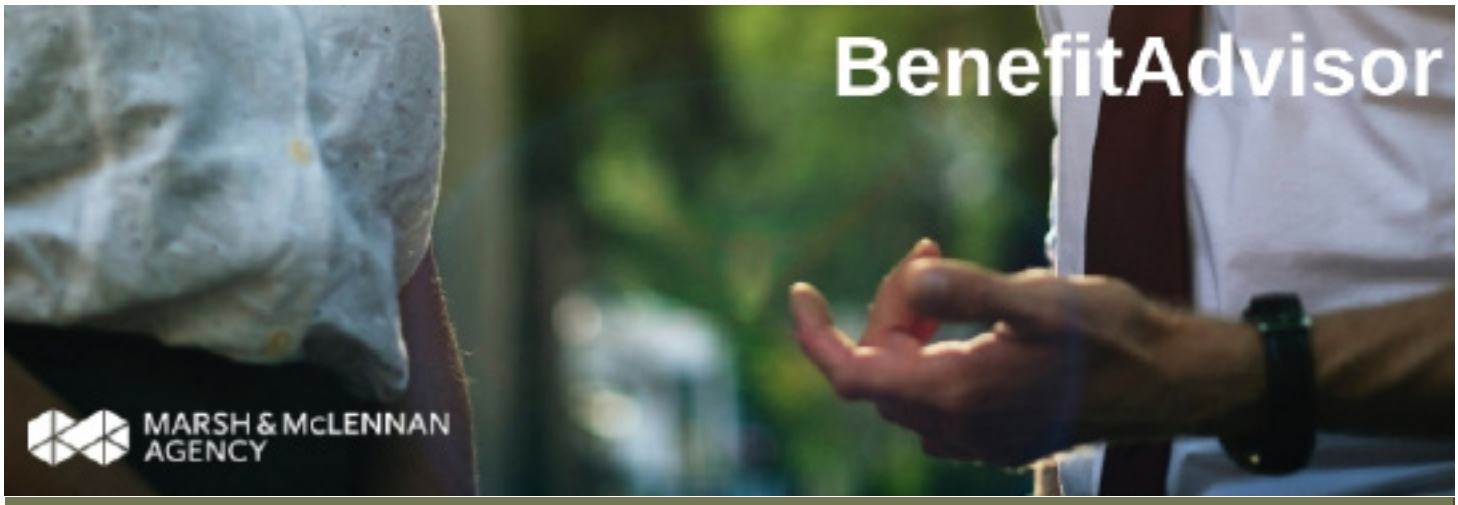

Volume Twenty-Three, Issue Seven December 2020

2020 YEAREND CHECKLIST

This has been a year of constant flux. The COVID-19 pandemic has upended almost all workplaces, and employers have had to respond to shutdown orders in almost all states. Many have had to transfer critical work to a work-from-home environment. In addition, the government passed laws and issued new rules because of the pandemic and its impact on employees and employers. Employers have had to decide how to help employees with child care, isolation, fear and other issues.

The pandemic is not over. It will continue to affect employers well into 2021. In addition, a new administration will be sworn in next January and that surely will affect benefit plans.

This *Advisor* recaps the following key issues that affect employers and their benefit plans:

- COVID-19 pandemic-related
  - Family First Coronavirus Relief Act
  - Extensions for certain time limits during the outbreak
  - High deductible health plans/health savings accounts (HSAs)/ telemedicine
  - Mid-year changes
  - FSA carryover increases and expanded grace periods
  - CARES Act requirements
- ACA-related regulations
  - Employer reporting summary and penalty process
  - Taxes and fees
  - Section 1557 final nondiscrimination rules
  - Grandfathered rules and proposed changes
  - MLR rebates and discounts
- Michigan law changes – No-Fault Auto Reform
- Clarifying rules on pharmaceutical drug coupons
- Proposed regulations on Direct Primary Care contracts and Health Care Sharing Ministries
- New model COBRA notices

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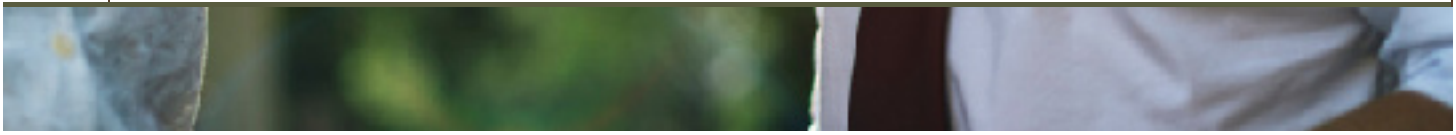
We welcome your comments and suggestions regarding this issue of our Benefit Advisor. For more information, please contact your Account Manager or visit our website at www.mma-mi.com.



- Final rules on reimporting drugs
- Annual reminders and updates

Employers should take a minute at yearend to review all the changes that will affect benefits this year and next.

COVID-19

The following new laws, regulations and notices have helped employers and employees struggling with this unprecedented pandemic in modern times.

