It Benefits You

Your Employee Benefits Newsletter

April 2022

In This Issue:

Trending Topics in Retirement Planning

Retirement benefits are important for your employees and their financial wellness and security. At the same time, the efficient use of resources with a limited budget is critical to your competitiveness within your peer group of businesses. Many pension plans are frozen, others are still open - and cash balance pension plans are the fastest growing retirement plan in the U.S. Also, many employers rely on their retirement savings plan to help employees build financial security for retirement. Employees with a sense of financial security and preparedness for the future perform better than employees who are anxious about their financial future.

Join your McGriff Retirement Consulting Team to learn how employers are managing their retirement plans. We'll discuss cost-effective solutions to recruiting, retention and compensation policies that can improve an employee's financial outlook.

April 28 | 2 p.m. ET | 1.0 SHRM PDC

Click HERE to Register!

Upcoming Compliance Deadlines

May 1

Summary Plan Description (SPD) (for new calendar year plans)

For new group health plans, welfare benefit plans, or pension benefit plans, the summary plan description (SPD) must be furnished within 120 days of the plan start date. For calendar year plans in 2022, the deadline is May 1, 2022. For existing plans, new participants must be provided an SPD within 90 days of becoming covered.

August 1*

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**. The fee amount for plan years ending on or after Oct. 1, 2021 and before Oct. 1, 2022 is $2.79 multiplied by the average number of lives covered under the plan.

August 1*

Form 5500 Filing Deadline for 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 August 1. 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.

*July 31, 2022 falls on a Sunday.

2022 New Compliance Considerations Keep Popping Up

If benefits compliance seems like a never-ending game of whack-a-mole, 2022 will not disappoint. While challenges related to the COVID-19 pandemic dominate headlines, a number of new 2022 benefits compliance obligations and updates may fly under the radar. While these changes may not be top-of-mind at the moment, it is critical employers understand them and take steps to comply when appropriate.

Transparency in Coverage

A series of new requirements are going into effect aimed at increasing transparency in health coverage with the hope of lowering costs and eliminating surprise medical bills for consumers. Bipartisan policymakers have been advocating for cost transparency in health care for years. Unfortunately for employers, transparency will add a number of requirements for group health plans. Employers should work with their carriers, Third-Party Administrators (TPAs), and Pharmacy Benefit Managers (PBMs) to coordinate compliance obligations and understand what action is needed. In many cases, it will be necessary and appropriate for vendors to assist with compliance.

- ### Effective for plan years beginning on or after January 1, 2022

  Insurance ID Cards – Insurance ID cards must include in-network and out-of-network deductibles, out-of-pocket maximums and a telephone number and website address for assistance.

  Accurate Network Provider Directory – Plans must ensure in-network provider directories are up-to-date and accessible online and by phone. Participants relying on inaccurate plan information in out-of-date directories will only be responsible for in-network rates.

  Ban on Surprise Medical Bills and Participant Notification – Plans can no longer charge members out-of-network rates for emergency care, services provided by certain out-of-network providers at in-network facilities, and air ambulance services. Notice of these changes must be posted on a public website.

  Continuity of Care Notification – If a provider is removed from a plan's network, plans must notify patients receiving or scheduled to undergo certain treatment from that provider. If elected, plans must cover services by the provider under the same terms and conditions for up to 90 days following notice.

- ### Effective July 1, 2022

  Machine-Readable Files – Non-grandfathered group health plans must disclose certain cost-sharing information on a public website in machine-readable files. The files must be available by either July 1, 2022, (for plan years beginning between Jan. 1, 2022 and July 1, 2022), or the month in which the plan year begins (for plan years beginning after July 1, 2022). Enforcement of an additional file with prescription drug information is delayed pending further guidance.

- ### Effective December 27, 2022

  Reporting on Pharmacy Benefits and Drug Costs – Group health plans must report information on plan prescription drug spending to regulators, including plan year dates, number of enrollees, each state where coverage is provided, and most common and costly prescription drugs dispensed by the plan. Information for 2020 and 2021 is due by Dec. 27, 2022, and for subsequent years will be due by June 1 of the following year.

- ### Likely Effective in 2022

  Ban on Gag Clauses Attestation – Group health plans are currently prohibited from entering into agreements with providers or administrators that would restrict plan access and sharing of certain cost, quality of care, and claims information with certain stakeholders. Plans are required to confirm compliance with this rule by submitting an attestation form annually to government regulators. While it is not yet clear when attestation compliance will be required, regulators expect to provide guidance and begin collection in 2022.

