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Employer focus

Benefits Compliance Newsletter for Employers | Q4 2023

In this Issue

Fourth Quarter Benefits News Highlights

1 —

Student loan repayments that were suspended during the pandemic started up again in October, which may cause a hardship for some employees. We want to remind employers that they can pay or reimburse employees up to $5,250 in student loans on a tax-free basis under §127 through 2025.

2 —

HHS announced annual updates for certain civil monetary penalties related to HIPAA, Summary of Benefits and Coverage (SBC), and Medicare Secondary Payer (MSP) requirements. These amounts are typically updated annually. The updated amounts for SBCs and MSP are as follows:

- Failure to provide an SBC: $1,362 (up from $1,264) for each failure.
- Offering incentives to Medicare-eligible individuals not to enroll in a plan that would otherwise be primary: $11,162 (up from $10,360).
- Failure of responsible reporting entities to provide information identifying situations where the group health plan is primary: $1,428 (up from $1,325).

For HIPAA, penalties are based on different tiers of knowledge/severity and range from $137 to $ $2,067,813, with a calendar year cap for each penalty of $2,067,813. [Note that in 2019, HHS announced a lower maximum penalty amount for each penalty tier ($1.5 million) but continues to index the original statutory amounts each year, which leaves some confusion in place about exactly which penalty cap would apply.]

3 —

Instructions for completing and submitting Forms 1094 and 1095 for the 2023 calendar year early in 2024 were finalized with only a few changes from prior years' requirements. The instructions confirm that forms must be received by the IRS no later than February 28, 2024 for those submitted by mail and by April 1, 2024 for those submitted electronically. Copies of Form 1095s must be provided to individuals by March 1, 2024. The fee for failure to timely report accurate information is increased to $310/form (previously $290/form). And most importantly, beginning with the 2023 reporting, employers who file 10 or more tax forms must file the returns electronically (previously only those filing 250 or more forms

were required to file electronically). The count includes not only Form 1094 and Form 1095s, but also other tax filings such as Form W-2s and Form 1099s.

4 —

IRS Notice 2023-70 provides the updated PCORI fee of $3.22 for plan years ending in October 2023 – September 2024 (up from $3.00 for plan years ending in October 2022 – September 2023). For fully-insured plans, the carrier pays the PCORI fee. However, for self-funded group health plans, including HRAs, the employer is responsible for reporting and paying the PCORI fee by July 31st of the year following the end of the plan year using Form 720, Line 133.

5 —

The IRS recently announced updates in Notice 2023-75 for the definition of highly compensated employee (HCE) under §414(q) that is used in the cafeteria plan nondiscrimination tests. The amount increased from $150,000 for 2023 to $155,000 for 2024. However, it's important to remember that this is a so-called lookback test, i.e. whether an employee is an HCE in one year is based on their income in the preceding calendar year using that preceding year's §414(q) number. So an employee will be an HCE in 2024 if their income in 2023 exceeded $150,000, the 2023 §414(q) amount. The newly published 2024 §414(q) number will not be relevant until we are determining HCE status in 2025.

6 —

As many expected, the IRS confirmed the 2024 health FSA contributions are limited to $3,200 with the ability to carryover up to $640 into the 2025 plan year. In addition, monthly transportation limits were confirmed at $315.

7 —

The 11th Circuit has upheld the $2.67 billion settlement in the massive class action lawsuit against the Blue Cross Blue Shield Association. Barring some other unforeseen development, that means employers who previously filed claims for their share of the settlement proceeds should start receiving payments sometime in the first part of 2024. Employers who receive such settlement proceeds should be aware that a portion of those funds may be plan assets under ERISA if employees contributed towards the cost of the health plan during the time period covered by the settlement, and the employer may need to share the proceeds with health plan participants. Following the DOL's guidelines for handling MLR rebates should ensure the employer satisfies its obligations under ERISA with respect to these settlement funds.

