Brown & Brown

EMPLOYEE BENEFITS

Governmental Plan 2023 Compliance Guide

From the Brown & Brown Regulatory and Legislative Strategy Group

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Affordable Care Act (ACA)

The following are certain disclosures, notices and reporting currently required for group health plans under the ACA. This is not an exhaustive list of ACA requirements, nor does it include past requirements that are no longer applicable or future requirements that are not yet effective.

Summary of Benefits and Coverage (SBC)

Group health plans (other than excepted benefits and retiree plans) are required to furnish an SBC for each benefit option. The SBC is a uniform explanation of benefits that are required in addition to other disclosure requirements. Regulations specify the language and format that must be used. The agencies issued final regulations on a new SBC tempate, and instructions in April 2016. The rules apply to all SBCs created on or after April 1, 2017.

More recently, the CMS released a new SBC template that is required to be used with respect to all plan years beginning on or after January 1, 2021. Current and revised SBC templates can be found on the CMS website.

SBCs must be distributed

1. At initial enrollment;
2. Annually at re-enrollment;
3. Within 90 days after enrollment resulting from a special enrollment right; and
4. Within **seven** (7) business days of an employee/beneficiary request.

Notice of mid-year material modifications to an SBC must be provided at least 60 days ***prior to*** the effective date of the change.

Model Notice to Employees of Coverage Options ("Public Exchange" Notice)

The notice must broadly describe the existence of the Health Insurance Marketplace and the ramifications if an employee purchases individual coverage on the Marketplace instead of enrolling in the employer's coverage. The notice must be provided to new employees within 14 days of the employee's start date. This includes employees who are not eligible for the employer's health benefits.

Grandfathered Health Plan Disclosure – Grandfathered Health Plans Only

Grandfathered health plans must include language (in any plan materials describing the plan's benefits) indicating that the plan believes it is a grandfathered health plan under the health care reform law, and must provide contact information for questions and complaints.

Internal Claims and Appeals and External Review Requirements – Non-Grandfathered Health Plans Only

Governmental group health plans are not subject to ERISA. As a result, the ERISA claims and appeals requirements historically were not applicable to governmental plans. The ACA incorporated the ERISA claims and appeals requirements in the Public Health Services Act, which does apply to governmental group health plans. As a result, governmental group health plans (other than excepted benefits and retiree plans) must implement an internal claims and appeals process that satisfies the ERISA claims and appeals requirements. Group health plans must also implement new procedural requirements for appeals as required by the ACA and make external review available. Model notices have been issued for claim denials/external review decisions. Language generally should be included in plan documents. Employers should confirm that their health plan's appeals procedures comply with these requirements.

Selecting a Benchmark Plan

The final market reform rules require self-insured and large insured plans to select one of the three Federal Employees Health Benefit Program (FEHBP) options or a state benchmark plan to define essential health benefits (EHB) to ensure the plan imposes no annual or lifetime dollar limits on EHBs. This requirement applies to benefits provided in or out-of-network.

Patient Protection Disclosure – Non-Grandfathered Health Plans Only

Plans that require the designation of a primary care physician (PCP) must provide a notice of patient protections under health care reform whenever the plan or issuer provides a participant with a summary plan description or other similar description of benefits under the plan or health insurance coverage. NOTE: Plans that do not require/allow PCP designations are not required to provide this notice. In general, most Preferred Provider Organizations (PPOs) do not require PCP designation; however, we are seeing some carriers request or assign PCPs on PPOs for provider payment under accountable care contracts. We recommend confirming if this notice applies to your plans.

Medical Loss Ratio (MLR) Reporting

Health insurers of fully insured (including grandfathered) plans are required to report to the Department of Health & Human Services (HHS) each year the percentage of their premium revenue that the insurer spent on 1) clinical services for enrollees, 2) "activities that improve health care quality," and 3) all other non-claims costs, excluding federal and state taxes, and licensing or regulatory fees. Insurers in the small group market must spend at least 80% and insurers in the large group market must spend at least 85% of their premium revenues (excluding federal and state taxes and licensing and regulatory fees) on clinical services and quality improvement activities. Insurers that fail to do so will have to rebate the difference to their enrollees. Under the HHS rule, rebates must be paid by September 30 of the year following the year for which the MLR data is reported. In the case of an employer group health plan, rebates must be paid to the policyholder (that is, the employer). *Insurers must also report to their enrollees how the rebate was calculated.

The employer may be required to use a portion of the rebate for the benefit of the plan participants as opposed to simply retaining the entire rebate. More information regarding these requirements is available here (see the section on non-ERISA plans).

**Employer policyholders may have legal obligations to return some or all of the rebate to employees. If your organization receives an MLR rebate, it is recommended that you review your obligations with legal counsel.*

Rescission of Health Plan Coverage

Group health plans may not rescind coverage except for fraud or intentional misrepresentation of a material fact. A rescission includes any retroactive termination or retroactive cancellation of coverage except for a termination or cancellation due to failure to timely pay premiums. Therefore, if an employee is enrolled in the plan and makes the required contributions, then the employee's coverage may not be rescinded if it is later discovered that the employee was mistakenly enrolled and not eligible to participate. If a mistake was made and there was no fraud or intentional misrepresentation of a material fact, then the employee's coverage may be canceled prospectively but not retroactively. In cases where rescission is permitted, the plan must provide the covered person with 30 days advance written notice of the rescission.

Patient Centered Outcomes Research Institute Fee (PCORI)

Imposed on issuers of insurance policies and sponsors of self-insured health plans starting with the first plan year ending after September 30, 2012. While originally set to sunset with plan years ending on or after October 1, 2019, the 2020 SECURE Act extended the PCORI fee for an additional ten years.

