account are federal tax free. You may be able to claim a federal tax deduction for contributions you, or someone other than your employer, make to your HSA. State tax consequences for HSAs may vary.

Holly Murrah
McGriff Employee Benefits Solutions, Development Executive

Compliance Q & A: Reporting Prescription Drug and Health Care Spending

What steps do plan sponsors need to take to comply with the Prescription Drug and Health Care Spending Requirements? How do these rules fit into the larger picture of recent healthcare transparency laws?

Summary:

The Consolidated Appropriations Act (CAA) of 2021 includes many benefit and tax provisions affecting group health plans.[1] Section 204 of the CAA requires plan sponsors to submit general information annually regarding the plan or coverage, as well as detailed information surrounding prescription spending, total health care spending, and the impact of any prescription drug rebates, fees, or other compensation affecting premiums and out-of-pocket costs. This information is required in the form of a Prescription Drug and Health Care Spending ("RxDC") report.

In November of 2021, the Departments of Labor, Health and Human Services, and the Treasury (Departments) released an in interim final rule, "Prescription Drug and Health Care Spending," implementing Section 204.[2] Subsequently, the Department of Health and Human Services (HHS) released supporting documents for the regulations, including a review of who must submit and when, data submission instructions, and examples of specific categories of reporting. While insurers, third party administrators (TPAs) and pharmacy benefit managers (PBMs) are expected to provide much of the reporting, group health plans are ultimately responsible for ensuring that the necessary information is submitted on their behalf. The diagram on the next page is a visual overview of how the RxDC reporting fits into the larger scheme of health care transparency legislation ("Prescription Drug / Pharmacy Disclosures").

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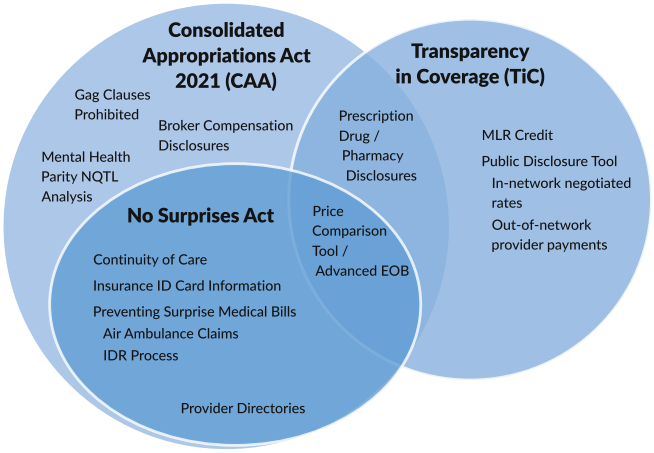

Detail

Who Must Report

While the Departments are expressly allowing—and indeed expect—that third parties such as TPAs, Pharmacy Benefit Managers (PBMs) and health insurers will provide much of the reporting, the CAA ultimately places the responsibility for compliance on group health plans. There is no exception to the reporting requirement for small groups, grandfathered, or fully-insured group health plans. The interim final rule addresses the concept of a "reporting entity" by providing an expansive definition that includes essentially any entity submitting the necessary information on behalf of a plan. Plan sponsors should discuss with insurers and/or TPAs to determine who will prepare and submit the necessary reporting for each plan. Agreements should be documented in writing.

Reporting Deadlines

The Centers for Medicare and Medicaid Services (CMS), the agency tasked with gathering the information required by Section 204, refers to these as "RxDC" reports. "Rx" stands for Prescription Drug, and "DC" stands for Data Collection. RxDC reporting is due on June 1 annually for the prior "reference year." A reference year is the calendar year immediately preceding the calendar year in which the RxDC report is due. So, for example, information for 2023 reference years—essentially just a calendar year—is due on June 1, 2024. The deadline applies regardless of a plan's renewal date or plan year. The deadline presents somewhat of a challenge for plan sponsors who change insurers/TPAs or PBMs mid-year, as it will require coordination to ensure that each vendor (or, if not, the plan sponsor themselves) is able to report partial year information.