Family First Coronavirus Relief Act (FFCRA)

Coverage Mandate for COVID-19 Testing

An FFCRA provision requires both fully insured and self-funded health plans to cover all costs for diagnostic and antibody COVID-19 tests. Covered diagnostic testing includes:

- All Food and Drug Administration (FDA) approved tests
- Non-FDA approved tests under an emergency use authorization request unless denied or the test developer does not file the request with the FDA on time
- State-approved tests when the state has notified Health and Human Services (HHS) it will use them
- Other HHS approved tests

Insurance fully covers these tests only when a physician orders them; it does not cover COVID-19 diagnostic tests when employers require them to return to work.

This coverage mandate applies only during the COVID-19 national public health emergency as determined by the Secretary of HHS.

FFCRA Paid Leaves

Some FFCRA paid leave requirements apply only to specific employers. The two new paid leave allowances are:

1. Emergency Paid Sick Leave (EPSL)
2. Emergency Family Medical Leave Expansion Act (EFMLEA)

These new leaves apply only to private employers with fewer than 500 employees and state and local governments. There is also a very limited exception for employers with fewer than 50 employees. Most federal employers are exempt from the FMLA and thus would not be subject to the EFMLEA. Private employers determine whether they have fewer than 500 employees when an employee requests a leave. These new leaves apply only from April 1, 2020, through December 31, 2020.

Employers must continue health insurance during these leaves and also provide job protection.

Key points about EPSL:

- Employees do not have to meet service or other requirements to be eligible.
- Six reasons someone is eligible for EPSL:
  1. Employee is under a federal, state, or local government or agency quarantine or isolation order.
  2. Health care provider has specifically told an employee to self-quarantine.
  3. Employee has COVID-19 symptoms and is seeking a diagnosis.
  4. Employee is caring for an immediate family member or person at home, including a roommate who is quarantined, or whose health care provider has advised the person to quarantine.
  5. Employee is caring for a son or daughter under 18 because the school or day care is closed or a child care provider is not available.
  6. Employee has any other substantially similar condition HHS guidance specifies. (Nothing has been specified to date.)
- Employees who can work remotely despite any of the above reasons are not eligible for EPSL.
- Employers must provide full-time employees 80 hours of EPSL. They must provide part-time employees the average hours they would normally have worked for two weeks; for example, an employee who works 20 hours a week would be eligible for 40 hours of EPSL.
- The benefit depends on the reason for the leave. For reasons 1-3, employees receive their entire regular pay capped at $511 a day. For reasons 4-6, they receive two-thirds of the regular rate of pay capped at $200 a day.

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Key points about EFMLEA:

- Employees must have been employed for at least 30 days when they request leave; there is no minimum hours worked requirement. In addition, the FMLA requirement to work at a location with 50 or more employees within a 75-mile radius does not apply to EFMLEA leaves.
- The only reason employees can qualify for EFMLEA leaves is that they need to care for their children under 18 because their children's school or day care is not open or their child care provider is not available.
- Employees who can work remotely despite the child's school or day care being closed are not eligible for EFMLEA.
- Employers must provide full-time employees 12 weeks of EFMLEA . Since the EFMLEA amended the FMLA, the employee is entitled to 12 weeks leave in total. So employees who used 12 weeks of FMLA in the first quarter of this year would not be eligible for EFMLEA even with a qualifying reason because they have already exhausted their 12 weeks of FMLA leave.
- The first two weeks of the EFMLEA are not paid; the remaining 10 weeks will be paid. The benefit is two-thirds of the regular rate of pay capped at $200 a day.

Private employers are eligible for a tax credit that should offset all of the cost of providing these leaves.

Extensions for certain time periods for the outbreak period

The COVID-19 Outbreak Final Rules suspends various plan administration deadlines during the outbreak period. The outbreak period started on March 1 and ends 60 days after the announced end date of the national emergency or another date announced by the Department of Labor or the Department of Treasury in future guidance.

The suspended deadlines apply to the following responsibilities:

- *ERISA Disclosures and Notices* – this includes plan documents, summary plan descriptions, summary of material modifications, summary of benefits and coverage, summary annual report, and benefit determinations. The Department of Labor expects employers to provide the materials in good faith as soon as it is administratively practical to do so. The official time periods to provide these disclosures and notices are suspended during the outbreak period.
- *HIPAA Special Enrollment Rights* – These rights generally apply to group health plans. HIPAA requires these plans to allow employees to make midyear changes if they acquire a dependent or lose other health coverage.
- *COBRA requirements* – The suspension affects the following:
  - The 60-day deadline for an employee or qualified beneficiary to notify the plan of a divorce or loss of dependent eligibility
  - The time period to request a disability extension for COBRA
  - The 60-day deadline to elect COBRA
  - The 45-day deadline to pay the initial COBRA premium and the 30-day grace period to pay subsequent COBRA premiums
- *Claims and Appeal Time Periods* – these are the time periods to file claims for benefits or appeals of adverse benefit determinations. This also means the run-out period to file claims on health care FSAs cannot expire until the end of the outbreak period. This does not give employees more time to incur a claim, only more time to submit a claim incurred in the plan year.

These delayed deadlines during the outbreak period do not apply to non-federal government plans. However, CMS encourages non-federal government employers to voluntarily extend their deadlines. ERISA plans must provide these extensions.

The new rules also relax ERISA's electronic delivery requirements. The DOL will consider communication with employees and participants by email, text messaging and/or websites to be good faith delivery of communications so long as the employer believes the employees and participants can access these electronic communications.

