2023

End of Year Benefits Wrap-Up

Presented by Benefit Comply

Assurex Global Partners

- Bolton & Company
- C3 Risk & Insurance Services
- CCIG
- Christensen Group Insurance
- Cottingham & Butler
- Cragin & Pike, Inc.
- The Daniel & Henry Co.
- Dean & Draper Insurance Agency
- Henderson Brothers, Inc.
- The Horton Group
- Houchens Insurance Group
- The IMA Financial Group
- INSURICA
- Kapnick Insurance Group
- Lyons Companies
- The Mahoney Group
- MJ Insurance
- Oswald Companies
- Parker, Smith & Feek, Inc.
- The Partners Group
- R&R Insurance
- RHSB
- RCM&D
- The Rowley Agency
- Starkweather & Shepley
- Sterling Seacrest Pritchard
- WA Group
- Watkins Insurance Group
- Woodruff Sawyer
- York International

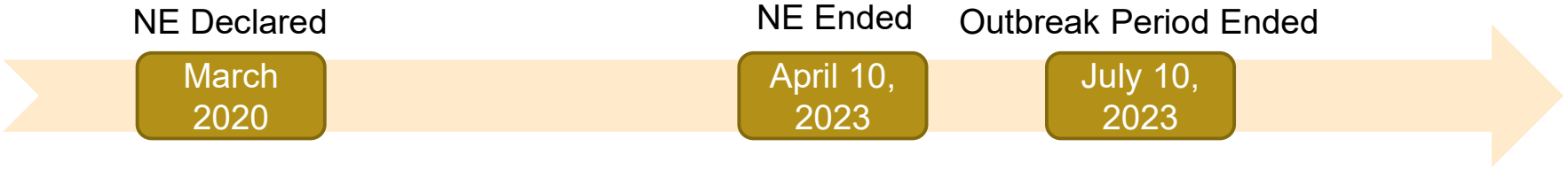
Agenda

- 2023 Review
  - End of Public Health Emergency and National Health Emergency
  - Adjustments to Annual Limits, Fees, and Penalties
  - Affordability % Change for 2024
  - Family Coverage Affordability
  - Mental Health Parity
- Health Cost Transparency Review and Update
  - Gag Clause Attestation
  - Other Development
- Things to Watch for in 2023 and 2024
  - Employer Reporting and IRS Electronic Filing for Small Businesses
  - Tax Treatment of Indemnity Plans
  - Telehealth and HSA Eligibility
  - Proposed HSA Legislation

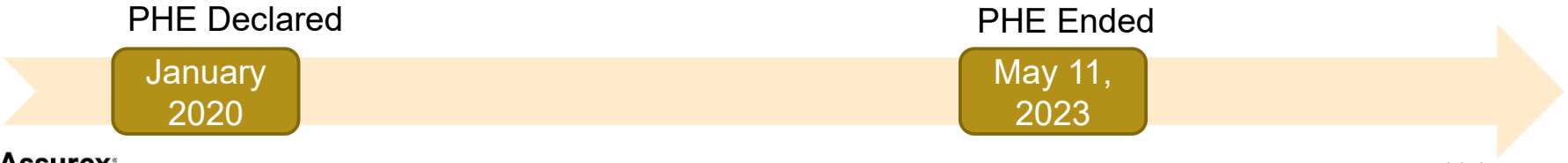
2023 Review

National Emergency & Public Health Emergency

- National Emergency (NE)
  - First Declared by President Trump March 2020 and renewed annually since then
  - Various benefit related deadlines suspended during Outbreak Period (NE + 60 days)