Information That Must be Included in the Reports

The interim final rule outlines several categories of information that must be submitted, including the following:

- General identifying information such as Federal Employer Identification Number (FEIN), plan year dates, covered lives and each state in which coverage is offered;
- Health care spending by type of cost including hospital costs, primary and specialty care provider and clinical service costs, prescription drugs, and other medical costs;
- Average monthly premium amounts paid by employers on the participants' behalf, and the average premium paid by participants, beneficiaries and enrollees;
- "Top 50" drug lists, including the top 50 most frequently dispensed drug brands and number of paid claims for each, the top 50 most expensive drugs by total annual spend by the plan for each drug, and the 50 prescription drugs with the greatest increase in plan expenditures over the plan year;
- Prescription drug rebates, fees and any other applicable remuneration paid by drug manufacturers to the plan, issuer, or its administrators or providers, and any impact the rebates, fees and remuneration has on the cost of drugs under the plan; and
- A "Top 25" drug list of prescription drugs generating the highest rebate amounts.

This data must be submitted via the CMS Health Insurance Oversight System (HIOS) through an RxDC module. CMS has provided reporting instructions, including help desk contact information, which can be found at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/Prescription-Drug-Data-Collection.

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Chief among these necessary compliance steps is communicating with carriers and TPAs about how they will assist with detailed reporting requirements, as most, if not all, group health plans will not possess the requisite information on their own.

These instructions are periodically updated to provide clarity on frequently asked questions, such as how to calculate average monthly premiums.

What Should Plan Sponsors Do Now?

The Departments have strongly encouraged plan sponsors and insurers to prepare well in advance to comply. For group health plan sponsors, chief among these necessary compliance steps is communicating with relevant vendors about how they will assist with detailed reporting requirements, since few, if any, group health plans will possess the requisite information on their own. The actions plan sponsors will need to take will vary based on their group health plan's structure, the level of the insurer's or TPA's involvement, and other factors, such that a one-size-fits-all checklist is impracticable. That said, there are several steps that plan sponsors can take to prepare.

Fully-Insured Plan Sponsors

Plan sponsors will need to confirm who will submit the required data via CMS's HIOS system through the RxDC module. Fully-insured plan sponsors will generally be able to rely on carriers for this step but should verify whether the carrier will be submitting all or a portion of the data on the sponsor's behalf. Even where insurers will submit information on a plan's behalf, they will generally need additional information from plan sponsors such as employer versus member premiums. To that end, plan sponsors should be alert to carrier communications requesting any additional information, noting any deadlines imposed by the carrier.

Fully-insured groups can shift liability to the carrier. The regulations state, "if a health insurance issuer and a group health plan sponsor enter into a written agreement under which the issuer agrees to provide the information required... and the issuer fails to do so, then the issuer, but not the plan, violates the reporting requirements..." As to what is sufficient to constitute that written agreement has not yet been clarified. A generic email announcement stating what the carrier is willing to do probably would not, under a conservative reading of the rules, constitute a "written agreement" that would shield the plan sponsor from liability should the carrier fail to report the requisite information. Certainly, a signed written agreement between the plan sponsor and carrier is preferred and encouraged as a best practice; although, practically speaking, a mass communication may be the only assurance many plan sponsors are able to obtain from the carrier. Clarification from the Departments on this point would be welcome.

Self-Funded Plan Sponsors

While self-funded plan sponsors can also enter into agreements with vendors to complete these requirements, ultimately, they cannot shift liability for compliance. Therefore, more proactive action is prudent for self-funded plan sponsors.

First, because the necessary reporting information may reside with multiple sources, plan sponsors will need to determine which sources possess the required information. For example, while plan sponsors will typically have information on the average monthly premium paid by the plan and enrollees, the TPA is more likely to have the data related to prescription drug and health care expenditures and impact of rebates. While the insurer will often handle all prescription benefits for a fully-insured plan sponsor, self-funded plan sponsors – particularly those with carved-out prescription benefits – may have to coordinate the reporting process with not only the TPA but also their PBMs or even other vendors. Determining where the information is might be as simple as an email exchange with the relevant vendors, but this is an important step in the data collection process.