High Deductible Health Plans/ Health Savings Accounts (HSAs)/Telemedicine

The following rules for high deductible health plans (HDHPs)

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were modified to allow coverage before the deductible on a number of services while still allowing plan participants to contribute to their HSAs:

- An HDHP can cover testing **and** treatment of coronavirus before the participant meets the minimum deductible.
- An HDHP can also cover testing for Influenza A and B, norovirus, other coronaviruses and respiratory syncytial virus (RSV) before the plan participant meets the minimum deductible.

This relief also applies to telemedicine treatment and testing. Since it would be difficult for plans to discern when telemedicine is used specifically for COVID-19 testing and treatment, the CARES Act allows HDHPs to cover all telemedicine visits before the plan participant meets the minimum HDHP deductible. While plans do not need to cover these additional teleweb visits completely, they can cover them subject to a copay or at a level below fair market value. This relief applies to plan years beginning on or before December 31, 2021.

Finally, employers can offer telemedicine as a standalone benefit without violating the ACA plan design requirements if the plan year begins before the COVID-19 national public health emergency ends. This change applies only to large employers who averaged 51 or more employees in the previous calendar year with at least two employees on the first day of the telemedicine plan year.

Plans may permit midyear changes

IRS Notice 2020-29 allows employers to permit midyear plan changes to pre-tax elections for health coverage, health care FSAs and dependent care FSAs. Midyear changes are usually permitted only if the employee has a qualified life event permitted under the 125 plan and the underlying plan involved. Employers have tremendous flexibility in deciding when, how and if they want to allow these midyear changes because of the COVID situation.

Employers can make these changes in the 2020 plan year if they amend their plans to allow them by December 31, 2021. Employers have several choices:

- They can implement a midyear change opportunity or not.
- They can pick and choose what midyear changes to allow. For example, they could limit the changes to dependent care FSAs. Before they decide to allow midyear coverage to be elected for their medical coverage, employers need to verify their medical plan carriers and stop loss carriers will allow it.
- Employers can choose whether they will permit:
  - Any election changes
  - Any enrollment or drop in coverage but not a change in plan option
  - Enrollment in the lowest cost medical plan
  - Dropping FSA coverage
- Employers can set a time period for when they will allow these changes.

Employers can allow employees to drop coverage only if the employees have other coverage or will enroll in other coverage shortly.

Employers can amend their plan retroactively to allow employees to make these changes. All employee-initiated changes must be prospective. Also, employers do not have to permit employee reductions or terminations in FSA funds below the amounts already reimbursed in the plan year.

FSA carryover increases and expanded grace periods

IRS Notice 2020-29 allows employers to amend their 125 plans for medical and dependent care FSAs to allow a grace period for unused funds for any grace period or plan year that ends in 2020. This extension allows plans to reimburse eligible expenses incurred through December 31, 2020. Again, employers can decide whether to amend their plans.

Although the IRS does not normally allow grace periods and carryovers in the same plan year, this notice temporarily does allow it for plan years ending in 2020. Even plans that offer carryovers or rollovers this year can add the grace period.

The IRS, however, did not make allowances for this grace period to co-exist with HSAs. A grace period for a full-scope FSA could affect eligibility to contribute to an HSA. Assume an employee has funds available in the full-scope FSA because you have added or extended a grace period. That employee enrolled in an HDHP and wants to contribute to an HSA. That employee cannot contribute to the HSA until the grace period ends on December 31, 2020.

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Employers should think carefully about whether it makes sense to extend the grace period.
IRS Notice 2020-23 increased the medical FSA carryover amount for 2020 plan years to $550. This amount, just like the annual medical FSA statutory maximum, will be indexed annually. The carryover amount will be 20 percent of the statutory medical FSA going forward.

CARES Act requirements

The CARES Act includes several provisions that affect businesses and individuals. For example, it includes the Paycheck Protection Act (PPA) and the stimulus payments that have helped many households in these challenging times. It also includes the employee retention tax credit for qualifying organizations.

The CARES Act dictates the reimbursement rates to providers for covered COVID-19 diagnostic testing. It also includes the requirement that once a vaccine is approved for use, health plans must cover it at 100% within 15 days.

The CARES Act permits HSAs, medical FSAs, and health reimbursement arrangements (HRAs) to reimburse over- the-counter medications on a tax-favored status without a prescription. This is a permanent change.

ACA-RELATED REGULATIONS

The ACA continues to affect employers significantly. Following are several changes and reminders for 2020.

Employer Reporting

Potential penalties under the "pay or play" rules are based on information Applicable Large Employers (ALEs) provide when they file Forms 1094 C and Forms 1095 C. The forms look very different for 2020 reporting; however, many of the changes were made to accommodate reporting for Individual Coverage Health Reimbursement Arrangements (ICHRAs). Not many employers offer ICHRAs to their employees.