The PCORI fee (as indexed by inflation) will continue to apply to all plan years ending before October 1, 2029. The fee for plan years ending on or after October 1, 2021, and before October 2022 is $2.79 per covered member. The fee for plan years ending on or after October 1, 2022 and before October 2023 is projected to be $2.93 per covered member. The fee is reported and paid once per year on IRS Form 720 no later than July 31 of the calendar year immediately following the last day of the plan year for which the fee is owed. For fully insured plans, the carrier will make the payment on the employer's behalf. If you are self-insured or have an HRA integrated with a fully-insured plan, you are responsible for making the payment. Employers with a fully-insured plan and an HRA can use the "one life per participant" rule - meaning spouses and dependents do not have to be counted.

Employer Shared Responsibility ("Play or Pay")

Applicable Large Employers (ALEs) , subject to the ACA's Employer Shared Responsibility requirement, are those with 50 or more full-time and full-time equivalent employees on average during the preceding calendar year. ALE status is determined by counting all employees in a controlled group. Under this provision, employers are subject to penalties if they do not offer health coverage (minimum essential coverage (MEC)) to substantially all full-time employees and their dependents, and at least one full- time employee receives a premium tax credit and purchases coverage on the Marketplace (public Exchange). "Full-time employee" is defined as a common-law employee who is employed an average of at least 30 hours of service per week (or at least 130 hours of service per calendar month) determined using the monthly measurement method or the look-back measurement method.

- Substantially all" is defined as offering MEC to at least 95% of all full- time employees in the applicable month.
- "Dependents" is defined to include only natural/adopted children to the end of the month they attain age 26, but does not include spouses.

If the applicable threshold is not met, and at least one full-time employee receives a premium tax credit and purchases coverage on the Marketplace (public Exchange), the employer is subject to a penalty per each common-law full-time employee that works for the employer, less the first 30 FT employees. The thresholds and corresponding penalties are evaluated on a monthly basis. For 2022, the penalty is $229.17 per month (1/12 of $2,750) x the number of full-time employees* x the number of months in which the threshold is not met. The penalty is indexed each year for inflation, and the 2023 adjusted amount increases to $240.00 per employee per month (1/12 of $2,880).

**The penalty is waived for the first 30 full-time employees.*

Rather than evaluating eligibility on a monthly basis, the IRS has outlined an alternative look-back measurement method that employers can use with a large population of part-time and/or "variable hour employees" (an employee whose hours of service per week cannot be reasonably determined at date of hire). This allows employers to avoid the penalty if they provide prospective eligibility to employees who met the definition of full-time in the retrospective measurement period.

Even if an ALE offers "substantially all" of its FT employees MEC, the employer may still be subject to a penalty if the coverage is not offered to a full-time employee or the coverage offered to full-time employees is inadequate (less than 60% minimum value) or unaffordable (employee-only coverage costs more than 9.61% (in 2022) of household income). The affordability safe harbor percentage reduces to 9.12% in 2023. For 2022, the penalty is$343.33 (1/12 of $4,120) x the number of full-time employees who receive a premium tax credit or cost-sharing assistance per month. For 2023, the inflation-adjusted penalty will be $360.00 (1/12 of $4,320) x the number of full-time employees who receive a premium tax credit or cost-sharing assistance per month.

The IRS recognizes that employers do not know employees' household incomes and have therefore issued three affordability safe harbors (Federal Poverty Line, Rate of Pay and W-2) that are generally based only on the earnings of the employee. NOTE: If an employer offers an opt-out payment for employees who waive coverage, the amount of the payment may be required to be included in the affordability calculation unless it was in place by December 16, 2015 or it is conditioned on the employee providing reasonable evidence of enrollment by the employee and his/her expected tax family in minimum essential coverage other than individual market coverage.

Large Employer Reporting

Beginning in 2016, employers and other entities are required to annually report (regarding the prior year) information to assist the IRS with enforcing the individual mandate, administering premium tax credits and making employer penalty determinations. The reports (due after the year ends) must include information related to full-time employee status and coverage information for each month of the year covered by the report.

There are two reporting requirements:

1. Code section 6055 reporting: Requires various reporting entities (including employers and insurance carriers) to report information on each individual with minimum essential coverage. The IRS intended to use the information to enforce the individual mandate, but that mandate has since been effectively repealed because the penalty has been reduced to $0. However, these reports may still be useful in states that have adopted a state-based individual mandate. The forms used for filing returns are 1094-B (transmittal form) and 1095-B (individual statement).

Reporting for Applicable Large Employers that are self-funded plan sponsors can be satisfied by submitting the 1094-C and 1095-C forms (referenced below); however, in this situation an employer may still issue the B forms for reporting on enrolled non-employees. A provider of minimum essential coverage will be treated as having satisfied the section 6055 requirements if the form is made available through the provider's website and certain conditions are met as further described in the Instructions for Form 1094-B and 1095-B.

2. Code section 6056 reporting: Requires Applicable Large Employers that are subject to the Employer Shared Responsibility (Play or Pay) penalties to report information on the coverage offered to full-time employees. The IRS will use the information to enforce the play or pay penalties. The forms used for filing returns are 1094-C (transmittal form) and 1095-C (individual statement). Self-funded employers that are also Applicable Large Employers will be permitted to satisfy both Code Section 6055 and Code Section 6056 reporting requirements by submitting a combined information return. There are also simplified section 6056 reporting alternatives that may apply to certain employers/groups of employees. In concept, the reports are similar to Form W-2 reporting – for example, an aggregate filing must be made to the IRS, and an individual statement must be provided to applicable employees.

The date to furnish Form 1095-Cs to individuals has been permanently extended beginning with plan years on or after December 31, 2020. Employee statements must be furnished no later than the first business day that occurs 30 days on or after January 31 following the end of the calendar year being reported (i.e., 2022 employee statements must be furnished by March 2, 2023). The IRS filing is due no later than the first business day on or after February 28 (if filed by mail) or March 31 (if filed electronically) following the end of the calendar year being reported. Employers issuing 250 or more forms must file electronically via the AIR system. For 2022 Forms, the deadlines for electronic filing or by mail remain unchanged.

Reporting is subject to the general reporting penalty provisions under section 6721 (failure to file correct information returns) and section 6722 (failure to furnish correct payee statement). The penalty for failure to file an IRS return or provide individuals statements is up to $280 per return ($560 per employee) with a calendar year maximum penalty up to $3,426,000.