Plan sponsors will also have to decide who will perform the reporting. Keep in mind that it is possible for a plan to meet its Section 204 reporting obligation by having multiple entities submit files on its behalf. Many vendors are giving clients the option to request their individual plan data to

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submit the reporting themselves, or to allow the vendor to perform at least a portion of the reporting on their behalf. And naturally, many plan sponsors will want to allow these third parties to assist in this way. Vendors will have specific deadlines that must be met by plan sponsors and should be carefully noted. It is expected that vendors will charge fees in connection with preparing this information, with the level of fee dependent on the complexity of the pharmacy benefits. One consideration when deciding who should report should be that, while the Departments have encouraged aggregate submissions, multiple entities should not submit the same data for a plan, i.e., avoid "double reporting." So, in essence, plan sponsors should keep track of who is reporting what.

Plan sponsors should obtain contractual commitments, if possible, from any vendor providing such reporting on the plan's behalf. As stated above, vendors may be unwilling to enter into a contractual agreement wherein they agree to bear liability for noncompliance.

Because data is filed for a prior reference period, plan sponsors who changed carriers, TPAs or PBMs should always confirm with the prior service provider to verify the assistance they will provide with the required reporting – whether by filing on behalf of the former client or by providing necessary information to the former client to report for themselves.

Finally, plan sponsors should remain alert to the possibility of future guidance or clarification to the existing rules.

Penalties

While the regulations do not outline any specific penalty for failure to comply, there is the possibility that regulators could levy an IRS excise tax penalty of $100 per day per affected individual. The Department of Labor can also enforce compliance for ERISA plans, while the Department of Health and Human Services can enforce compliance on non-ERISA plans.

Conclusion

While the CAA's prescription drug and health care reporting requirements ultimately place responsibility for compliance on group health plans, plan sponsors will need to lean heavily on carriers and TPAs in order to provide the necessary reporting. Because the data may be submitted by a variety of entities and the Departments have said their expectation is that many insurers, TPAs and PBMs will submit for the plans, sponsors should contact and negotiate with carrier and TPA partners to provide the necessary information. Group health plan sponsors should familiarize themselves with the law and existing guidance and work with vendors to ensure proper coordination of efforts.

References

1. Section 204 of Division BB of the CAA, https://www.congress.gov/116/plaws/publ260/PLAW-116publ260.pdf
2. Prescription Drug and Health Care Spending, https://www.govinfo.gov/content/pkg/FR-2021-11-23/pdf/2021-25183.pdf

Stephanie Raborn, JD
McGriff Employee Benefits Compliance Officer

McGriff Insights: Mergers & Acquisitions

Top Health and Welfare Considerations in an M&A Deal

Employee benefits can present unique challenges in an M&A deal, especially since it often takes a back seat to other parts of the deal. Buyers should consider potential benefits-related liabilities, such as shifting COBRA liability and ACA pay-or-play and reporting obligations. They should also make decisions about post-close benefit plan design and negotiate accordingly while considering the viability of their approach given time to close.

View full article here.

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McGriff Employee Benefits Compliance Officer

Key M&A Due Diligence in Today's Insurance Market

In order to navigate the complexities of valuation, risk exposure, and policy alignment, companies must understand the nuanced focus area of due diligence outlined in this article. From property valuation intricacies to casualty risk control measures, each focus area serves as a compass for navigating the multifaceted challenges inherent in M&A transactions. By proactively addressing these concerns, companies can not only mitigate potential risks, but also optimize their strategic positions in a rapidly evolving market.

View full article here.

Paul Zederbaum
McGriff Practice Leader
Private Equity Risk Advisors (PERA)

McGriff Brings You Mineral!

April 23 | 3:00 p.m. EST

Register

McGriff is excited to provide our Employee Benefits clients with MINERAL – a robust web-based HR and compliance resource! You have access to several valuable tools, including:

- ***Mineral Live*** – A team of HR experts standing by to answer your questions or provide advice on virtually every HR or compliance-related issue
- ***Mineral Comply*** – An award-winning online resource center for all of your workforce issues, including a Living Handbook Builder
- ***Mineral Learn*** – An incredible online training platform with more than 250 web-based courses for your employee training needs

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