The due dates for the 2020 forms are as follows:

- **1095 C Forms to employees** – Delayed to March 2, 2021
- **1094 C and 1095 C Forms to IRS** – March 1, 2021, (on paper) and March 31, 2021, (electronically)

The final forms and instructions for 2020 reporting can be found at:

- Form 1094 C - https://www.irs.gov/pub/irs-pdf/f1094c.pdf
- Form 1095 C - https://www.irs.gov/pub/irs-pdf/f1095c.pdf
- Form 1094 B – https://www.irs.gov/pub/irs-pdf/f1094b.pdf
- Form 1095 B - https://www.irs.gov/pub/irs-pdf/f1095b.pdf
- Instructions for the C Forms - https://www.irs.gov/pub/irs-prior/i109495c--2020.pdf
- Instructions for the B Forms - https://www.irs.gov/instructions/i109495b

Most employers follow a process or use vendors to produce and submit the IRS forms electronically. If your organization is considering submitting the forms electronically, start early. The process is complicated and time-consuming. It involves phases for setting up a system to submit these forms. It also takes time to be assigned a transmission code and to test data files. This can't be done with a short lead-time. Employers should schedule a time to prepare the data and the forms as well as a plan to distribute these forms to employees. To avoid IRS penalties, employers must submit these forms on time.

A few states have enacted their own individual mandates requiring taxpayers to obtain health coverage or pay a state tax penalty. Most of these states enacted their mandates after the federal government zeroed out its individual mandate penalty. Massachusetts has had an individual mandate since 2007. New Jersey, Vermont, California and the District of Columbia enacted individual mandates when the federal mandate was zeroed out. For the mandates that are in effect, most states (other than Massachusetts) require employers to submit employee 1095Cs to the state.

The IRS continues to review 1094C and 1095C forms and assess potential penalties. The IRS may send you Letter 226J proposing a penalty under the ACA employer shared responsibility requirements. If you receive it, your organization has 30 days to respond or appeal any proposed penalty. You can submit Form 14765 (included with Letter 226J) to agree or disagree with any part of the assessed penalty. To contest the penalty, you need to explain why it does not apply.

The IRS will respond with a Letter 227. This letter may revise the penalty or, if the IRS does not agree with your response, main-

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tain the original penalty. ALEs can request a conference with the IRS Office of Appeals if they still disagree with the proposed penalty assessment. Letter 227 and Publication 5 explain how to request that conference.

Once it determines the penalties, the IRS issues Notice CP220J demanding payment. This notice summarizes the penalties, shows any payments made to date and explains how to pay.

If your organization successfully appeals a penalty, check your subsequent filings to make sure you have not repeated the same reporting errors. If so, correct those errors and resubmit the corrected forms to avoid another penalty letter.

Updates to affordability determinations

Many aspects of the ACA have annually indexed parameters. One of these is the percentage to use for determining affordability. For plan years beginning in 2020, it is 9.78 percent. For plan years beginning in 2021, it will be 9.83 percent.

The Marketplaces use the indexed percentage to determine whether employer coverage is affordable based on the employee's household income and whether the employee is eligible for premium subsidies. Employers use the indexed percentage when they test for affordability based on any of the following safe harbors:

- Box 1 of the W-2
- Rate of pay
- Federal Poverty Level (FPL)

The actions your organization took in 2020 to manage through the pandemic may affect the W-2 safe harbor and the rate of pay safe harbor. If you cut an employee's pay, the rate of pay and the W-2 safe harbor was likely affected. If you laid employees off without pay, the W-2 safe harbor was likely affected. Remember, failing an affordability test does not necessarily mean you will be assessed a penalty. To be assessed a penalty, a full-time employee that you failed to offer minimum value/affordable coverage must have obtained subsidized coverage in the Marketplace.

Taxes and fees

Patient Centered Outcomes Research Institute (PCORI) Fees

PCORI fees apply to group health plans. If your plan is fully insured, the insurance carrier pays the fee. If your plan is self-funded, you pay the fee.

Employers with self-funded plans use Form 720, the Quarterly Federal Excise Tax Return, to report the average number of covered members and to pay the annual PCORI fees. You can find more details on calculating the average number of covered members and other provisions of this fee at https://www.irs.gov/affordable-care-act/patient-centered-outcomes-research-trust-fund-fee-questions-and-answers.

The fee increases annually. The amount depends on when the plan year ends. If the plan year ends on or after October 1, 2018, and before October 1, 2019, the fee per covered life is $2.45. If the plan year ends on or after October 1, 2019, and before October 1, 2020, the fee per covered life is $2.54. If the plan year ends on or after October 1, 2020, and before October 1, 2021, the fee per covered life is $2.66.

If your organization fully insures your comprehensive health plan but self-funds a health reimbursement arrangement (HRA), you must pay the PCORI fee for the HRA plan.

Market Share Tax

The market share tax affects employers with insured health plans. The targeted annual revenue is indexed annually. This tax applied to health plans in 2020. It has been permanently repealed for all plan years starting January 2021 and beyond.

Cadillac Tax Repealed

The Cadillac Tax was a 40 percent excise tax on employer-sponsored health coverage exceeding specific thresholds. The Cadillac tax was permanently repealed by the Further Appropriations Act of 2019.

SECTION 1557 NONDISCRIMINATION RULES

Section 1557 nondiscrimination rules were part of the ACA. They were the first health care nondiscrimination rules to prohibit discrimination based on sex. Sex includes pregnancy, gender identity, and sex stereotyping.