W-2 Reporting

Employers providing applicable employer-sponsored group health plan coverage are required to report the aggregate cost of applicable employer-sponsored group health plan coverage on Form W-2. Employers who issued fewer than 250 Form W-2s in the preceding calendar year are not subject to the reporting requirement until further guidance is issued.

Section 1557 Nondiscrimination

Section 1557 of the Affordable Care Act (ACA) prohibits covered entities from discriminating in health programs on the basis of race, color, national origin, age, disability or sex.

These rules apply to "covered entities," which are broadly defined to include certain health programs or activities that receive federal financial assistance from the Department of Health & Human Services (HHS). Under this definition, most insurance carriers and health care providers are covered entities, and the rules apply not only to all operations of these entities (including third-party administrative services), but also to the group health plans sponsored by these entities. Other employer group health plans will generally be treated as covered entities only if the employer/plan receives federal financial assistance from HHS (for example, this could include employers who receive the retiree drug subsidy and employers who sponsor a self- insured employer group waiver plan (EGWP) for retirees).

In final regulations issued in 2016, HHS interpreted the definition of "sex" to include sexual orientation and gender identity. As a result, many group health plans that are covered entities adjusted their provisions addressing gender reassignment and treatment of gender dysphoria. The final regulations also require covered entities to post nondiscrimination notices in "significant" communications targeted to participants and beneficiaries (for health care employers this also means patients) and "taglines" to alert individuals with limited English proficiency of the availability of language assistance services.

The taglines are short statements written in non-English languages and must be posted in at least the top 15 non- English languages spoken in a relevant state or states. HHS has provided a model notice as well as taglines.

In 2019, a federal court determined the final regulations, including the provision defining sex to include sexual orientation and gender identity, were overbroad and vacated certain portions of the regulations. Subsequently, in June 2020, HHS issued amended regulations to remove sexual orientation and gender identity from the definition of covered classes. The amended regulations also eliminated the requirements regarding taglines. However, shortly before the amended regulations were to become effective, a federal court blocked HHS from enforcing the provisions of the amended regulations that removed gender identity and sexual orientation from the protections. Litigation regarding Section 1557 is ongoing and employers that are covered entities should consult with counsel to determine their obligations under Section 1557 in the meantime.

Consolidated Omnibus Budget and Reconciliation Act (COBRA)

COBRA generally requires all group health plans to provide covered employees and dependents an opportunity to continue coverage under the plan when such coverage would be lost (under the terms of the plan) as a result of a particular event (which are specified in the statute). COBRA imposes a variety of notice requirements on group health plans.

General Notice

Group health plans must give each employee and each spouse of an employee who becomes covered under the plan a general notice describing COBRA rights. The general notice must be provided within the first 90 days of coverage. Group health plans can satisfy this requirement by furnishing the notice to employees and spouses, or by including the general notice in the plan's Summary Plan Description (SPD) (provided the SPD is distributed to both the employee and the spouse within this time limit). The Department of Labor (DOL) updated its model COBRA general notice in May 2020 to include information regarding the interaction between Medicare and COBRA coverage.*

Election Notice

Group health plans must also send a COBRA election notice to qualified beneficiaries following a qualifying event. For certain qualifying events (termination of employment, reduction of hours and death of an employee), the employer has 30 days to notify the plan administrator and the plan administrator has 14 days to send the notice to qualified beneficiaries (44 days if the employer is also the plan administrator**). For other qualifying events (divorce, legal separation and a child ceasing to be eligible), the covered employee or other qualified beneficiary has 60 days to notify the plan administrator, and the plan administrator has 14 days to send the notice.**

The DOL updated its model COBRA election notice in May 2020 to include information regarding the interaction between Medicare and COBRA coverage.*

** While the DOL does not enforce COBRA against governmental employers, the agency that does so (HHS) has not made model notices available. Governmental employers may find the DOL model notices helpful when developing their own notices.*

*** The plan administrator is not the same as the COBRA administrator*

Notice of Unavailability

Group health plans must send a notice of unavailability of COBRA coverage if the plan administrator determines that an individual is not eligible for COBRA coverage. This notice must be furnished within 14 days of the administrator's receipt of the coverage election notice furnished by the covered employee or other qualified beneficiary for qualifying events that include divorce, legal separation or a child ceasing to be eligible.

Notice of Early Termination

Group health plans must send a notice of early termination of COBRA coverage to qualified beneficiaries if COBRA coverage terminates earlier than the maximum period of coverage. The notice must be provided by the plan or COBRA administrator as soon as practicable after the decision to terminate COBRA coverage is made.

COBRA Notice of Insufficient Payment

If a COBRA premium payment is insufficient by an "insignificant amount," a notice must be provided of the insufficient payment. (In addition, a reasonable period of time, such as 30 days, must be given to pay the insufficient amount.)

Health Insurance Portability and Accountability Act (HIPAA)

Special Enrollment Rights

Special enrollment is available under group health plans (other than excepted benefits) in the following situations:

- A loss of eligibility for group health coverage or health insurance coverage;
- The acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption; and
- Becoming eligible or ceasing to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage and/or for Medicaid or CHIP premium assistance subsidies.

Plans must notify eligible employees of their special enrollment rights upon their initial eligibility to enroll in the plan.

Governmental plans were previously allowed to opt-out of complying with HIPAA special enrollment (and other HIPAA portability) requirements. The ability to opt out was eliminated by the Affordable Care Act (ACA).

