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EMPLOYEE BENEFIT SOLUTIONS

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Your Employee Benefits Newsletter

November 2023

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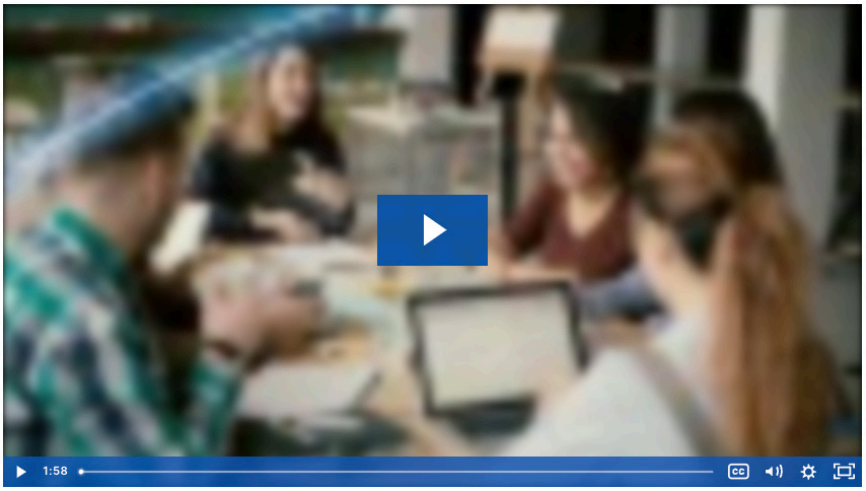

What do you see when you look at the world? We see risk and opportunity, business and life, and the need to protect from anything that threatens it. When typical insurance doesn't cut it, you need a broker that's different than the rest. We are McGriff and we believe that when it comes to protecting your most valuable assets, you should never settle for less than the best.

The Impact of Diversity & Inclusion on Management Liability – a McGriff Webinar

November 16 | 2:00 pm EST | 1.0 PDC SHRM/HRCI

Senior leaders have become increasingly accountable for their organization's diversity and inclusion practices. We will discuss the consequences leaders can face for not addressing these measures and the benefits of fostering a diverse workforce and inclusive environment.

Register

Upcoming Compliance Deadlines

December 15

Summary Annual Report (SAR) Extended Deadline for Calendar Year Plans

A Summary Annual Report (SAR) summarizes a plan's Form 5500 annual report, provides a financial statement regarding the plan, and informs participants of their rights to receive additional information.

Generally, the plan administrator provides the SAR within nine months of the close of the plan year; however, if an extension to file Form 5500 is obtained, then the plan administrator must furnish the SAR within two months after the close of the extension period. For calendar year plans, that deadline is December 15.

December 31

Initial No Gag Clause Attestation Deadline

The Consolidated Appropriations Act of 2021 (CAA) prohibits plans and issuers from entering into agreements with health care providers, third-party administrators (TPAs) and other service providers that would restrict the plan or issuer from providing, accessing or sharing certain information about provider pricing and quality of care as well as de-identified claims.

Plans and issuers must annually submit an attestation of compliance with these requirements – or "Gag Clause Prohibition Compliance Attestation (GCPCA)" – using the Centers for Medicare and Medicaid Services' (CMS) Health Insurance Oversight System (HIOS).

The first attestation, covering the period beginning December 27, 2020 through the date of the attestation, must be filed by December 31, 2023.

January 31

Form W-2 Reporting Cost of Employer-Sponsored Health Coverage

Under the ACA, employers who issued 250 or more W-2s in the prior calendar year are required to provide employees with the aggregate cost of employer-sponsored group health plan coverage on employees' Forms W-2. Currently the reporting is optional for employers who file fewer than 250 W-2 forms.

Why You Should Audit Your Monthly Carrier Invoices: Bill Reconciliation from a Compliance Perspective

Have you reviewed your bills lately?

While conversations about finances are always first on the agenda at annual renewal meetings, there are a variety of reasons why plan sponsors and HR should be paying attention to carrier invoices year-round. As a former account manager, I cannot count the number of times that a client who nearly had a heart attack when reviewing a carrier renewal – and understandably so – would allow company money to be misspent by failing to term ineligible participants in a timely

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fashion. In addition to the obvious problem of unnecessarily letting money out of the company door, there are compliance issues that can arise by not paying attention to invoices.

In no particular order, below is a non-exhaustive list of reasons why plan administrators should pay attention to invoices as they come in.