These rules applied directly only to the health programs and activities HHS funded or administered. The impact broadened because the rules stated that health insurance issuers receiving federal financial assistance must comply in all their operations, not just the operations related to receiving federal funding. In addition, some employer-sponsored health plans need to comply directly with the rules if they receive federal funds, for example, retiree drug subsidies if the employer sponsors a

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retiree health plan.

Two things occurred this year in relation to these rules. First, the government released final regulations that seriously eroded protections for individuals based on gender identity; second, in the same week, the Supreme Court issued a decision in Bostock v. Clayton County, Georgia. The ruling established that the Title VII protections in the Civil Rights Act of 1964 ("Title VII") extend to those who are discriminated against in the workplace based on sexual orientation or gender identity. This ruling makes it clear that employment discrimination based on sexual orientation or gender identity violates Title VII.

The ruling, however, seems to conflict directly with the final 1557 non-discrimination rules that:

- Eliminated the general prohibition on discrimination based on gender identity
- Eliminated the required health insurance coverage protections for transgender individuals
- Removed rules that stop health insurers from discriminating against specific people such as LGBTQ individuals

The final rules removed the requirement to include the taglines and access to interpretation and translation services. It also removed the notice requirements.

If you intend to discriminate in terms of your health benefits based on gender identity, you should review your plan with an attorney as it could be seen as employment discrimination.

Grandfathered Rules

Employers with grandfathered plans need to review proposed changes every year to see whether the changes will cause their plans to lose their grandfathered status. To recap, a plan is considered grandfathered if coverage was in effect on March 23, 2010, and no changes were made that would cause the plan to lose that status. Very few plans have been able to maintain grandfathered status. Plans lose grandfathered status if they change cost sharing amounts that exceed a certain margin or increase contributions to a point that exceeds a specific margin.

Grandfathered plans can delay the effective date for the following health care reform requirements until they lose grandfathered status:

- Non-discrimination rules for fully insured plans (currently delayed for all insured plans until additional guidance is issued)
- Specific expanded preventive care services with no member cost-sharing
- New claim rules and appeal procedure requirements
- Primary care physician designation rules (applies only to plans requiring a member to have a primary care physician)
- Emergency room coverage rules on how out-of-network providers should be covered
- Requirement to cover specific services when a member is in a clinical trial
- Requirement to cap out-of-pocket maximum cost to annually indexed maximum limits. All cost-sharing for essential health benefits must accumulate toward the maximum

This year the Trump administration issued proposed regulations so that the following two plan changes would not cause plans to lose their grandfathered status:

1. Grandfathered HDHP group health plans would be allowed to change fixed-amount cost-sharing requirements that would normally cause them to lose grandfathered status if those changes are necessary to remain a qualified HDHP. For example, if the minimum deductible required for an HDHP increases and the plan then increases the deductible to be considered an HDHP, then the plan would not lose its grandfathered status.
2. The rules redefine "maximum percentage increase" which is another way to determine the amount based on the premium adjustment percentage. The premium adjustment percentage is generally a higher percentage than medical inflation. That percentage will be published annually in the HHS Notice of Benefit and Payment parameters.

These changes will not go into effect until final regulations are published.

Organizations with grandfathered plans need to evaluate and document changes in their health plans and employee contributions each year to show they did not exceed the allowable margins for grandfa-

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thered plans. Employee communications must state that the plan is grandfathered.

MLR Rebates and Discounts

This year was unpredictable when it came to health plan claims. Early in the COVID-19 pandemic, there was significant concern that this pandemic would drive up claims. In fact, many plans had a significant drop in claims at the beginning of the pandemic when many health care providers closed their offices to stop the spread. In the last two quarters of this year, claims have been picking up but, in many cases, they are running below what health plans expected.

For fully insured plans, this drop would likely result in a Medical Loss Ratio (MLR) rebate in 2021. The ACA's MLR standard target is a percentage of the premium that must be spent on claims expenses and a percentage that can be used for administrative expenses. When insurance carriers miss the administrative targets, they must rebate the amounts that exceed the targets in the following plan year.

Because of this year's unique situation, insurance carriers are expecting to miss MLR targets significantly. Many carriers have offered premium refunds or discounts. For health plans, refunds are a return of premiums already paid, and are considered plan assets under ERISA. Employers can generally keep discounts if they reduce future premiums because they aren't considered plan assets. However, employers can't charge an employee more than what they pay their insurance carriers. In some cases, the discount may be a refund. If the insurance carrier refers to the credit as a discount, but it is, in fact, a credit based on premiums already paid, that is technically a refund. Remember, MLR rebates and refunds are considered plan assets and if employees contribute to premiums, employers must share these rebates with employees in the same ratio as the percentage of premium the employer pays and the percentage of premium the employee pays.

MICHIGAN STATE LAW CHANGES – NO-FAULT AUTO REFORM

Changes in Michigan's no-fault auto insurance law apply to policies purchased or renewed after July 1, 2020.