Coverage of COVID-19 Tests

Effective January 15, 2022, all group health plans are required to cover Over-the-Counter (OTC) COVID-19 diagnostic tests at no charge whether ordered by a physician or not. Previously, only tests ordered by an attending health care provider were required to be covered. While plans may require participants to pay for tests out-of-pocket and submit for reimbursement, regulators encourage plans to provide for direct reimbursement at the point of sale, with no out-of-pocket cost to the consumer. Plans that allow for direct reimbursement are able to limit reimbursement to 8 tests per covered member per 30-day period, and reimbursement for tests purchased at out-of-network pharmacies can be limited to the lesser of $12 or the cost of the test.

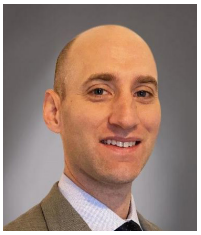
Employer ACA Reporting and Elimination of Good Faith Standard

Since 2015, Applicable Large Employers (ALEs) and self-funded group health plans have been required to complete informational reporting regarding coverage and offers of coverage to their employees under the Affordable Care Act. Although there are statutory penalties for filing failures for each prior year of reporting, the IRS has provided transitional penalty relief for plans that showed they made good faith efforts to comply. The IRS has announced that transitional relief is no longer available for the 2021 tax year reporting due in 2022. As a result, the IRS can impose penalties for filing failures, including failure to report all required information and reporting incorrect information. It is not clear how aggressive the IRS will be in assessing penalties. However, the maximum potential penalty amount is significant - $280 for each return or statement to which a failure relates, capped at $3,426,000 per calendar year.

Expiration of COVID-19 Related Relief

The CARES Act allowed no-cost telemedicine services to be provided to individuals without compromising HSA eligibility for plan years beginning January 1, 2020, through December 31, 2021. For plan years beginning on or after January 1, 2022, telemedicine services (unless limited to permitted insurance, permitted coverage or preventive care) provided below fair-market value before the minimum HSA deductible is met will cause individuals to lose eligibility to make HSA contributions. In addition, relief applicable to Section 125 plans and Flexible Spending Accounts (FSAs), including mid-year election changes without a qualifying event and carryover of unlimited unused FSA funds, will expire in 2022.

Employers hoping for a calm 2022 with few new benefits compliance obligations will be sorely disappointed. But employers should get their proverbial game faces on, act now and get ahead to ensure compliance, because new requirements are sure to pop up in 2023.



Chris Macali, JD
McGriff Employee Benefits Senior Compliance Officer

Payroll / Benefits Administration Technology: API Considerations

If your current tech stack consists of disparate systems for payroll/HRIS and benefits administration (ben admin) you may be eager to integrate these systems. Establishing Application Programming Interfaces (APIs) between platforms might allow you to keep best-in-class technology in each area, while eliminating the "clunky-ness" and inefficiency of weekly EDI files that often require manual review and intervention.

However, because of the relative novelty of APIs between ben admin and payroll providers, there is currently no established standard. As a result, you should thoroughly inquire about the following before saying yes to an API:

Key Questions to Ask

What are the costs?

Ask each provider if there is a cost for the API and how it's structured (one-time fee, recurring monthly fee, etc.).

Which data elements are exchanged?

Ask which fields are exchanged and whether they are exchanged in both directions or only one.

Which data elements are not included in the API?

Ask which fields are not exchanged and confirm whether this impacts benefits eligibility.

Are there timing considerations or limitations with the API?

Ask if the API will impact enrollment windows or can handle future benefit effective dates.

How are errors reported and resolved?

Ask if there is a dashboard or notification system for proactive error alerts.

Kisha Moliere
McGriff Benefits Administration Technology Practice Leader

Compliance Q&A: Short Plan Year Compliance Issues

Employers consider changing plan years for a variety of reasons: to align with the calendar year, to offer employees a new open enrollment opportunity after switching carriers mid-year, or to take advantage of more favorable insurance rates.

While changing plan years is generally permissible, there are a variety of compliance issues to consider. For example, how will this impact employees' pre-tax deductions under a Section 125 plan, and will this require a plan amendment? How might this impact an employee's HSA and/or FSA contributions? And how does this impact COBRA qualified beneficiaries?

Click **here** to learn more about what you should keep in mind when considering a short plan year.

Coverage of Over-the-Counter COVID-19 Tests

Group health plans as of Jan. 15, 2022, must cover all over-the-counter (OTC) diagnostic COVID-19 tests, whether ordered by an attending health care provider or not, subject to a few limitations. The Families First Coronavirus Response Act (FFCRA) and subsequent guidance already required group health plans and insurers to cover the cost of diagnostic COVID-19 tests; however, prior to the U.S. Department of Labor (DOL) update, coverage was available only for tests authorized by an attending health care provider.