- **The ACA's Anti-Rescission Rules** – The Affordable Care Act prohibits insurers and group health plans from rescinding coverage of covered individuals except in very limited circumstances, specifically fraud or "intentional misrepresentation of material fact." To rescind coverage is to retroactively cancel it, and even in circumstances where rescission is permitted, 30 days advance notice is required. The plan document(s) also should clearly indicate circumstances when rescission is permissible (e.g., in the event of fraud or intentional misrepresentation).

  Both fraud and intentional misrepresentation are a high standard and require the plan sponsor to be able to show that something beyond an inadvertent misstatement or plan error has occurred. For example, even in a case where an employee misrepresented their use of tobacco to qualify for a lower premium, a court held that the remedy was to recoup the appropriate premium rather than rescind the coverage altogether. This means that in most circumstances coverage termination must be prospective, occurring no earlier than coverage back to the date of the termination of employment or failure to pay the employee's share of premium.

  A detailed explanation of the ACA's prohibition on rescissions can be found here.

- **COBRA Complexities** – When a participant is left on coverage, particularly in circumstances where the individual remains on the plan well beyond the date of eligibility for benefits, the question of when COBRA should be offered is complex. While the employer plan sponsor may want to terminate coverage as of the date of the loss of eligibility for benefits (which also typically raises rescission concerns), you are left with the problem of timely notification and how to recoup the participant's share of premium payments. COBRA election notices must be provided to qualified beneficiaries within 14 days after an administrator receives notice of a qualified event from the employer or a qualified beneficiary. When the employer is also the COBRA administrator, the employer must provide an election notice to the qualified beneficiary within 44 days of the date of the qualifying event or the date on which the qualified beneficiary loses coverage due to the qualifying event, whichever date is later.

  As an example, let's say that ABC Company uses a COBRA administrator, COBRA Admin Company. ABC has a former employee who terminated employment on June 10 whose coverage should have been terminated on June 30. It is now October 30 and ABC Company wants to terminate coverage as of the loss of eligibility. Clearly, ABC Company has failed to notify COBRA Admin Company of the qualifying event within the required timeframe, so no approach is without some risk. ABC Company could choose to terminate coverage as of June 30 and ask COBRA Admin Company to send the COBRA election notice to the former employee's last known address as soon as possible, or ABC Company could terminate coverage immediately and notify COBRA Admin of a termination date of October 30 (or October 31 if coverage runs through the end of the month). In either case, the former employee must be provided 60 days to decide whether to elect COBRA and then 45 days from the date of their COBRA election to make the first payment.

  Under the first option, it may be more difficult for the former employee to come up with several months of payment for COBRA premiums upfront, and it may increase the likelihood that the former employee is upset about the delinquent notice. An advantage is that the plan sponsor would only have to offer 18 months of COBRA, absent the occurrence of a second qualifying event. Some plan sponsors will give individuals an extended period of time in which to make initial payments when there has been a delinquent notice, and others will offer to pay some or all of the retroactive premiums in order to offset concerns with the delinquent notice. The second option leaves the plan sponsor on the hook for several months of premium during those months where the former employee has not elected coverage and was nonetheless on the plan. This approach effectively extends the amount of time during which the former employee could be on COBRA, i.e., the four months they were left on the plan when they should have been terminated, and the 18 months of actual COBRA coverage they are eligible for due to the termination of employment.

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Clearly, neither option is ideal. However, even if retroactive termination would be permitted under the rescission rules – such as in cases where termination is occurring due to non-payment of premiums – because of the administrative challenges and potential for an upset former employee, terming an individual prospectively and offering COBRA from that date of termination is typically the better approach.

- **Avoiding Inadvertently Self-Insuring Claims** – As a general rule, insurers and reinsurers expect plan sponsors to abide by the terms of their contracts and the plan sponsors' own plan documents when monitoring participants' eligibility for coverage. While the principle is fairly basic, this can be a painful lesson for the unwary when a participant who is ineligible under the terms of the contract hits the plan with large claims. Vendors do not typically police eligibility, at least until a large claimant is identified. We have seen a carrier deny large medical claims because coverage was continued for an employee on an extended leave of absence where the plan sponsor had no written policy or documentation of the practice of continuing benefits during extended leaves of absence. It is not uncommon for carrier documents to include provisions limiting coverage to 12 weeks of FMLA or 30 days of non-FMLA leave. Even where a carrier contract does not state a specific length of time under which coverage may be continued, there is then the expectation that the employer abide by their plan's own eligibility provisions. No plan document is (nor should it be!) so generous as to provide coverage to former employees or even current employees on extended leaves of absence for an indefinite period.

As painful as regular bill reconciliation is, the effort of proactive review is worth the potential savings and avoidance of compliance headaches for both plan sponsors and participants. Ask me about the time my HR contact forgot to enroll an executive in their new plan and realized it when the executive's wife went to the doctor. Or maybe don't.

