2022 End of Year Health and Welfare Compliance Checklist

2022 has seen many changes in the health and welfare landscape, and the year is quickly coming to an end. As employers try to wrap up their year-end To-Do List, make sure that these health and welfare plan items are considered. Keep in mind that this is not intended to be an all-inclusive compliance checklist but an overview of common-sense things that need to be reviewed. If you have questions about any of these topics or would like to have a more complete compliance audit, please discuss this with your Alera Group Employee Benefits Team.

Ongoing COVID-19 Public Health Emergency (PHE) Means Ongoing Coverage Mandates

On October 13, 2022, President Biden continued the PHE an additional 90 days, making its effective date last through mid-January 2023, absent another 90-day extension. The President also said that the Secretary of Health and Human Services will provide at least 60-days' notice before the end of the PHE.

For employers sponsoring group health plans, the PHE primarily mandates COVID-19 diagnostic testing and preventive services. During the PHE, all group health plans, and health insurance issuers must cover a broad range of testing and certain other items or services intended to diagnose COVID-19 without cost sharing (deductibles, copays, or coinsurance), prior authorization, or other medical management requirements. In January of 2022, the mandate was expanded to include at-home over the counter COVID-19 tests, limiting a participant to no fewer than eight (8) tests per month.

For non-grandfathered group health plans, these mandates are a permanent part of the ACA market reforms. Grandfathered plans may choose to impose cost sharing and other utilization tools after the PHE ends and doing so will not impact their grandfathered status.

Ongoing COVID-19 National Emergency Means Ongoing Extension of Certain Deadlines

On March 13, 2020, President Trump signed the Proclamation on Declaring a National Emergency Concerning the Coronavirus Disease 2019 (COVID-19) Outbreak (COVID-19 National Emergency). President Biden extended the COVID-19 National Emergency on February 24, 2021, and again on February 18, 2022.

This extension impacts health and welfare benefit plan sponsors by extending certain deadlines to the lesser of one year after the event would normally occur or 60 days after the end of the COVID-19 National Emergency. This extension impacts the following:

COBRA

- Extends time for employees to notify employers of a qualifying event or a disability extension
- Extends the length of time employees have to elect COBRA coverage
- Extends the grace period employees have to pay their COBRA premium
- Extends the time employers have to provide the required Election Notice to a qualified beneficiary

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FLEXIBLE SPENDING ACCOUNTS

- Extends the length of time for a participant to file a claim
- Extends the deadline for appealing a claim and requesting an external review of a claim

MID-YEAR ELECTIONS

- Extends the length of time employees have to notify employers of HIPAA special enrollment events. As a reminder, mid-year enrollment changes must be made on a prospective basis unless the event is the birth or adoption of a child.

New Rules to Eliminate the Affordable Care Act's "Family Glitch"

- Employers should be prepared for some employees to drop family coverage effective January 1, 2023, due to their family now being eligible for subsidies through their state Exchange or Marketplace.
- Employers will need to decide if they want to amend their Section 125 Plans to allow a new Qualified Life Event (QLE) that allows employees to change their family coverage during the middle of a plan year if the family becomes eligible for a subsidy through their state Healthcare Exchange. Remember that 125 plan documents do not have to be shared with plan participants, but practically speaking, employees should be notified of any changes that impact them. This information can be shared in any way the employer feels is effective.

Changes In Employer Size

As employers expand or contract, different health and welfare plans apply. Many of those rules are based on the number of employees a company had in the prior calendar year, so now is the time to do a review. Remember as well that controlled groups must consider the number of employees of their companies within the controlled group. These laws apply to groups that have the following employee counts:

15 or More Employees the Americans with Disability Act (ADA), the Age Discrimination in Employment Act (ADEA), Pregnancy Discrimination Act, Genetic Information Nondiscrimination Act (GINA) and Title VII of the Civil Rights Act.
20 or More Employees COBRA and the Medicare Secondary Payer (MSP) Rules
50 or More Employees Family & Medical Leave Act (FMLA), Mental Health Parity Act/Mental Health Parity & Addiction Equity Act (MHPAEA) and the ACA Employer Responsibility rules (including penalties if Form 1095 is not distributed to employees and Form 1094 is not submitted to the IRS)
100 or More Employees Department of Labor requirements to submit Form 5500 apply to health & welfare plans that have 100 or more employees enrolled on the first day of the plan year
250 or More Form W-2's Employers that issue 250 or more Form W-2's must include the total value of the health plan on the Form W-2 in box 10 with code DD.

Imputed Income on Life Insurance and Domestic Partners

- The IRS considers the value of group term life insurance in excess of $50,000 as income to an employee, and imputed income must be calculated and paid for amounts over $50,000 (common with 1x or 2x salary plan designs). If dependent life insurance exceeds $2,000, then taxes are due on the entire amount of the dependent life coverage.