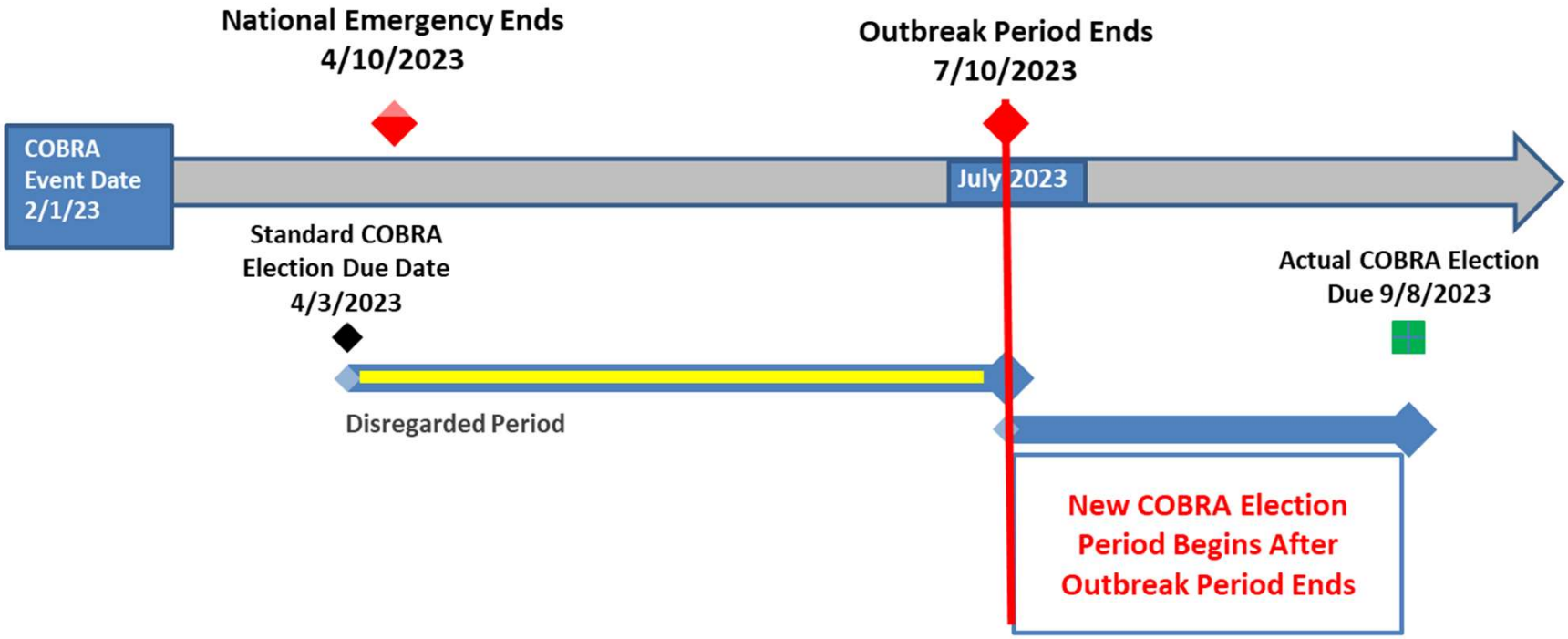


- Public Health Emergency (PHE)
  - Declared by Dept. of Health & Human Services Jan. 2020 & renewed every three months
  - Plan coverage for COVID vaccination and testing, stand-alone telehealth, Medicaid rules



End of National Emergency Example

- Outbreak Period Ended July 10th
  - Timelines for HIPAA Special Enrolment, COBRA Notices, and Claims Deadlines



Benefit Limits

Health Flexible Spending Acct (HFSAs)	2023 Limits	2024 Limits
Employer Salary Reduction Contribution	$3,050	$3,200
Employer Contributions	Greater of: • Matching contribution (up to $3,050); or • $500 (plus Employee's salary reduction contribution)	Greater of: • Matching contribution (up to $3,200); or • $500 (plus Employee's salary reduction contribution)
Maximum Carryover	$610	$640
HSA/HDHP	**2023 Limits**	**2024 Limits**
HSA Self-Only Maximum Contribution	$3,850	$4,150
HSA Family Max Contribution	$7,750	$8,300
Catch-Up Contribution (55 or older)	$1,000	$1,000
Minimum Self-Only HDHP Deductible	$1,500	$1,600
Minimum Family HDHP Deductible*	$3,000	$3,200
Maximum Self-Only HDHP OOP Limit	$7,500	$8,050
Maximum Family HDHP OOP Limit	$15,000	$16,100

**If the family HDHP plan design includes an embedded individual deductible, the embedded individual deductible must be at least the amount of the required minimum family deductible ($3,000 in 2023, $3,200 in 2024) to ensure that the HDHP does not begin paying before the minimum family deductible has been satisfied.*

Benefit Limits

Qualified Transportation Fringe Benefits	2023 Limits	2024 Limits
Parking (Monthly Limit Excludable from Income)	$300/month	$315/month
Transit Pass/Commuter Vehicle (Monthly Limit Excludable from Income)	$300/month	$315/month

Health Plan OOP Max	2023 Limits	2024 Limits
Max OOP for Self-Only Coverage	$9,100	$9,450
Max OOP for Family Coverage	$18,200	$18,900