By Stephanie Raborn, JD
McGriff Employee Benefits Compliance Officer

HRAs, HSAs and FSAs – What's the Difference?

The four key types of employee benefits are health and welfare plans, retirement savings plans, paid time off, and fringe benefits. Each one includes several options and alternative arrangements to choose from.

Most employers understand that employee benefits are an important part of any compensation package, a way to attract and retain the most qualified and talented employees. That's why employers must consider the needs of their employees when designing a benefits package, as well as the affordability of the benefits. Employers should also be able to clearly communicate the details of their employee benefits package to their employees.

The focus of this article is to explain the often-misunderstood world of Health Reimbursement Arrangements (HRAs), Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs). These programs can be offered as part of a comprehensive health and welfare benefit offering and can be extremely valuable to employees. However, the differences between the arrangements can be difficult to understand and to communicate.

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HRAs

For employees, the main attraction of employer-funded HRAs is that they're free. Everybody loves something that's free, and this benefit can be extremely valuable.

An HRA is designed to help employees bridge the gap on eligible healthcare expenses (otherwise unreimbursed expenses under Section 213(d) of the Internal Revenue Code). These arrangements are not portable and generally do not have carryover options.

HRAs are highly customizable and a great way for organizations to help employees offset rising healthcare costs. Common eligible expenses include deductibles, coinsurance and copays. In addition to restrictions imposed by law, employers may limit which expenses are eligible for reimbursements. Employees are responsible for making sure that any expenses they submit for reimbursement are eligible.

HRAs also qualify for state, federal and FICA tax deductions for employers. Distributions are tax-free to employees. HRAs have no contribution limits and employers can decide the maximum amount that will be contributed every year.

Employees usually enroll in a health plan and sign up for an HRA during their employer's annual enrollment period. Some employers even design their plans to include automatic enrollment.

HRAs are subject to COBRA and employers have two options for determining the premium. Technically an employer can charge up to 102% of the "Applicable Premium," which is determined by either the "Past-Cost" method (utilization plus administrative fees) or the "Actuarial Method." The Actuarial Method is for first-time plans that require the actuary or administrator to make a reasonable estimate of the cost of providing HRA coverage (reasonable estimate of the employer's exposure or HRA utilization plus administrative fees). Importantly, the COBRA statute does not mandate that employers must hire an actuary to use the Actuarial Method, but if a qualified beneficiary decides to challenge the COBRA premium as too high, the employer would probably need to retain an actuary to defend the premium structure.

HSAs

HSAs allow employees to save money on their healthcare premiums, rollover unused funds from year to year, invest for future healthcare expenses, and maximize tax savings. HSAs are only offered in conjunction with high deductible health plans.

HSAs let employees use pre-tax money to pay for qualified medical expenses, and the account is fully funded by the employee. HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax deductible with very few exceptions. Employers should consult a tax advisor regarding their state's rules. HSAs must have an HSA-qualified health plan.

Many employees are not aware that funds can be invested and grow with tax-free earnings, a key feature of an HSA. Moreover, funds in these accounts never expire, even if an individual changes health plans or employers, or they retire.

For 2024, the contribution limits for HSAs are $4,150 for single coverage and $8,300 for family coverage. Employees 55 and older may contribute an extra $1,000 to their annual maximum amount.

Although employees experiencing a qualifying event may have continuation rights to their medical plan under COBRA, an HSA is not a medical plan and therefore not covered by COBRA. Interestingly though, participants can make tax-free distributions from an HSA to pay medical premiums when they continue coverage through COBRA or collect unemployment benefits.

FSAs

An FSA is an account that can be used to pay for a wide variety of healthcare expenses on a pre-tax basis.

FSAs enable employees to set aside pre-tax money to pay for eligible medical expenses (otherwise unreimbursed expenses under Section 213(d) of the Internal Revenue Code). FSAs are never taxed at the federal level when used appropriately for qualified medical expenses. Also, most states recognize FSA funds as tax deductible with very few exceptions. Employers should consult a tax advisor regarding their state's specific rules.

FSAs are employer-owned; participants in an FSA do not keep their unused FSA money. Funds may be forfeited back to the employer. FSAs are most frequently paired with a traditional health plan. Some FSAs offer grace periods or limited carryover (up to $610 for 2023).

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For 2023, the contribution limit for an FSA is $3,050. The IRS has not yet released the 2024 contribution limit.