8 —

The agencies released the proposed 2025 Benefit and Payment Parameters regulations suggesting **the 2025 out-of-pocket (OOP) maximums permitted for group health plan coverage of essential health benefits will be reduced to $9,200 for self-only coverage and $18,400 for other than self-only coverage** (currently set at $9,450 and $18,900 for 2024). A fact sheet, including a link to the proposed rules, can be found here – https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2025-proposed-rule

9 —

The IRS released a draft of its 2024 Publication 15-B addressing the taxation of fringe benefits. The publication provides a good resource for confirming which benefits qualify for tax-favored treatment and the annual limits that may (or may not) be adjusted from one year to the next. The draft version is available here – https://www.irs.gov/pub/irs-dft/p15b–dft.pdf

10 —

For purposes of determining what language services and notice taglines are required for group health plans, the Culturally and Linguistically Appropriate Services (CLAS) County Data has been updated (the previous version was provided back in 2016). The data identifies which counties have 10 percent or more of the population that are literate only in the same non-English language and also includes sample taglines for applicable non-English languages, which an agency FAQ clarifies should be used for plan years beginning on or after Jan. 1st , 2025. The agency FAQ, including a link to the 2023 CLAS County Data, can be found here – https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-63

11 —

The affordability of an ICHRA is tied to the lowest cost silver plan available on the public Exchange. To assist with calculating affordability, since the rates will vary based on an employee's worksite or residence, CMS publishes premium data via a Look-Up Table for Federally-facilitated Exchanges and State-based Exchanges using the Federal Platform. Plan year data for 2019 – 2024 can be found here – https://www.cms.gov/marketplace/private-health-insurance/health-reimbursement-arrangements.

12 —

A proposed rule to formally rescind the 2018 rule around Associated Health Plans (AHPs) was released at the end of 2023. Back in 2018, agency rules provided a path for small employers and working owners to form association health plans (AHPs) that would have allowed the AHP to offer a large group health plan to members who otherwise would have been required to offer small group market coverage. In addition, it would have allowed the AHP to be treated as a single plan for ERISA purposes rather than treating each participating employer as a separate ERISA plan sponsor. A court decision in 2019 invalidated portions of the final rule, removing the expanded AHP option. Now, in an effort to clarify that the path provided in the 2018 final rules is not available, the agencies released a proposed rule that formally rescinds the 2018 AHP rules and confirms that only associations in a bona fide organization unrelated to the provision of benefits that satisfies certain commonality and control requirements is permitted to offer coverage as a single employer. In most cases, when unrelated entities offer shared benefits via a multiple employer welfare arrangement (MEWA), the small or large group coverage available for a participating member will be determined based on that particular member's size, and each participating member will be seen as sponsoring their own separate group benefit plan(s) for ERISA purposes. The DOL's announcement, along with a link to the proposed rules, can be found here - https://www.dol.gov/newsroom/releases/ebsa/ebsa20231219. For the vast majority of employers, these rules will have not have any impact, and employers participating in established, industry based AHPs should still be okay under the pre-2018 rules. The formal repeal of the 2018 AHP rules just reinforces that it is generally difficult for unrelated employers to band together to offer coverage to their employees.

FEATURE: Federal Benefit Compliance Calendar for 2024

This calendar highlights important compliance due dates for employee health and welfare benefits.

NOTE: Compliance due dates that are tied to a plan year assume a calendar year plan. Actual due dates may differ for some items if the employer's plan runs on a non-calendar year. Please see the Appendix for variable due dates in 2024-2025 for certain reporting requirements tied to plan year rather than calendar year.

The Summary of Benefits & Coverage (SBC) and other notices must be distributed annually during the employer's open enrollment. These notices are not addressed in the calendars below.

Calendar

Month	Requirement	Due Date	Description
January	Price Comparison Tool	Jan 1	A price comparison tool, including estimates of cost-sharing for all covered health care items and services from each provider, must be made available via a web-based tool as well as by phone or paper upon request. This applies to plan years beginning on or after January 1, 2024 (previously only required for 500 specified items and services in 2023).
	W-2s	Jan 31	Employers that filed at least 250 W-2s in the previous year must report the cost of coverage (employer and employee) in Box 12 (Code DD). Employers must report all employer contributions to employees' HSAs in Box 12 of Form W-2, using code W. Employers must report the amount of dependent care benefits paid or incurred on an employee's behalf in Box 10 of Form W-2. Amounts over $5,000 ($2,500 in the case of a separate return filed by a married individual) are also included in Box 1.
February	1094-B, 1095-B, 1094-C, 1095-C Forms due to IRS (if mailing)	Feb 28	Applicable Large Employers and Employers with self-funded plans must report offer and coverage information as required under §§6055 and 6056. *NOTE: When reporting for the 2023 calendar year, almost all employers must report electronically (previously employers filing <250 forms could file by mail).*
March	HIPAA Breach Notifications due to OCR	Mar 1	Employers sponsoring group health plans must report any breach of Protected Health Information (PHI) affecting fewer than 500 individuals to OCR within 60 days of the end of the calendar year (regardless of when the plan year ends).