Privacy and Security Requirements

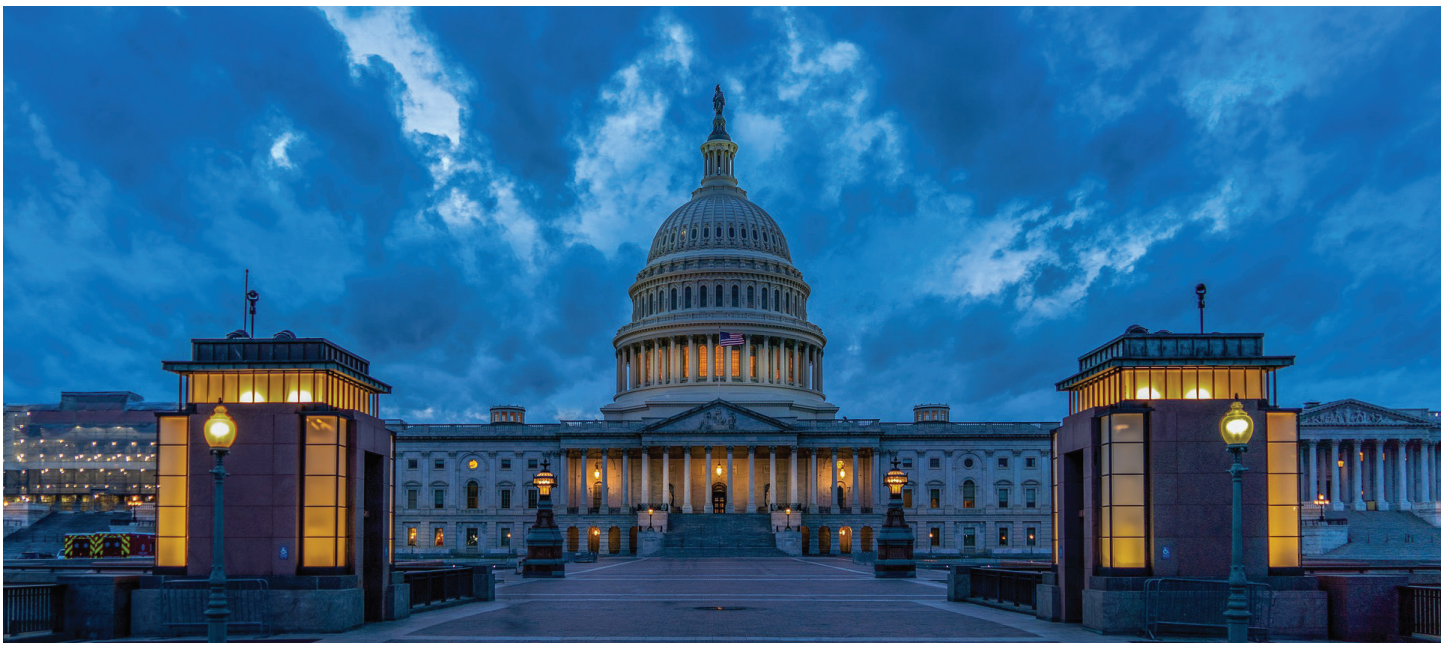
Covered entities and business associates must create and implement policies and procedures to comply with the security rule's standards, implementation specifications and other requirements. Policies and procedures may be changed at any time, but the changes must be documented.

Notice of Privacy Practices

A HIPAA Notice of Privacy Practices must be provided to participants and beneficiaries upon enrollment and when there are material changes to the notice, generally within 60 days of the material change. Every three years, the notice must be re-issued, or participants must be notified that a Notice of Privacy Practices is available and how to obtain it.

Nondiscrimination Requirements

Group health plans (other than excepted benefits) may not discriminate with respect to eligibility, benefits and contributions on the basis of health status-related factors.



Other Laws

Children's Health Insurance Program Reauthorization Act (CHIPRA)

Since 2009, special enrollment rights to immediately enroll in an employer's health plan arise if an individual becomes eligible for a state premium assistance subsidy under Medicaid or CHIP. The subsidy helps low-income individuals pay for employer coverage, transferring them from government-sponsored health programs to employer health plans. CHIPRA imposes a notice requirement on employers who maintain health plans with participants residing in one of the states providing a premium assistance subsidy. The notice must be provided annually to all employees residing in each premium assistance subsidy state, including employees not enrolled in the plan. Model notice language, which is periodically updated, is available on the DOL website and includes contact information for each state offering a premium assistance subsidy. Before distributing the notice each year, you should check the DOL website for any updates to the model. (The DOL typically updates the notice each January 31 and July 31.)

Mental Health and Substance Abuse Parity

The Mental Health Parity Act of 1996 prohibits group health plans from having lower annual or aggregate lifetime dollar limits for mental health benefits than for medical/surgical benefits. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 broadened the "parity" requirements by making them applicable to substance use disorder benefits and by mandating parity for financial requirements and treatment limitations. Prior to December 29, 2022, self-insured governmental plans were able to opt out of complying with this law. Existing elections in effect on that date will remain in place, but cannot be renewed.

For plans that have not opted out, the plan generally may not impose a financial requirement (deductible, copay, etc.) or quantitative treatment limitation to a mental health/substance abuse classification that is more restrictive than the predominant requirement or limitation applied to substantially all medical/surgical benefits in the same classification.

Plans must be tested for compliance with the parity law. While not required to be done annually, it should be done when there is a change to plan design (e.g., to a cost sharing or utilization management provision) that affects a financial or treatment limitation within a defined classification or sub- classification. Plans also may not impose nonquantitative treatment limits (NQTLs) for mental health/substance abuse benefits unless certain conditions are met. Beginning February 10, 2021, group health plans must complete a comparative analysis that demonstrates that the processes, strategies, evidentiary standards or other factors used to apply any NQTL to the plan's mental health and substance use disorder benefits are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards and other factors used to apply NQTLs to medical or surgical benefits. These comparative analyses must be provided to the HHS upon request.

Michelle's Law

Michelle's Law requires group health plans to continue coverage for dependent college students who take a medically necessary leave of absence or switch to part-time student status due to a serious illness or injury. The leave must be medically necessary, begin while the child is suffering from illness or injury and cause the child to lose coverage. Coverage must extend for one year after the first day of leave. This requirement applies only if a group health plan requires student status for children age 26 or older.

Since the ACA requires coverage for all dependent children up to age 26, regardless of student status, Michelle's Law typically no longer impacts group health plans. Self-insured governmental plans may opt-out of complying with this law.

Newborns' and Mothers' Health Protection Act

The Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.