The COBRA rules applicable to FSAs are complicated, and somewhat beyond the scope of this article. However – in general – a Health FSA is a group health plan subject to COBRA. However, COBRA coverage is available only for underspent accounts and only through the end of the plan year of the qualifying event. An exception applies when the FSA offers a carryover. In this case, COBRA continues to be available for the full (typically 18-month) maximum coverage period.

Conclusion

Employers should carefully consider whether to adopt an HRA, HSA or FSA as part of a comprehensive health and welfare benefits offering and should be able to clearly explain the benefits of these programs to all eligible employees as an important part of taking care of their health care needs.

Did you know McGriff offers Flexible Benefit administration for a full range of accounts including FSA, DCAP, HSAs, HRAs, Transit and Lifestyle Spending Accounts? Using industry-leading technology and unparalleled service, McGriff provides the functionality, reliability, and integration you need to offer worry-free benefits to your employees. Reach out to your McGriff Employee Benefits Consultant for more information.

By Richard Plumpton, JD, MBA
McGriff Flex and COBRA Compliance Leader

Gag Clause Prohibition Compliance Attestation: Who, When, What & How!

The Consolidated Appropriations Act of 2021 includes many benefit and tax provisions affecting group health plans. One such provision prohibits plans and issuers from entering into agreements with health care providers, third-party administrators (TPAs) and other service providers that would restrict the plan or issuer from providing, accessing or sharing certain information about provider pricing and quality of care as well as de-identified claims.

Click the image to watch and listen!

Plans and issuers must annually submit a **Gag Clause Prohibition Compliance Attestation (GCPCA)** using the Centers for Medicare and Medicaid Services (CMS) Health Insurance Oversight System (HIOS). The first attestation, covering the period beginning December 27, 2020 through the date of the attestation, **must be filed by December 31, 2023**.

While most fully-insured carriers will submit on the plan sponsor's behalf, many self-funded plans will be responsible for filing their own GCPCA. Plan sponsors should proactively reach out to their carrier/TPA to confirm who will be filing the attestation and what assistance the carrier/TPA will be providing to comply.

Completing the attestation through the CMS' HIOS is fairly simple. **We have recorded a short tutorial to assist employer group health plan sponsors if their carrier/TPA is not willing to complete the attestation on their behalf.**

CMS has provided detailed instructions for this process, as well as a user manual. McGriff has also prepared a Gag Clause Prohibition Compliance Attestation Placemat to help explain this new reporting requirement.

By Laura Clayman, JD, SHRM-CP
McGriff Employee Benefits Compliance Officer

Health Plans Must Expand Price Comparison Transparency Tool for 2024

Beginning in 2024, group health plans and health insurance issuers must expand the internet-based price comparison tool they make available to participants, beneficiaries and enrollees so that it includes all covered items, services and drugs. The purpose of this tool is to provide consumers with real-time estimates of their cost-sharing liability from different providers for covered items and services, including prescription drugs, so they can shop and compare prices before receiving care. Upon request, plans and issuers also must provide this information in paper form or over the telephone.

This requirement comes from final rules regarding transparency in coverage (the "TiC rule") that were issued by the U.S. Departments of Labor, Health and Human Services, and the Treasury in November 2020. The TiC rule is applicable to all plans except grandfathered plans, excepted benefits and account-based plans (e.g., HRAs, FSAs and HSAs).

Compliance Deadlines

For plan years beginning on or after January 1, 2023, plans and issuers were required to make price comparison information available for 500 shoppable items, services and drugs. For plan years beginning on or after January 1, 2024, price comparison information must be available for all covered items, services and drugs.

Action Steps

Most employers rely on their issuers or third-party administrators (TPAs) to develop and maintain the price comparison tool and provide related disclosures on paper or over the phone upon request. To help ensure compliance, employers should consider the following steps:

Fully insured health plans: An employer with a fully insured health plan is not required to provide the price comparison tool if the issuer agrees in writing to provide the tool. Employers with fully insured health plans should confirm that their issuer is providing the cost comparison tool and this responsibility is addressed in a written agreement.

Self-insured health plans: Employers with self-insured plans (including level funded plans) may contract with another party, such as a TPA, to provide the required tool. Employers with self-insured health plans should reach out to their TPAs (or other service providers) to confirm that they are providing this tool and that this responsibility is addressed in a written agreement. In addition, employers should monitor their service provider's compliance with this requirement. Unlike fully insured plans, the legal responsibility for this tool stays with a self-insured plan even if its service provider agrees to provide the price comparison tool on its behalf.

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Monthly Mineral Demonstration

November 21 | 2:00 p.m. EST

Did you know? Mineral Live Advisors answered more than 2,000 questions for McGriff clients last year!