Health Reimbursement Arrangements (HRAs)	2023 Limits	2024 Limits
Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) Maximum Benefit for Self-Only Coverage	$5,850	$6,150
Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) Maximum Benefit for Family Coverage	$11,800	$12,450
Excepted Benefit HRA Maximum Benefit	$1,950	$2,100

Benefit Fees & Penalties

PCORI Fee	2023 Amount	2024 Amount
Payable by July 31st	$2.79 per covered life for plan years ending in January 2022 – September 2022. $3.00 per covered life for plan years ending in October – December 2022.	$3.00 per covered life for plan years ending in January 2023 – September 2023 $3.22 per covered life for plan years ending in October – December 2023

Employer Shared Responsibility (§4980H)	2023 Amounts	2024 Amounts
4980H(a)	$2,880/year $240/month	$2,970/year $247.50/month
4980H(b)	$4,320/year $360/month	$4,460/year $371.67/month
Affordability Percentage	9.12%	8.39%
Federal Poverty Level for Single-Only Household (Mainland)	$13,590 (2022) for calendar year plans, $14,580 should be used for non-calendar year plans.	$14,580 (2023) for calendar year plans, TBD for non-calendar year plans.
Federal Poverty Level for Single-Only Household (Alaska)	$16,990 (2022) for calendar year plans, $18,210 for non-calendar year plans.	$18,210 (2023) calendar year plans, TBD for non-calendar year plans.
Federal Poverty Level for Single-Only Household (Hawaii)	$15,630 (2022) for calendar year plans, $16,770 for non-calendar year plans.	$16,770 (2023) for calendar year plans, for non-calendar year plans.

Health Plan Affordability

- Health Plan Affordability %
  - Reduced significantly for 2024

Affordability Percentages	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
	9.56%	9.66%	9.69%	9.56%	9.86%	9.78%	9.83%	9.61%	9.12%	**8.39%**

- Affordability matters for two reasons:
  1. Premium tax credit eligibility for coverage through the public Marketplace
  2. Applicable large employer (50 or more FTEs) compliance with §4980H(b)

Affordability Employer Safe Harbors

Federal Poverty Level (FPL) Safe Harbor

- Calendar year plans:
  - 2023= $103.28/mo. ($13,590 x 9.12% / 12)
  - 2024 = $101.93/mo. ($14,580 x 8.39% /12)

W-2 Safe Harbor

Employee Wages	2023 Form W-2	2024 Form W-2
	Amount that is affordable	
Box 1 Wages		
$20,000	$152.00	$139.83
$30,000	$228.00	$209.75
$40,000	$304.00	$279.67
$50,000	$380.00	$349.58

Rate of Pay Safe Harbor

Employee Wages	2023 Rate of Pay	2024 Rate of Pay
	Amount that is affordable	
HOURLY		
$8	$94.85	$87.26
$10	$118.56	$109.07
$12	$142.27	$130.88
$14	$165.98	$152.70
$16	$189.70	$174.51
$18	$213.41	$196.33
$20	$237.12	$218.14
SALARIED		
$1,500	$136.80	$125.85
$2,000	$182.40	$167.80
$2,500	$228.00	$209.75

Family Coverage Affordability

- IRS changed the definition of affordability for qualification for premium tax credits when purchasing individual coverage through the public Exchange

Old Affordability Rule – "The Family Glitch"

If employee contribution for employee-only (single) coverage was affordable (less than 8.39% of household income in 2024), the employee **AND all family members** were ineligible for subsidy when purchasing individual health insurance through the public Marketplace/Exchange

New Family Affordability Rule Effective 01/01/23

- Affordability for employee is still based on employee contribution for single coverage (8.39% in 2024)
- Affordability for family members is now based on **employee contribution for family coverage** 8.39% (2024)

Family Coverage Affordability

- Example
  - Assume a family household income of $120,000
  - 2024 coverage is unaffordable if employee contribution is greater than $839 mo. (8.39% of $10,000)

2024 Monthly EE Contribution Single = $250, Family = $850
• **Old Rule** - Affordable for employee and all family members • **New Rule** - Affordable for employee, **but not affordable for family members** - $850 is greater than $839

- **Important!**
  - Employers do not have to offer affordable family coverage and there is no employer penalty if family coverage is unaffordable

Family Affordability

- When is Family Contribution Unaffordable?