As a result, many more OTC test purchases will be eligible for reimbursement through insurance. Plans and insurers may require individuals to pay out-of-pocket when purchasing an OTC COVID-19 test and submit a claim for reimbursement to the plan, although the DOL "strongly encourages" direct coverage.

Diagnostic OTC COVID-19 tests are also medical expenses eligible for reimbursement from a Flexible Spending Account (FSA) or Health Savings Account (HSA). However, an individual cannot be reimbursed for the OTC test by both the group health plan and an FSA or HSA.

In a Feb. 4, 2022, **FAQ**, the DOL reminded health FSA and HSA plan sponsors and participants that receiving reimbursement for over-the-counter (OTC) COVID-19 tests from both a major medical plan and an FSA or HSA is prohibited. Known as "double-dipping," this is a violation of the tax code and can lead to negative tax consequences for individuals.

If a participant seeks reimbursement from the health FSA for the OTC tests that are later reimbursed from the medical plan, the participant must refund the FSA. As a reminder, for every FSA claim submitted, the participant certifies that reimbursement will not be provided by another source. If a participant receives a reimbursement from both an HSA and the medical plan, they should repay the amount to the HSA.

Employers sponsoring both a group health plan and an FSA or HSA should review the FAQ and communicate the OTC COVID-19 coverage details to participants. It is very important to communicate these requirements and the "double-dipping" rules to plan participants.

Paula Smith, SHRM-CP, PHR, FCS, CFC
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7 Ways to Reengage Your Workforce and Inspire Loyalty

You've probably been hearing about the Great Resignation (or however you want to describe it) for months now. Even if you're not dealing directly with increased turnover, your employees know they have options. Their friends, family, and people they know peripherally or on social media have made the leap and are gleefully announcing it on LinkedIn.

Some job-hoppers may be emboldened by the movement to quit good jobs in the hope of something better—better pay, more flexibility, or more opportunities for advancement. Some have simply been pushed to the brink by dead-end jobs, lousy company culture, or ineffective managers. Others have given up trying to "have it all" and left the workforce completely.

But what if employers could capitalize on this current "I quit" mood? What if you could keep your employees engaged, inspire loyalty, and make it easier to attract and hire those that are looking for that next best thing?

We've got some ideas for both prioritizing current employees and making it easier to attract new ones.

1. **Understand and be responsive to employee needs, motivations, and priorities.** A paycheck may be the reason everyone has a job in the first place, but it's not the only reason people choose to work or decide to work for one employer over another. Your employees stick with you because there's something in it for them besides the money. The job is useful to them. Knowing why it's useful enables you to keep employees satisfied and, better yet, make their jobs even more appealing.

2. **Prioritize employee development.** A work environment in which people gain knowledge, learn new skills, and advance in their careers speaks more clearly and loudly than any marketing message can. People like working where they can grow and develop. And a better trained workforce is also a more productive and profitable workforce!

3. **Invite employees to be co-creators of the organization.** Empower them to make decisions about how things are done and where the organization is going. People feel more a part of something when they see themselves in it. They're more engaged when their decisions bring about real change.

4. **Reward success. In fact, reward anything you want to see more of.** Whether large or small, the rewards have to be meaningful. Ideally, figure out what type of reward speaks to each employee. For some, acknowledgment in a company meeting will make their heart sing. For others, receiving a token of your appreciation, such as a coffee gift card, will be more meaningful.

5. **Allow for a healthy work-life balance.** Flexibility is a big selling point for employees looking for better balance between work and life. Your employees have other commitments they need to attend to. Some are caring for young children or other family members while navigating daycare and school closures or multiple appointments. Give employees the time to see to those commitments and have a life outside of work, and you'll get more from them when they're on the job. Options may include remote or hybrid work, paid time off, flex hours, four-day workweeks, alternative schedules, and reducing workload. Remember, however, that policies are only as good as the practices around them. Ensure that employees don't need to jump through hoops to request time off. Remind managers to be responsive to requests for time off and on the lookout for signs that employees are feeling overwhelmed.

6. **Conduct "stay interviews."** Don't wait until people are leaving to investigate what could have inclined them to stay. Talk to employees now about what's going well, what pain points they're experiencing, and what could be done to take the relationship to the next level. Stay interviews enable you to address problems and unfulfilled wishes before they drive people out the door.

7. **Let people go who want to go.** You have only so much time in the day. Don't spend it trying to entice people to stay if they really want to leave the organization. That time is better spent ensuring smooth transitions and engaging employees who don't have one foot out the door.

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