	Part D Creditable Coverage Report due to CMS (for calendar year plans*)	Mar 1	Employers sponsoring prescription drug plans must report to CMS within 60 days after the beginning of the plan year regardless of whether the coverage is creditable. **See Appendix for due dates for non-calendar year plans.*
	1095-B and 1095-C forms due to individuals	Mar 1	Applicable Large Employers must provide offer of coverage information to employees (copies of 1095-Cs). Employers with self-funded plans must provide coverage information to covered individuals (copies of 1095-Bs or 1095-Cs). In addition, certain employers offering coverage to residents of California, New Jersey, Rhode Island, and the District of Columbia must comply with state-level requirements that require providing federal form 1095s to covered individuals.
April	1094-B, 1095-B, 1094-C, and 1095-C Forms due to IRS (if filing electronically)	Apr 1	Applicable Large Employers and Employers with self-funded plans must report offer and coverage information to the IRS as required under §§6055 and 6056. *NOTE: When reporting for the 2023 calendar year, almost all employers must report electronically (previously employers filing <250 forms could file by mail).*
	Last day for 2023 HSA contributions or corrections	Apr 15	Employers and individuals have until the tax filing deadline to make HSA contributions and corrections for a given calendar year.
June	Prescription Drug Reporting	Jun 1	Due date for reporting data for the 2023 calendar year.
July	Last day to issue a Summary of Material Modification (SMM) for the prior plan year (for calendar year plans*)	Jul 28	ERISA requires that a Summary of Material Modification (SMM) be issued any time there is a change in a plan provision that is "material" (but not a reduction) or any time there is a change in a plan provision that is required to be in the Summary Plan Description (SPD). The due date is 210 after the end of the plan year to which the change applies. *See Appendix for due dates for non-calendar year plans. *NOTE: For a material reduction, an SMM is required within 60 days of the adoption of the change.*
	PCORI Fee	Jul 31	Patient-Centered Outcomes Research Institute (PCORI) fee is due for policy or plan years that ended in 2023.
	5500 Filing (for calendar year plans*)		Employers must file 5500s for plans with at least 100 participants (i.e., employees) at the start of the plan year. In addition, employers with plans that have fewer than 100 participants must file a 5500 if

			the plan is "funded" (i.e., the assets of the plan are segregated from the general assets of the plan sponsor through a trust). **See Appendix for due dates for non-calendar year plans*
September	Summary Annual Report (SAR) (for calendar year plans*)	Sept 30	A summary annual report (SAR) is a summary of the Form 5500. A SAR is required for any plan subject to Form 5500 filing, except for self-insured plans without any segregation of assets in a trust or otherwise (unfunded). It is due within 9 months of the close of the plan year. **See Appendix for due dates for non-calendar year plans*
	MLR Rebates (Due date for carriers to issue rebates)	Sept 30	Carriers are required to report prior year MLR data to HHS by July 31. If the MLRs are not met, premium rebates must be provided to employers by the end of September.
October	Medicare Part D Creditable Coverage Notices to Individuals	Oct 14	Employers offering prescription drug coverage must issue the Notice of Creditable Coverage to individuals by October 14. (Note: Employers may provide the notice at any time during the 12 months preceding October 15 – e.g., during open enrollment).
	5500 Filing Due Date with Extension (for calendar year plans*)	Oct 15	Employers must file 5500s for plans with at least 100 participants (i.e., employees) at the start of the plan year. In addition, employers with plans that have fewer than 100 participants must file a 5500 if the plan is "funded" (i.e., the assets of the plan are segregated from the general assets of the plan sponsor through a trust). **See Appendix for due dates for non-calendar year plans*
December	Last day for employer to distribute portion of MLR rebate that is considered plan assets	Dec 29	Employers sponsoring fully-insured group health plans must distribute the portion of an MLR Rebate that is considered plan assets within 90 days of receipt (i.e., for rebates received September 30, by December 29). Otherwise, the employer may be subject to the general ERISA trust requirements.
	Gag Clause Attestations	Dec 31	Employers and carriers must submit an attestation of compliance with the gag clause prohibition contained in the Consolidated Appropriations Act (CAA).