Monthly Employee Contribution for Family Coverage	$500.00	$750.00	$1,000.00
Unaffordable for Household Incomes Using 9.12% (2023)	$65,789.47	$98,684.21	$131,578.95
Unaffordable for Household Incomes Using 8.39% (2024)	**$71,513.71**	**$107,270.56**	**$143,027.41**

- Open Enrollment Season - When Might This Matter Most?
  - Many employers have fall open enrollment for a 12/1 or 1/1 plan year
  - Healthcare.gov 2023 open enrollment 11/1/23 – 1/15/24
    - Some state-run Exchanges may have different dates

Mental Health Parity

- Mental Health Parity Requirements Background
  - ✓ Plans that offer mental health or substance use disorder benefits must provide coverage for those benefits "in parity" with medical/surgical benefits
    - ✓ Quantitative parity (e.g., deductibles, co-pays, etc.)
    - ✓ Non-quantitative parity (e.g., second opinion rules, pre-authorizations, provider access)
  - ✓ Notices when mental health or substance use disorder claims are denied
  - ✓ Comparative analysis performed on any non-quantitative treatment limitations (NQTLs)

Mental Health Parity – Current Structure

Annual & Lifetime Limits

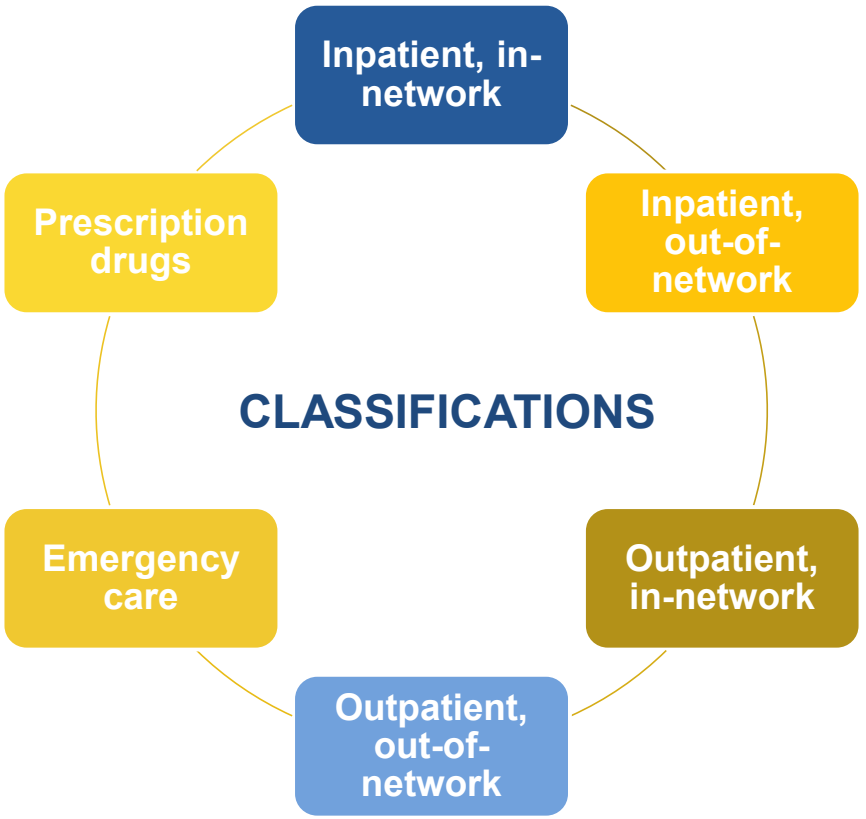
- Must be the same or more generous than for medical/surgical benefits

Financial Requirements & Quantitative Treatment Limitations

- Cannot be more restrictive than the predominant requirements or limitations that apply for substantially all (2/3) medical/surgical benefits

Non-Quantitative Treatment Limitations (NQTLs)

- Cannot impose processes, strategies, evidentiary standards or other factors that are more stringent than for medical/surgical benefits



Mental Health Parity

- New Proposed Rules Summary
  - New 3-part test applied to NQTLs including looking at outcomes data
    - Example of outcomes data – approval/denial rate for pre-auth compared to med/surg
  - Special rule for network composition
  - ERISA plans will require certification of a named fiduciary
  - Effective for plan years starting on or after 1/1/25

Mental Health Parity – Compliance Options

- Fully-Insured Group Health Plans
  - Carrier is directly responsible for compliance
  - Carrier is required to complete a written comparative analysis