However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier. The Act specifies a notice that must be included in the plan document verbatim. Self-insured governmental plans may opt out of complying with this law.

Women's Health and Cancer Rights Act (WHCRA)

WHCRA requires group health plans to cover reconstructive surgery following a mastectomy. Notices about this law must be provided upon enrollment and annually thereafter. Self-insured governmental plans may opt out of complying with this law.

National Medical Support Notices (NMSNs)

Under the NMSN rules, when a plan administrator determines the NMSN was appropriately completed it must notify the employee, child and custodial parent that coverage is or will become available and furnish the custodial parent a description of the coverage available and the effective date of the coverage. This includes, if not already provided, a summary plan description (or similar document used by a governmental plan) and any forms, documents or information necessary to effectuate such coverage, as well as information necessary to submit claims for benefit.

No Surprises Act and Related Transparency Requirements

The No Surprises Act, which was passed as part of the Consolidated Appropriations Act, 2021, imposes various transparency and surprise medical billing requirements on group health plans. The No Surprises Act builds on the health plan transparency requirements contained in the Affordable Care Act, which were addressed in final regulations released in October 2020. These requirements are being implemented in stages over the next couple of years. The following is a list of key provisions by effective date:

- Effective for plan years beginning in 2022:
  - Surprise medical bill rules
  - Health plan ID card changes
  - Prohibition on gag clauses
  - Provider directory requirements
  - Continuity of care requirements
- Effective July 1, 2022:
  - Publicly available machine-readable file containing in-network provider rates for covered items and services and out-of-network allowed amounts
- Effective December 27, 2022:
  - Prescription drug cost reporting (first report covering 2020 and 2021 due by 12/27/22; future reports for a calendar year due by the following June 1)
- Effective for plan years beginning in 2023:
  - Requirement to make price comparison information available to participants
- Effective at a future date (after issuance of regulations):
  - Advance EOB requirements

Additional information regarding these requirements is available in our prior articles *Requirements for the Surprise Billing Under the No Surprises Act, Guidance on Health Plan Transparency Rules Delays Some Compliance Dates* and *Health Care Cost Transparency Reporting for Group Health Plans* and *Departments Issue Further FAQ Guidance on the No Surprises Act and Transparency in Coverage Final Rules.*

Medicare Requirements

Medicare Part D Creditable Coverage Notice

Employer-sponsored group health plans that provide prescription drug coverage must notify Medicare-eligible plan participants whether the plan's drug coverage is creditable or non- creditable. The notice must be provided to Medicare beneficiaries who are active employees and those who are retired, as well as Medicare beneficiaries who are covered as spouses or dependents under active or retiree coverage. The notice must be provided prior to the participant's effective date of coverage, prior to an individual's initial enrollment period in Part D*, by October 15 of each year, upon a change in creditable coverage status, and upon request.

**An annual notice to all participants by October 15 will satisfy this requirement.t.*

Plan Sponsor's Medicare Part D Creditable Coverage Disclosure

Online disclosure is due to Centers for Medicare and Medicaid Services (CMS) no later than 60 days after the beginning of the plan year. This requirement applies to sponsors of group health plans that provide prescription drug coverage to Medicare Part D eligible individuals.

Application for Retiree Drug Subsidy (RDS)

Plan sponsors must apply for the retiree drug subsidy annually by submitting a valid application and a valid retiree list to CMS no later than 90 days prior to the beginning of the plan year. (Requests for extension must be approved by CMS.)

Reconciliation for Retiree Drug Subsidy (RDS)

Plan sponsors must apply for the retiree drug subsidy annually by submitting a valid application and a valid retiree list to CMS no later than 90 days prior to the beginning of the plan year. (Requests for extension must be approved by CMS.)

Medicare Mandatory Reporting Requirements

Insurers, third-party administrators and administrators of self-insured and self-administered group health plans must collect specific information from plan participants and report this information to CMS.

Other Compliance Requirements

Compulsory Short-Term Disability

Laws require employers to provide coverage for non-work-related short-term disability benefits for employees in five states – California, Hawaii, New Jersey, New York and Rhode Island; and one U.S. territory - Puerto Rico. In some cases, providing this coverage is optional for governmental employers.

State Paid Family Leave Laws (PFL)

Many states have enacted laws and regulations which may impact group plans in their state. For example, several states, including New York, California, Connecticut, Massachusetts, New Jersey, Rhode Island and Washington, plus the District of Columbia provide job-protected, paid leave for various reasons including to bond with a new child, care for a loved one with a serious health condition or help relieve family pressures when someone is deployed on active military service.

In Connecticut, PFL contributions began in January 2021 with benefits commencing in 2022. Oregon and Colorado have each adopted legislation that will require covered employers to provide PFL beginning in 2023 and 2024, respectively.

Other states are in the process of considering similar legislation. Employers are therefore well advised to consult with legal counsel to ensure compliance with the various state specific laws which impact their operations.

In some cases, compliance with these requirements is optional for governmental employers.

Family and Medical Leave Act (FMLA)

FMLA entitles eligible employees of covered employers to take unpaid, job-protected leave for certain reasons. General employer requirements:

- Allow eligible employees to take up to 12 weeks of unpaid leave during a 12-month period for certain statutory reasons, or up to 26 weeks in a single 12-month period to care for a service member or an injured/ill veteran
- Continue the employee's group health benefits and any employer contributions while on leave
- Restore the employee to the same or equivalent job and reinstate benefits upon return from leave
- Not take any adverse action against an employee for taking FMLA leave
- Provide employees with:
  - A general notice about the FMLA (through a poster and/or an employee handbook upon hire);
  - An eligibility notice;
  - A rights and responsibilities notice; and
  - A designation notice.

Employers are responsible for designating any leave taken as FMLA leave and for notifying an employee of the designation. Note that additional state leave laws may apply.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

USERRA requires employers to provide certain re-employment and benefits rights to employees who take a leave of absence for service in the military. The maximum period of coverage under the election to continue employer-sponsored health care benefits while on active duty is 24 months. Upon completion of active duty, the employee is entitled to his/her most recent employment status, pay and benefits.