One of the significant changes was in PIP (personal injury protection) coverage. Auto policyholders can now limit their PIP coverage. In July 2020, auto insurance policyholders had six PIP options to consider:

- Option 1: Unlimited PIP
- Option 2: Limited coverage of $500,000 PIP
- Option 3: Limited coverage of $250,000 PIP
- Option 4: Limited Coverage of $250,000 PIP with some or all persons excluded from PIP medical. This option is available only if you choose the $250,000 PIP medical limit.
  - The named insured must have qualifying health coverage that is not Medicare.
  - Any resident relative or spouse who wishes to exclude PIP medical must have qualifying health coverage.
  - Qualifying health coverage means either:
    - Health and accident insurance that covers injuries from auto accidents and has an annual individual deductible of $6,000 or less
    - Coverage under both Medicare Parts A and B.
  - Anyone who is excluded will have no PIP medical coverage. Anyone who is not excluded will have $250,000 in PIP medical coverage.
- Option 5: Limited coverage of $50,000 PIP. This option is available only if both of the following apply:
  - The applicant or named insured is enrolled in Medicaid
  - The spouse and all resident relatives have one of the following:
    a. Qualified health coverage
    b. Medicaid coverage
    c. Coverage under another auto policy with PIP medical coverage
- Option 6: No PIP medical coverage for anyone this policy covers. This option is available only if:
  - The applicant or named insured is covered under both Medicare Parts A and B, **AND**
  - A spouse and all resident relatives the policy covers have qualified health coverage or are covered under another auto policy with PIP medical coverage.

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This coverage includes Medicare and employer-sponsored health plans with a deductible of less than $6,000 a person. Whether the employer-sponsored health plan pays primary or secondary does not affect whether the plan is qualifying health plan coverage.

With limits in PIP coverage, some risk could be transferred to employer-sponsored health plans but that depends on the payment status of the plan as determined by funding status and ERISA status:

- Fully insured plans – Michigan auto insurance law requires fully insured plans to pay primary to no-fault auto PIP. Employers with these plans will not have any additional risk as they have always paid primary to the auto carrier.
- ERISA self-funded plans – these plans can take three approaches to coordinating with PIP benefits:
  - Primary payment stance – in this case the health plan will pay primary to PIP. If your plan is currently not paying primary, this will be a big potential increase in risk. Your plan will pay before any PIP benefits.
  - Secondary payment stance – in this case, the health plan will pay after benefits are exhausted under PIP. With the July changes, plan participants can now limit or even opt-out of PIP benefits. The plan may have to pay for injuries from an auto accident if the accident expenses exceed the PIP elected limits.
  - Exclusionary stance – the health plan could exclude medical expenses related to car accidents. Two potential considerations:
    1. Employees may elect a PIP limit (such as $250,000 or $500,000) that may not to cover all their medical expenses.
    2. This stance may leave out-of-state employees with a substantial liability since other states do not allow such generous PIP benefits. One solution is to exclude auto related medical expenses for anyone Michigan no-fault auto insurance covers and take a secondary stance for anyone it does not cover.
- Non-ERISA self-funded plans – these plans are limited to taking either a primary stance or an exclusionary stance. Liability concerns are noted in the previous bullets.

PIP benefits are not equal to your health plan's benefits. They go well beyond just reimbursing medical expenses. In addition, PIP benefits are based on the coverage level at the time of the accident. PIP pays for:

- Attendant care benefits if the insured needs help with activities of daily living
- Income replacement with limits and for only a limited period
- Home and auto modifications if needed
- Any medical service a physician orders with no deductibles, copays, coinsurance or plan limitations that are typical under a health plan

Make sure your employees understand that health plan benefits and PIP benefits are not equivalent.

FINAL GUIDANCE ON PHARMACEUTICAL MANUFACTURER COUPONS

The Notice of Benefit and Payment Parameters for 2021 included final guidance on prescription drug manufacturer coupons. The 2020 Notice of Benefit and Payment required employer plans to exclude the value of the coupon for a brand-name drug when they apply out-of-pocket limits if a medically-appropriate generic was available. This guidance conflicted with rules in place for high deductible health plans (HDHPs). Under HDHPs, the full cost of the drug cannot be applied to the deductible if a participant uses a coupon and actually pays less for a medication.

Under the 2021 Notice, the DOL allows, but does not require, group health plans to exclude the value of prescription drug coupons from a participant's out-of-pocket maximum. This no longer depends on whether a medically-equivalent generic is available. Keep in mind that some states may have laws mandating how fully-insured plans manage discounts. HDHPs must comply with the IRS rules allowing only the amount paid to be credited to the deductible.

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PROPOSED REGULATIONS ON DIRECT PRIMARY CARE CONTRACTS AND HEALTH CARE SHARING MINISTRIES

The IRS guidance concerns the fees paid for, or by, Direct Primary Care (DPC) contracts and Health Care Sharing Ministries (HCSM).

A DPC is a contract between a patient and one or more primary care physicians in which the physicians agree to provide medical care for a fixed annual or periodic fee without billing a third party.

An HCSM is an arrangement where people of common religious or ethical beliefs agree to pay a monthly fee to share medical costs with the group. While it appears to be insurance, it is not and there is no guarantee that it will cover participants' health care expenses.

Code Section 213 allows taxpayers to claim an itemized deduction for medical expenses if the expenses exceed a certain percentage of adjusted gross income. Eligible medical care expenses include amounts paid for diagnosing, curing, mitigating, treating or preventing disease or for insurance. At this point payments for coverage under a DPC or HCSM are not Section 213 medical expenses.