- Self-Funded Group Health Plans
  - Employer as plan sponsor is directly responsible for compliance
    - TPA, PBM and other service providers may be co-fiduciaries and therefore share joint liability

- Self-Funded Group Health Plans
  - Review any financial requirements (e.g., copay, coinsurance, deductible) and quantitative treatment limitations (e.g., day or visit limits) applied to behavioral health coverage
  - Reach out to TPAs, PBMs and other service providers requesting information about efforts to comply, both in regard to plan design and claims processing
  - Confirm whether service provider will prepare a comparative analysis
    - If not, confirm whether service provider will provide necessary data for the analysis
    - Consider engaging 3rd party to prepare a comparative analysis

Health Cost Transparency Review and Update

Health Cost Transparency Timeline

2021

January 2021

Hospital Cost Reporting

No Gag Clauses

2022

January 2022

ID Card Updates

Provider Directory Accuracy

July 2022

Carriers & Plan Release Health Plan Cost Data Machine Readable Files

December 2022

RxDC Reporting

2023

January 2023

Price Transparency Tools - 500 Items & Services

June 2023

RxDC Reporting Round 2

December 2023

Gag Clause Attestation

2024

January 2024

Price Transparency Tools - All Items & Services

June 2024

RxDC Reporting Round 3

Delayed Until Additional Guidance Is Released

- Prescription Cost Data Machine Readable File
- Provider cost estimate & Advanced EOB

Gag Clause Prohibition

Effective in late 2020, group health plans and carriers prohibited from entering into agreements with service providers containing gag clauses

Required to attest to compliance for 2021 – 2023 by Dec. 31, 2023

Annual attestation required each year by Dec. 31

Gag Clause Attestation

- Gag Clause Attestations – Which Plans Must Comply?

- Applies to plans of all sizes, fully-insured and self-funded, and grandfathered
- Examples:
  - Group medical plans
  - Rx carve-outs (PBMs)
  - Behavioral health networks
  - Telemedicine
  - Direct primary care arrangements

- Does **NOT** apply to:
  - Excepted benefits (e.g., dental, vision, health FSA, EAP)
  - Retiree-only group health plans
  - Account-based plans (e.g., HRAs)

- Responsibility for Attestation
  - Fully-Insured Group Health Plans - Carriers likely to attest on behalf of the plan
  - Self-Funded Group Health Plans - TPAs and PBMs may be willing to attest on behalf of the plan, but otherwise the employer must handle the attestation
  - Other Group Health Plan Arrangements - Employer must attest for any service providers that will not attest on behalf of the plan

Other Transparency Developments

- Expansion of Health Cost Transparency Tools
  - On 1/1/2023, plans and carriers were required to provide a health cost estimator tool for 500 specific health services
  - On 1/1/2024, requirement is expanded to include all covered services
- RxDC Reporting Round 3 due by June 30, 2024

Coming Soon?

Provider Cost Estimate Requirement & Advanced EOBs…

Things to Watch for in 2024

Employer 1094 / 1095 Reporting

Employers Subject to Reporting

Applicable large employers (ALE)

50+ average monthly FTEs in the preceding calendar year

Required to report offer of coverage information for all employees who were full-time for at least one month