As a McGriff Employee Benefits client, you can access senior-level, certified HR professionals by phone or electronic submission through your Mineral portal every business day from 7:00 am to 7:00 pm ET.

Mineral Live Advisors provide comprehensive, actionable answers with documentation supporting all responses and are knowledgeable about all aspects of the employee life cycle.

If you are involved with HR compliance or employee issues at any level, Mineral is another valuable benefit from your trusted McGriff team that can save you time and money. Join us for an overview of Mineral and all the resources available to you as an employee benefits client of McGriff.

Register

You've Gotta Count the Beans: ROI and the Measurement of HR Success

Everywhere we turn these days, it seems the economic outlook is in debate. Experts point to conflicting data showing exceptionally low unemployment numbers (good) while also showing stagnant wages (bad). We see inflation rates have stabilized (good) but also reports of record high credit card debt (bad). In our HR world, we have the unenviable job of balancing the needs of the business with the needs/desires of our workforce. Add to that the extreme competition for skilled talent, and the challenge becomes even greater.

As a science, the study of Human Resources typically does not include a requirement for business accounting. While it is mentioned in many undergraduate degree programs, it is almost never mentioned in graduatenprograms. When it comes to the business side of HR, as professionals we are not as prepared as we need to be to adequately address cost drivers, specific return benchmarks, and how to truly measure bottom line success.

Several years ago, a business consultant created a presentation to teach non-financial managers how business leaders measured assets, liabilities, and profit. Acronyms like EBITDA, P&L, ALM were all foreign to many, and he helped explain them by using a simple method to illustrate how the "bean counters count the beans." He used all kinds of beans in giant bowls and would move them from bowl to bowl to show how costs were allocated. He would even throw jellybeans into the audience to show how often money was wasted. It was fascinating to watch, and it drove home his point: YOU GOTTA COUNT THE BEANS!

How does HR meet this directive? We talk often about what we perceive to be the "return on investment" (or ROI) on this program or that program. But we are all too often stumped by how to truly measure this important business tool. Why is that?

First of all, not all HR initiatives can be directly tied to an investment strategy. Wellness programs are a good example. These programs are important – for many reasons – in the workplace. We know a healthy workforce is a happier workforce – but what does happiness mean to the CFO? Is there a line item that shows the value of employee happiness? Probably not. However, we have to follow the line of the employee life cycle to show true return to the bottom line.

Wellness programs often tout a decrease in insurance premiums over time. But that is tricky since some illnesses, injuries and conditions will not be improved by any wellness initiative. Year over year, there may be reduced costs associated with medical expense claims, but there may not be a big return in the short term. Maybe we're measuring the wrong thing!

Consider this: Healthier employees equal happier employees. Happier employees are more engaged. A more engaged workforce tends to have lower absenteeism. Lower absenteeism from an engaged workforce will equal greater productivity. Greater productivity equals higher output, improved service, and lower risk. Now wellness sounds like a great investment!

Human Resources has long been assigned the role of the "people persons." Somehow our profession has been relegated to party planners and paper pushers and often left out of important business decisions. HR professionals have spent endless hours trying to figure out how to get a "seat at the table" in the hope that our voice in decision-making will elevate our importance. The thing that will get us to that executive table more often is being seen as valuable as RISK managers. And RISK management after all is a keystone of all business. Everything decided at the corporate level is measured by the amount of risk exposure the company accepts when making those decisions. How much more do HR initiatives and decisions have their origins in managing risk?

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Example: *Recruitment has risk exposure* – hiring the right people, at the right time, at the right compensation reduces the risk of loss of business continuity. But when recruitment is done poorly, the risk increases exponentially.

A second example: *Retention also has risk exposure* – keeping employees engaged, paying them not just fairly but competitively and giving them opportunity for career and financial growth reduces the risk of turnover and, thus, loss of business knowledge and reduced productivity.

A third example: *Benefits has a tremendous risk exposure* – not just financially in terms of what we pay on behalf of the employee, but what it says to current and potential employees that helps us recruit and retain our best talent. When done well, our benefits platforms can boost our ability to recruit the best and brightest and then keep them long-term to help our organizations grow.

So, what does all this mean for the HR professional and the people to whom HR departments report? It means there must be a greater focus on hiring more business-savvy HR executives who understand how businesses make money and how they measure bottom line success. There must be a push to require current HR pros to expand their business acumen through formal study (university/college/online) and through mentorship. It is no longer enough to understand only the "people business." We MUST improve our understanding of the business of business.

Because ultimately, at the end of the day, we've just gotta count the beans!

By Janie Warner, SHRM-SCP
McGriff HR Advisory Practice Leader

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