Under the proposed rules, DPCs would qualify as either medical care or insurance for medical care. To qualify as insurance, an HCSM needs to meet the following:

1. It is a Code Section 501 (c)(3) tax exempt entity.
2. The members share a common set of ethical or religious beliefs and share medical expenses without regard to the state in which the member lives or works.
3. A member can't lose membership because of a medical condition.
4. The HCSM (or its predecessor) has existed continuously since December 31, 1999, and has shared members' expenses continuously and without interruption.
5. An independent CPA firm audits the HCSM annually following generally accepted accounting principles and the audit is available to the public on request.

So what does this mean? Once the regulations are final and have an effective date, these arrangements can be considered Section 213(d) medical expenses. A Health Reimbursement Account (HRA) could then reimburse DPC fees or HCSM memberships if the HRA allows the reimbursement.

Both DPCs and HCSMs may not allow employee contributions to HSAs if the employee is covered by a qualifying HDHP. Since additional coverage under a DPC or HCSM would likely be considered other comprehensive coverage, accountholders would not be able to contribute to an HSA.

NEW MODEL COBRA NOTICES

The DOL released new model COBRA forms this year. The new forms explain the Marketplace options and the interaction with Medicare and COBRA more clearly.

The new model notices can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/cobra.

NEW MODEL FMLA NOTICES

The DOL posted new FMLA model notices and forms that are optional for FMLA administration. Remember, employers can't use forms that request more information than the FMLA permits.

Employers can use the following forms to meet FMLA requirements.

1. **General Notice, the FMLA poster** – satisfies the requirement that every covered employer must post an informative general notice about the FMLA. This notice or a handbook will satisfy the requirement to notify employees in writing when they are hired.
2. **Eligibility Notice, form WH-381** – informs employees when they are eligible for FMLA leave or gives at least one reason why they are not.
3. **Rights and Responsibilities Notice, form WH-381 (combined with the Eligibility Notice)** – informs employees of the specific expectations and obligations associated with FMLA leave requests and the consequences of not meeting them.
4. **Designation Notice, form WH-382** – informs employees whether their FMLA leave request is approved; also states the amount of leave allowed and will be counted against their FMLA entitlement. An employer may also use this form to inform employees that additional information is necessary.

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There are five DOL optional-use FMLA certification forms.

Certification of Healthcare Provider for a Serious Health Condition

- **Employee's serious health condition, form WH-380-E** – use when a leave request is due to an employee's medical condition.
- **Family member's serious health condition, form WH-380-F** – use when a leave request is due to the medical condition of the employee's family member.

Certification of Military Family Leave

- **Qualifying Exigency, form WH-384** – use when the leave request is due to the foreign deployment of the employee's spouse, son, daughter, or parent.
- **Military Caregiver Leave of a Current Servicemember, form WH-385** – use when requesting leave to care for a seriously injured or ill family member who is currently a service member.
- **Military Caregiver Leave of a Veteran, form WH-385-V** – use when requesting leave to care for a family member who is a seriously injured or ill covered veteran.

The new Serious Health Condition Certification Form is easier to understand. It covers situations that are considered serious health conditions under the law. It also has more check boxes rather than written answers.

FINAL RULES ON DRUG REIMPORTATIONS

Final rules were published to create a way for specific entities to legally re-import medications. The path involves several steps and is available only to specific entities. Following is an overview of the process:

1. States or Indian tribes can submit a Section 804 Importation Program (SIP) proposal to the Federal Drug Administration (FDA). The proposal can include co-sponsors which may be other non-federal government entities such as pharmacists and wholesalers. The SIP must identify the medications they want to include in the program. Only certain medications will be considered. The following medications are specifically excluded:
    a. controlled substances
    b. biological products
    c. infused drugs
    d. intravenously injected drugs
    e. drugs inhaled during surgery
    f. drugs subject to risk and mitigation strategies (REMS)
2. The SIP sponsor must identify a seller in Canada that will buy the eligible prescriptions directly from the manufacturer. The SIP sponsor must ensure:
    a. the supply chain is secure
    b. the medication is safe
    c. the labeling requirements are met
    d. the reimported medications will significantly reduce costs for the American consumer

The FDA must approve the proposal. It can decline the request if the SIP does not meet all the requirements.

Reimported drugs will need safety testing and re-labeling to be distributed in the United States.

Canada has repeatedly said it will not allow this practice because it could compromise the drug supply for the Canadian public health program.

ANNUAL REMINDERS AND UPDATES

2021 Medicare Information

The Department of Health and Human Services has released the following Medicare information for 2021 (see table at the top of page 12).

The hold harmless also applies when premiums are adjusted for income. Medicare Part B premiums are higher for those with higher incomes. Roughly seven percent of Medicare Part B beneficiaries pay the higher income-based premiums. CMS looks at the income from 2019 to determine Part B premiums for 2021. The ranges of income changed in 2021 (see table on page 12).

The indexed parameters for Medicare Part D for 2021 are as follows (see table on page 12).