All employers offering self-funded group medical plans

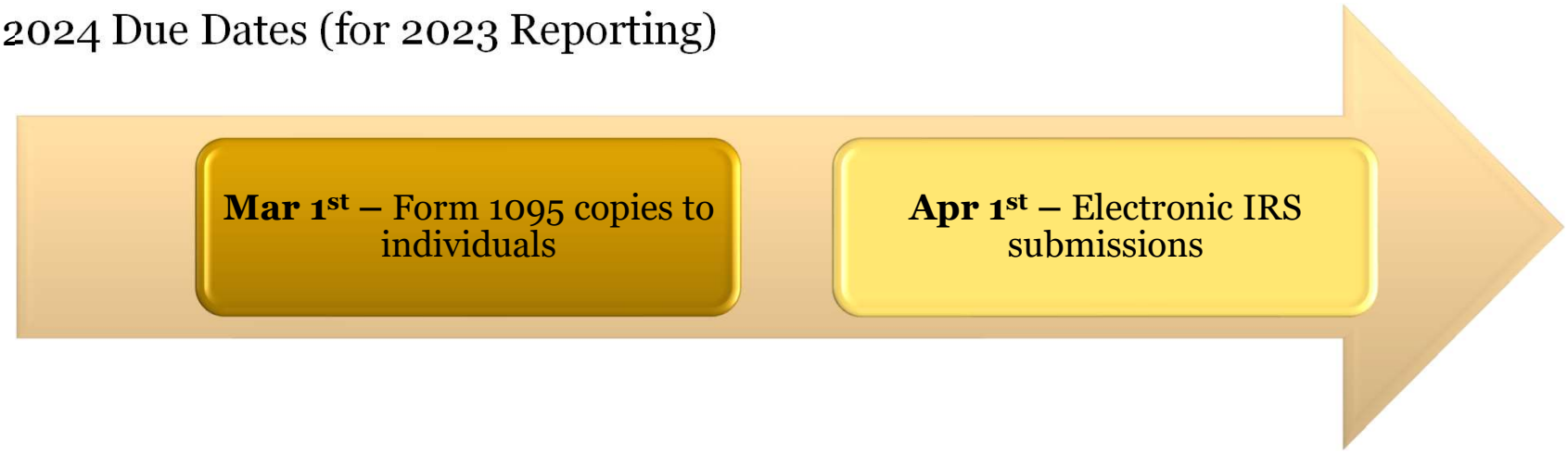
Required to report coverage information for all individuals enrolled in the self-funded group medical plan (includes level-funded plans, ICHRAs, and other HRAs that are not paired with another plan offered by the employer)

Which Form Do I Use?

I am an ALE and offer a self-funded group health plan	I am an ALE and do not offer a self-funded group health plan	I am not an ALE and offer a self-funded group health plan	I am not an ALE and do not offer a self-funded group health plan
1094C + 1095C Parts I, II, & III	1094C + 1095C Parts I & II	1094B + 1095B	No reporting required

Employer 1094 / 1095 Reporting

- New Electronic Reporting Requirements for 2023
  - Employers filing 10 or more forms required to submit reporting electronically
- 2024 Due Dates (for 2023 Reporting)



Hospital and Fixed Indemnity Plans

- IRS, DOL, and HHS have released new proposed guidance
  - Plans must pay on a "fixed period" basis

Not allowed to pay on a per service basis	Addresses plans being sold as excepted benefit indemnity plans but contain a significant list of “per service” payments making it look more like comprehensive fee-for-service health insurance.

  - Tighten the no coordination rule

Cannot be offered in conjunction with another plan that makes indemnity plan payments contingent on the participant having other coverage.	Targeting “preventive only MEC + indemnity coverage” plans that are being marketed as an alternative to comprehensive group health coverage.

  - Effective Date
    - New plans offered after publication of final rules
    - Existing group plans sold before publication of final rules - Plan years beginning January 1, 2027!

Taxation of Hospital and Fixed Indemnity Plans

- IRS proposing to amend regulations to reflect IRS existing interpretation of the tax treatment of hospital and fixed indemnity plans
- Benefits paid by plan must be treated as taxable compensation if:
  - Employee pays for the coverage using pre-tax deductions from pay through the employer's Section 125 plan or employer pays and does not treat payments as taxable income
  - Payments made by the fixed indemnity plan are made without regard for actual 213(d) medical expenses incurred by the employee
- Effective Date
  - Later of publication of final regulations or 01/01/24

Telehealth and HSA Eligibility

- Temporary Relief of Telehealth Impact on HSA Eligibility
  - The 2023 Consolidated Appropriations Act (CAA) provided relief allowing that telemedicine coverage would be temporarily disregarded for purposes of HSA eligibility for the 2023 and 2024 plan years
- Proposed Permanent Extension
  - Telehealth Expansion Act of 2023, HR 1843
    - Would permanently extend the relief to participants with telehealth benefits to remain HSA eligible
    - Passed the House Ways & Means Committee with bi-partisan support

Other Proposed HSA Legislation

- The Bipartisan HSA Improvement Act (HR 5688)
  - Would allow for participants to maintain HSA eligibility even if covered by certain benefits
    - Limited direct primary care ($150/month)
    - Spouse only FSA (will require that FSAs be able to differentiate spouse expenses)
    - Limited employer clinics
  - Includes an FSA/HRA to HSA rollover provision
- The HSA Act (HR 5687)
  - Allows HSA eligibility if participant has VA coverage, Medicare Part A, Native American Health coverage, bronze and catastrophic plan coverage
  - Permits HDHP to include $500 mental health services below HDHP deductible
  - Increases HSA contribution to the individual's deductible and OOP exposure (to a maximum of $7,500 individual, $15k family)

2023

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