State Benefit Laws

Since governmental plans are not subject to ERISA, there is no general preemption of state law available to governmental plans. Depending on the state, state law might address what benefits may be provided, to whom they may be provided and in what form. In addition, some states have special continuation coverage requirements that apply to governmental employers. State law may also regulate self-insured plans sponsored by governmental employers and may include limits or restrictions on the ability to self- insure, have filing and reporting requirements, and include other benefit mandates, etc.

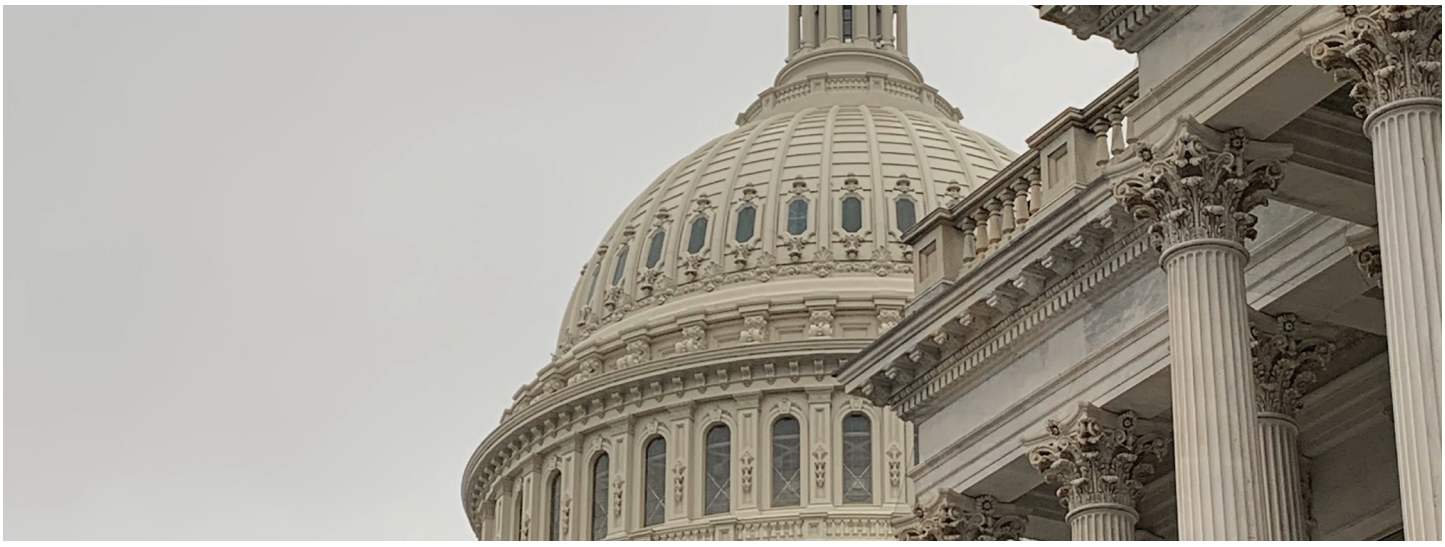
Electronic Distribution Rules

Unlike ERISA plans where a general set of applicable rules exist regarding electronic distribution of required documents and notices, there is no general rule of applicability regarding electronic distribution for governmental plans. Certain laws that require governmental plans to distribute certain notices/ documents have rules regarding the electronic distribution of those documents (e.g., Summaries of Benefits and Coverage (SBCs), HIPAA Notices of Privacy Practices, etc.). When no specific requirements apply to a document, a governmental plan might choose to follow the DOL's general regulations regarding electronic distribution (based upon the theory that HHS likely would not find a violation where the general DOL regulations on electronic distribution are followed). However, specific legal advice should be obtained before doing so.

Plan Documentation Requirements

Governmental plans are not subject to ERISA. Therefore, the ERISA written plan document, Summary Plan Description (SPD) and Summary of Material Modification (SMM) requirements are not applicable to governmental plans.* However, plan sponsors may still be required to adopt similar documents to be compliant with other laws and regulations, including rules under the Internal Revenue Code and/or state law. Even if there are no specific statutory/regulatory requirements for a plan sponsor to adopt a written plan document and/or communicate plan-related information to plan participants, there may be other reasons for governmental entities to adopt plan documents and distribute SPD and SMM-like documents to plan participants, including practical, contractual and legal considerations. Governmental entities sponsoring a health and welfare benefit plan should work with their legal counsel to determine what documentation, if any, is needed or desired for their health and welfare benefit plans.

**Similarly, governmental plans exempt under ERISA need not file a Form 5500 or distribute Summary Annual Reports (SARs) to plan participants. Therefore, sponsors of governmental plans choosing to adopt ERISA-like documentation need not file a Form 5500 or distribute SARs to plan participants.*



Internal Revenue Code – General Requirements

Cafeteria Plans

In order to enable employees to make pre-tax salary reduction contributions for health and welfare benefits, an employer must establish a Section 125 plan (a/k/a a cafeteria plan). The terms of a cafeteria plan must be set forth in a written plan document. Participants must make elections prior to the first day of the plan year. If the cafeteria plan document allows, mid-year election changes can be made in accordance with IRS regulations.

Self-Insured Group Health Plans

The terms of a self-insured group health plan must be set forth in a written plan document as required under IRS regulations.

Flexible Spending Account (FSA)

The Internal Revenue Code defines eligible FSA expenses and annual maximums (employers can set lower maximums). The maximum salary reduction contribution to a health care FSA for plan years beginning in 2022 is $2,850. The limit for plan years beginning in 2023 is $3,050. The maximum annual tax exclusion for dependent care FSA benefits is typically $5,000 per household.

Health care FSA plans may allow participants to carry over up to $570 in unused funds to the plan year beginning in 2023. A health care FSA plan can include the carryover provision or up to an 2½ month grace period, but cannot include both provisions.

Domestic Partner Benefits – Imputed Income

The general rules for excluding from income the value of health care benefits provided for employees, their legal spouses and their dependent children generally do not apply to domestic partners and their dependent children (unless they qualify as the employee's tax dependent – which is rare).