Variable Due Dates for Non-Calendar Year Plans

Medicare Part D Disclosures (Due 60 days after the start of the plan year)

Plan Year Beginning	Medicare Part D Creditable Coverage Reporting Due to CMS
December 1, 2023	January 30, 2024
January 1, 2024	March 1, 2024
February 1, 2024	April 1, 2024
March 1, 2024	April 30, 2024
April 1, 2024	May 31, 2024
May 1, 2024	June 30, 2024
June 1, 2024	July 31, 2024
July 1, 2024	August 30, 2024
August 1, 2024	September 30, 2024
September 1, 2024	October 31, 2024
October 1, 2024	November 30, 2024
November 1, 2024	December 31, 2024

5500 Reporting (Due the last day of the 7th month after the end of the plan year):

Plan Year Ending	5500 Due	Due Date with Extension
June 30, 2023	January 31, 2024	April 15, 2024
July 31, 2023	February 29, 2024	May 15, 2024
August 31, 2023	March 31, 2024	June 15, 2024
September 30, 2023	April 30, 2024	July 15, 2024
October 31, 2023	May 31, 2024	August 15, 2024
November 30, 2023	June 30, 2024	September 15, 2024
December 31, 2023	July 31, 2024	October 15, 2024
January 31, 2024	August 31, 2024	November 15, 2024
February 29, 2024	September 30, 2024	December 15, 2024
March 31, 2024	October 31, 2024	January 15, 2025
April 30, 2024	November 30, 2024	February 15, 2025
May 31, 2024	December 31, 2024	March 15, 2025

Summary of Material Modifications (Due within 210 days after end of plan year)

Plan Year Ending	SMM Due
August 31, 2023	January 27, 2024
July 31, 2023	February 27, 2024
August 31, 2023	March 29, 2024
September 30, 2023	April 28, 2024
October 31, 2023	May 29, 2024
November 30, 2023	June 28, 2024
December 31, 2023	July 28, 2024
January 31, 2024	August 31, 2024
February 29, 2024	September 28, 2024
March 31, 2024	October 28, 2024
April 30, 2024	November 27, 2024
May 31, 2024	December 28, 2024

Summary Annual Report (SAR) (Due within 9 months after end of the plan year)

Plan Year Ending	SAR Due
April 30, 2023	January 31, 2024
May 31, 2023	February 29, 2024
June 30, 2023	March 31, 2024
July 31, 2023	April 30, 2024
August 31, 2023	May 31, 2024
September 30, 2023	June 30, 2024
October 31, 2023	July 31, 2024
November 30, 2023	August 31, 2024
December 31, 2023	September 30, 2024
January 31, 2024	October 31, 2024
February 29, 2024	November 30, 2024
March 31, 2024	December 31, 2024

Employer Reporting Tips and Tricks

What is the difference between Codes 1A and 1E?

When reporting offers of coverage in Part II, Line 14 of the Form 1095-C, both codes 1A and 1E indicate an offer of minimum value coverage that is made available to the employee, spouse and children. The difference is tied to whether the employee contribution meets the FPL safe harbor.

1E = a minimum value offer of coverage to employee, spouse and children
1A = 1E + the offer meets the FPL safe harbor (also referred to as a "qualifying offer")

If the employer offers minimum value coverage to employees, spouses and children that meets the FPL safe harbor, it is considered a "qualifying offer." When that is the case, the employer has two options for coding offers of coverage on Line 14 the Form 1095-C:

1. Mark the "Qualifying Offer Method" on Line 22 of the Form 1094-C, and then use Code 1A on Form 1095-C (Line 14) and leave Lines 15 and 16 blank; or

2. Use Code 1E on Form 1095-C (Line 14), enter the contribution amount on Line 15, and enter Code 2G on Line 16.

Either way is correct. Using 1A just simplifies the reporting a bit in that Lines 15 and 16 can then be left blank. *NOTE: 1E could be paired with any of the affordability safe harbor codes (i.e., 2F, 2G, or 2H).*

FEATURE: Medicare Part D Creditable Coverage Disclosure to CMS

Background

Each year, plan sponsors must disclose to the Centers for Medicare and Medicaid Services (CMS) the group health plan's creditable coverage status for prescription drug coverage. This information is used to help CMS determine when there might be other coverage creditable available to individuals who are eligible for Medicare.

Who Has to Report

Any employer sponsoring a group health plan that provides prescription drug coverage is required to determine the plan's creditable status and report to CMS. There really are not any exceptions, even for small employers. This reporting is typically not done by the insurance carrier or the third-party administration (TPA), but instead must by handled by the employer as plan sponsor. Note that this reporting requirement is separate and distinct from the Medicare Secondary Payer reporting requirements under Section 111 that are due to CMS on a quarterly basis and typically handled by the insurance carrier or TPA.