- If a domestic partner is not an employee's tax dependent under Internal Revenue Code § 105(b), the value of the domestic partner's health coverage must be treated as income, reported on the employee's W-2, and subject to withholding taxes, including Federal Insurance Contributions Act (FICA) and Federal Unemployment Tax Act (FUTA).

Section 125 Plan Nondiscrimination Testing

All employers offering benefits on a pre-tax basis must do so through a Section 125 plan. Section 125 requires nondiscrimination testing be performed by the last day of the plan year. If the plan fails, then highly compensated employees and employers will need to pay additional payroll and income-based taxes.

Self-Funded Plans and Section 105(h) Nondiscrimination Testing

Self-Funded Plans, including level funded plans and health reimbursement arrangements (HRAs), are required to perform Section 105(h) nondiscrimination tests. Plans must pass both an eligibility and benefits test to ensure that the program does not favor highly compensated individuals.

Self-Funded Medical Plans and Plan Updates

Guidance was released by the Department of Health & Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) on several items that employers with self-funded health plans should take note of. Health plans that provide coverage for the following items should make sure that they are compliant:

- Hearing aids cannot have age limitations
- Autism Spectrum Disorder (ASD) cannot have age limitations
- Foot care coverage whether for diabetes or routine care cannot have age limitations
- Tiering of prescription drug coverage for chronic conditions must be based on neutral principals and cannot place all drugs for certain expensive chronic conditions in "specialty tiers"

Update and Distribute Plan Documents

Plan Documents, SPD's and Wrap Documents may need to be updated due to changes in the health and welfare program. Remember to get these important documents updated or create Summaries of Material Modification (SMMs) and distribute them to all plan participants. Do not forget to send them to retirees, COBRA enrollees, and COBRA qualified beneficiaries that are still in their extended enrollment period.

CMS Reporting

Medical plans must report to CMS whether their prescription drug plan is creditable or non-creditable within 60 days of the start of the plan year. For employers with calendar year plans, the deadline is March 2, 2023.

ACA Reporting

- Applicable Large Employers (ALEs) should be planning to get their Form 1095's created, reviewed and ready to distribute to employees prior to the deadline of March 2, 2023.
- The deadline to submit paper copies of Form 1094 to the IRS is February 28, 2023.
- The deadline to electronically submit Form 1094 to the IRS is March 31, 2023.
- Remember that the IRS no longer provides "good faith effort" penalty relief. It is vital that these forms be accurate and distributed/filed on a timely basis.

Pharmacy Data Collection (RxDC) Reporting

- By December 27, 2022, health plans must report information through CMS' Health Insurance Oversight System (HIOS) regarding pharmacy utilization during the 2020 and 2021 calendar years. By June 1, 2023, health plans must post the same pharmacy utilization information for the 2022 calendar year.
- For fully insured plans, generally the insurance carrier will be doing the reporting. Some carriers require employers to sign a release for their information to be included in the reporting.
  - Employers sponsoring fully insured health plans should consult with their carrier to ensure their reporting is being handled appropriately.
- With self-funded or level funded plans, the Third-Party Administrator (TPA) or Pharmacy Benefit Manager (PBM) will often be reporting the information, or some of the information. Some TPAs/PBMs are charging their clients for the reporting as the cost may not have been included in the prior administrative agreement. A small number of TPAs/PBMs will not be reporting but will provide information to the client to report.
  - Employers sponsoring self-funded health plans should check with every TPA and PBM they work with to see if the employer is responsible for submitting some or all of the data on their behalf.
- Employers should ensure that the reporting is being done for each calendar year.

Nonquantitative Treatment Limits (NQTL) Testing

- The Department of Labor (DOL) is emphasizing that Health Plans perform required NQTL testing. In 2021, the DOL issued new requirements to ensure that Mental Health and Substance Use Disorders have the same nonquantitative treatment limits as Medical/Surgical benefits.
- If requested by the DOL, another Federal/State agency, or a plan participant, the testing results need to be provided within 30 days. Employers need to verify that the test results are available.
  - Fully insured plans can normally get the test results from their insurance carriers.
  - Self-funded or level funded plans should work with their plan administrator or an outside vendor to ensure the testing is completed.
  - This analysis takes time so beginning the process in early 2023 will help ensure future success in the event of a DOL request.

As mentioned before, this is not an all-inclusive compliance checklist. It is intended as a reminder of key things for employers to review. If you have questions about any of these topics or would like to have a more complete compliance audit, please discuss this with your Alera Group Employee Benefits team.

Employers that get these things done early can start the new year with less stress and a shorter To-Do list for 2023.

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