The value of coverage for a domestic partner and his or her children may be subject to federal, FICA, state, local and any other applicable payroll taxes.

NOTE: The June 2015 Supreme Court ruling in Obergefell v. Hodges requires all states to license and recognize same-sex marriages. As a result, employers no longer need to impute federal or state income tax on benefits for same-sex spouses. However, imputed income still applies to domestic partners who are not legally married, unless the domestic partner is a tax dependent.

Heroes Earnings Assistance & Relief Tax Act

Cafeteria plans may permit distribution of unused health care FSA account balances when reservists are called to active duty for 180 days or more.

Life Insurance Plans

IRC Section 79 requires employers to impute income for the fair-market value of employer-sponsored group-term life insurance benefits in excess of $50,000. Voluntary/ Supplemental life insurance rates that straddle Table I (which are found in Table 2-2 of IRS Publication 15-b) and/or supplemental life insurance that is paid for by the employee on a pre-tax basis may also be subject to imputed income.

Disability Plans

If the cost of coverage under a disability plan is fully or partially subsidized by the employer without imputing income to the employee for the cost of such coverage,or the disability plan is paid for by employees on a pre-tax basis, upon disability of the employee, the disability payments made under the plan to the employee will be subject to federal/state income taxation (in proportion to the employer subsidy or pre-tax share).

Nondiscrimination Requirements Section 125* – Cafeteria Plans

Cafeteria plans (that allow employees the ability to contribute to benefits on a pre-tax basis) sponsored by governmental employers are subject to two nondiscrimination tests: Eligibility Test and Benefits and Contributions Test. The nondiscrimination tests are designed to prevent the plan from favoring highly compensated employees to an impermissible degree. The tests apply with respect to any health and welfare benefits offered by the employer to which employees make pre-tax, salary reduction contributions.In some cases, benefits offered through a Section 125 plan are also subject to separate nondiscrimination requirements under the tax code provision that applies to that specific benefit as further discussed below.

**Cafeteria plan regulations are proposed; final regulations are pending.*

Section 105(h) – Self-Funded Health Plans

Self-funded health plans (including health care FSAs and HRAs) are subject to two nondiscrimination tests: Eligibility Test and Benefits Test. Per the Affordable Care Act (ACA), this testing was to also apply to fully insured plans. However, the compliance date has been delayed until regulations or other guidance is issued and it appears the IRS has no plans to do so for the foreseeable future.

Section 129 – Dependent Care Assistance Plans

Dependent care assistance plans (including dependent care FSAs) sponsored by governmental employers are subject to three nondiscrimination tests: Eligibility Test, Benefits Test and 55% Average Benefits Test.

NOTE: Until further guidance is issued, it is advisable that most nondiscrimination tests be performed at least annually* and that the 55% Average Benefits Test under Section 129 be performed as early in the year as possible in case adjustments are necessary for highly compensated employees

**IRS regulations do not specify when or how often nondiscrimination testing should be performed.*

Wellness Program Requirements

HIPAA Wellness Requirements

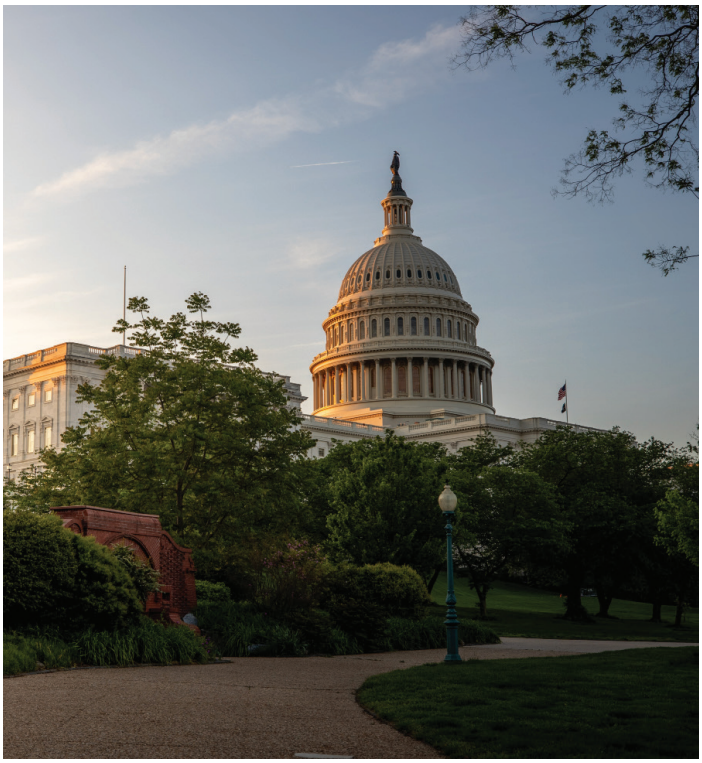
Wellness programs that require individuals to meet a standard related to a health factor (activity-based or outcome-based) in order to obtain a reward or avoid a penalty under a group health plan are subject to a variety of requirements under HIPAA, including limits on the amount of reward/penalty, requirements regarding earning the reward/avoiding the penalty through alternative means and certain notice requirements.

Americans with Disabilities Act (ADA)

Employers who offer wellness programs that collect employee health information (e.g., via health risk assessments, biometric screenings) in exchange for an incentive must comply with certain requirements to ensure the wellness program is voluntary. Key requirements include a limitation on the amount of incentive that may be provided and a requirement to provide a notice to employees informing them of what information will be collected, how it will be used, who will receive it and what will be done to keep it confidential. The EEOC has issued a sample notice. A federal court ordered a portion of the ADA wellness rules (specifically the portion addressing the maximum size of the incentive that may be provided under a program subject to the ADA) to be vacated as of January 1, 2019.

The EEOC is in the process of developing new regulations. In the interim, it appears the notice portion of the rules continues to apply but it is unclear what size incentive can be provided.

Employers with wellness programs that collect medical information should consult with counsel to discuss compliance with the ADA.