When to Report

This reporting is due within 60 days of the beginning of each new plan year. For example, for calendar year plans, the due date will be March 1 (or February 29 if a leap year). In addition, disclosure must be made within 30 days after termination of the

prescription drug plan, and within 30 days after any change to the creditable status of the prescription drug plan. This reporting is separate from the required Medicare Part D creditable/non- creditable coverage notice that is provided to participants upon initial eligibility and annually each year.

How to Report

- CMS has provided detailed instructions that include screen shots. That document can be located here: CredCovDisclosureCMSInstructionsScreenShots110410.pdf.
- Start by navigating to the CMS online portal and follow the prompts.

Information You Will Need to Complete the Reporting

General employer information – Employers should report using the name and federal ID number (EIN) of the plan sponsor. If multiple employers within a controlled group are covered under the same plan, the EIN for the parent company (or other entity if it is the plan sponsor) may be used under a single filing. If each individual entity reports separately, each should report using its own EIN. The EIN of the insurance carrier or third-party administrator should not be used.

Type of coverage – Most employers will choose "Group Health Plan: Employer Sponsored Plan," but there are also options for church plans and state and local government plans.

Plan option information – Employers must report the number of prescription drug options offered and the creditable or non-creditable coverage status for each (i.e., number of group health plan options offered with different prescription drug benefits).

Determining Whether an Employer's Prescription Drug Coverage Is Creditable

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D. In other words, coverage is creditable if the expected amount of paid claims under the coverage is at least as much as the expected amount of paid claims under the standard Medicare Part D benefit. Often an insurance carrier or third-party administrator will provide information to a plan sponsor detailing whether a plan's drug coverage is creditable. But if a plan sponsor does not receive this information from the carrier or administrator, the plan sponsor (e.g., the employer) is responsible for making the determination, or hiring an actuary to help with the determination.

Some plans meeting the simplified determination method can assume their coverage is creditable. See the criteria for the simplified determination method here – https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/CCSimplified091809.pdf. If a plan does not meet the criteria under the simplified determination method, that does not automatically mean the plan is not creditable; but in that case, the plan must obtain an actuarial determination of whether the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D.

NOTE: For high deductible health plans (HDHPs), the prescription drug coverage will typically be integrated with the HDHP (i.e., shared deductible and maximum limits, if any), in which case the HDHP will not meet the simplified determination criteria for creditable coverage status because the annual deductible will always exceed $250. This does not mean that an HDHP can never qualify as creditable coverage. If the carrier or administrator does not advise as to the creditable status of the HDHP, it may require an actuarial determination to determine creditable status.

Estimated number of Medicare Part D individuals covered under each plan – CMS will accept a reasonable estimate of how many Medicare eligible individuals are expected to be covered under the plan. Remember that dependents can be Medicare eligible, and eligibility may be based on age, disability, end-stage renal disease, or ALS. The form also asks how many Medicare-eligible individuals are expected to be covered by a retiree plan.

- If the employer offers retiree coverage, the employer should indicate how many Medicare-eligible individuals are expected to be covered by the retiree coverage.
- If the employer does not offer retiree coverage, "0" should be entered.

Date of creditable coverage notice distribution – The most recent date (MM/DD/YYYY) that the required annual creditable or non-creditable Medicare Part D Notice was distributed to participants.

Frequently Asked Questions

Q. Is the disclosure to CMS tied to a group health plan's plan year, policy year, or fiscal year?

A. The disclosure to CMS should be tied to the ERISA plan year, which may be different than the plan's contract year with the carrier or the employer's fiscal year. Ideally, the ERISA plan year is set forth in plan documentation.

Q. After submitting the online disclosure, I realized that I had made a mistake. How can I correct that?

A. Fixing submission errors requires a new disclosure submission, which will override previous submissions.

Q. Due to turnover in HR, it appears the reporting was not done last year. Is there a way to find out if the disclosure was submitted to CMS for previous years?

A. We are not aware of any way to look up whether a plan has previously submitted this disclosure. However, there is no specific penalty for failing or being late to report to CMS for this disclosure requirement. The only specified penalty relates to a retiree plan attempting to receive the retiree drug subsidy…such a plan would be denied the subsidy if it had not complied with the required Medicare Part D notifications. As reporting is required it is our recommendation that you report now (late) and going forward on a timely basis.