Genetic Information Nondiscrimination Act (GINA)

GINA restricts the ability of health plans (including wellness programs that are part of or tied to health plans) and employers to collect and use genetic information, including family health histories (which generally includes information about a spouse or child's health conditions).

Regulation issued under GINA Title II allowed limited collection of information about a spouse's current health conditions as part of a wellness program, but that portion of the regulation was vacated along with parts of the ADA wellness regulations and the regulations under GINA Title I do not specifically allow the collection of information about a spouse's current health conditions.

Employers with wellness programs that include health risk assessments should consult with counsel to discuss compliance with GINA.

General Notice Timeline

Generally, all new employees should receive:

- CHIPRA Notice
- Notice of Exchange

Notices eligible employees should receive when enrollment is offered or upon enrollment:

- COBRA General Notice (Spouse must also receive)
- HIPAA Notice of Privacy Practices
- HIPAA Notice of Special Enrollment Rights
- Medicare Part D Creditable Coverage or Non-Creditable Coverage
- Summary of Benefits and Coverage
- Summary Plan Description (SPD)
- Women's Health and Cancer Rights Act (WHCRA) Enrollment Notice

Notices participants should receive on an annual basis:

- HIPAA Notice of Privacy Practices (once every 3 years)
- Medicare Part D Creditable Coverage or Non-Creditable Coverage
- Summary of Benefits and Coverage
- SPD or Summary of Material Modification
- Summary Annual Report (SAR) for ERISA plans subject to filing Form 5500 (e.g., plans with 100 or more participants on the first day of the plan year and plans funded through at trust)
- Women's Health and Cancer Rights Act (WHCRA)
- Other potential notice requirements:
  - Patient Protection Disclosure (with SPD or similar benefit description)
  - Notice of Grandfathered Status (with materials describing benefits)
  - Wellness Program Disclosure (in all materials describing terms of wellness program and/or before collection of medical information)

Notices that all employees should receive on an annual basis:

- CHIPRA Notice

Potential notices a terminated employee may receive:

- COBRA Election Notice
- Conversion/Portability Notice (fully-insured benefits)

Other:

- Balance Billing Notice (must be posted on a public website and provided with any Explanation of Benefits issued with respect to an item or service to which the surprise medical bill requirements apply)

General Reporting Requirements:

- W-2 Reporting i.e. aggregate cost of employer sponsored coverage, imputed income for life insurance, imputed income for domestic partner coverage, dependent care assistance benefits
- Medicare Part D Creditable/Non-creditable Coverage Disclosure Notice to CMS
- Section 6055 and 6056 reporting
- PCORI Fee
  - Medical plans that are self-funded (if fully insured the carrier reports and pays)
  - Self-funded prescription drug plans
  - Some dental or vision plans
  - Health Reimbursement Arrangements (HRAs) (Special Rules)
  - Retiree-only health plans
  - Some FSAs

Due Dates and Links

Benefit Notice	Due Date	Link
ACA		
Summary of Benefits and Coverage (SBC)	With open enrollment materials (or at least 30 days prior to the start of the plan year if enrollment is automatic), with initial application materials (or if the plan does not distribute written application materials for enrollment, no later than the first date on which the participant is eligible to enroll in coverage), within 90 days of special enrollment, no later than 7 business days following a request	Model SBCs and instructions, as well as final regulatory guidance, are available on the CMS's website at: SBC's and Instructions Link
Marketplace (Public Exchange) Notice	Within 14 days of date of hire	If you offer a health plan: Marketplace Notice If you do not offer a health plan: Marketplace Notice
Grandfathered Health Plan Disclosure – Grandfathered Health Plans Only	In any materials describing benefits available under the plan.	Model notice is available on the DOL's website: Grandfathered Health Plan Disclosure Link
Patient Protection Disclosure – Non-Grandfathered Health Plans Only	Whenever a SPD or similar description of benefits is distributed (only applies HMO/POS)	Patient Protection Model Notice
Internal Appeals and External Review Requirements – Non-Grandfathered Health Plans Only	Language required in SPD	Model notice is available on the CMS's website: Internal Appeals and External Review Requirements Link
COBRA		
General Notice	Within the first 90 Days of Coverage	Click on "COBRA Model General Notice" General Notice Link
Election Notice	Employer has 30 days to notify the plan administrator and the administrator has 14 days to send the notice (44 days total if the employer is also the administrator)	Click on "COBRA Model Election Notice" Election Notice Link

Benefit Notice	Due Date	Link
HIPAA Notices		
HIPAA Notice of Special Enrollment Rights	At or before initial enrollment period	Notice of Special Enrollment Rights can be found here. (page 138)
Notice of Privacy Practices	Upon Enrollment and within 60 days of material change, every 3 years participants must be provided a new notice or notified that a notice of privacy practices is available	Notice of Privacy Practices Link
Other Law Notices		
Children's Health Insurance Program Reauthorization Act (CHIPRA)	At enrollment and annually	CHIP Model Notice - United States Department of Labor
Newborns' and Mothers' Health Protection Act	Must be included in the plan document	Newborns' and Mothers' Health Protection Act Link (page 140)
Women's Health and Cancer Rights Act (WHCRA) Notices	At enrollment and annually	WHCRA Model Notices can be found here. (page 141)
No Surprises Act (NSA)	Group health plans and health insurance issuers must post notice on plan website and include notice of rights and protections on EOBs	Balance Billing Model Notice
Medicare Notices		
Medicare Part D Notice of Creditable (or Non-Creditable) Coverage	Prior to October 15 each year, prior to an individual's initial enrollment period in Part D, prior to an individual's effective date of coverage under the employer's plan, upon change in creditable coverage status and upon request.	Model Notice for Creditable Coverage Link Model Notice for Non-Creditable Coverage Link
Wellness Notices		
EEOC notice	At enrollment and annually if applicable	EEOC Notice Link

How Brown & Brown Can Help

Connect with your Brown & Brown service team to learn more about how we can help find solutions to fit your unique needs.

Brown & Brown

Find Your Solution at BBrown.com

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