The ACA reduced the financial strain of the Medicare Part D coverage gap. While the stan-

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dard Part D benefit plan design remains the same, the Medicare beneficiary's cost for drugs in the coverage gap has decreased. For brand-name drugs, the government, along with manufacturers, is subsidizing 75 percent of the cost during the coverage gap; the Medicare beneficiary pays the remaining 25 percent. For generic drugs, the government is subsidizing 75 percent of the cost in the coverage gap and the Medicare beneficiary pays the remaining 25 percent. Most of the negotiated cost for both generic and brand name drugs will apply to the true out-of-pocket maximum.

The premiums for Medicare Part D coverage are also income-based. However, Medicare Part D operates differently from Medicare Part B. The government sets the standard plan design and insurance carriers cover different drugs with different cost-sharing requirements. The carriers set the premiums. Since premiums differ among carriers, income-based premiums are presented as an increase to the Part D premiums. CMS looks at the income from 2019 to determine Part D adjustments for 2021. The income range changed slightly in 2021 (see table at top of page 13).

Medicare Part D may also affect employers sponsoring retiree drug plans. If their drug benefits are as good as or better than the Medicare benefits, employers can apply for a government-paid subsidy based on a percentage of claims paid. The subsidy equals roughly 28 percent of prescription claims for covered medications that fall between the cost threshold and the cost limit. The cost threshold and cost limit are annually indexed.

Medicare Information	
Medicare Part A Deductible (per benefit period)	$1,484.00
Hospital **Per Day** Copay (per benefit period)	
60 to 90 day stays	$ 371.00
90+ day stays	$ 742.00
Skilled Nursing Facility **Per Day** Copay (for days 21-100 of each benefit period)	$ 185.50
Medicare Part B Monthly Premiums	$ 148.50*
Medicare Part B Annual Deductible	$ 203.00

*These Part B premiums generally apply only to those who elect Part B in 2021. However, not everyone pays $148.50 for Part B. When the Social Security cost of living increase is less than the increase in Medicare Part B premiums, the increase in Part B premiums can't exceed the increase in Social Security income benefits.

Income Ranges		
Individual Return	**Joint Return**	**2021 Part B Monthly Premium**
$88,001-$111,000	$176,001-$222,000	$207.90
$111,001-$138,000	$222,001-$276,000	$297.00
$138,001-$165,000	$276,001-$330,000	$386.10
$165,001-$499,999	$330,001-$749,999	$475.20
$500,000 or more	$750,000 or more	$504.90

Indexed Parameters	2021
Annual Deductible (amount the Medicare beneficiary pays before benefits are payable)	$445
Initial Coverage Limit (once the beneficiary meets the deductible, the plan pays 75% and the beneficiary pays 25% until the total prescription expense - paid by plan and beneficiary - reaches the initial coverage limit)	$4,130
True Out-of-Pocket Maximum (once the Medicare beneficiary has paid the true out-of-pocket cost, Medicare catastrophic coverage will pay most of the prescription drug cost. The standard plan pays no part of expenses after the initial coverage limit until the true out-of-pocket maximum is reached.)	$6,550
Total Covered Part D Expenses Before Catastrophic Coverage (if the beneficiary has no coverage other than the Medicare Part D plan)	$9,313.75
Catastrophic Coverage Medicare pays most of the prescription drug expense after the catastrophic coverage level is reached. The Medicare beneficary pays the greater of 5% of the drug's cost or a $3.70 generic or $9.20 brand-name copay.	

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The 2021 amounts are as follows:

	2021
Cost Threshold	$ 445
Cost Limit	$9,200

Retiree drug subsidies are treated as taxable income to organizations. Organizations that pay federal taxes may want to consider alternatives to the retiree drug subsidy if they cover drugs for post-65 retirees.

Income Ranges		
Individual Return	Joint Return	2020 Part D Monthly Increase to Premium
$88,000 or less	$176,000 or less	No Adjustment
$88,001-$111,000	$176,001-$222,000	$12.30
$111,001-$138,000	$222,001-$276,000	$31.80
$138,001-$165,000	$276,001-$330,000	$51.20
$165,001-$499,999	$330,001-$749,999	$70.70
$500,000 or more	$750,000 or more	$77.10

MEDICARE PART D NOTICE REMINDER

Employers need to issue two Medicare Part D notices annually. The first concerns creditable coverage for prescription benefits. It must be sent to Medicare-eligible plan participants. As a rule, Medicare beneficiaries must enroll in a Medicare Part D plan when they first become eligible or pay a penalty for late enrollment. However, if your prescription coverage is creditable and the Medicare beneficiary maintains creditable coverage, then the late enrollment penalty will not apply.

Employers need to assess creditability every year and whenever they change their drug plans. Interestingly, more and more employer plans are finding that their coverage is no longer creditable because of ACA changes to Medicare Part D. Since the government and brand-name drug manufacturers are picking up a significant amount of the cost in the coverage gap, the actuarial value of Medicare Part D is rising. In the last few years, employers have been shifting significantly more cost for plan usage to employees. This means more employer plans will likely be found non-creditable. Be sure to notify your employees when the drug coverage is determined to be non-creditable. Medicare beneficiaries may have to pay late enrollment penalties if they do not have creditable drug coverage.

More details on the wording of the latest model notice can be found at https://www.cms.gov/CreditableCoverage/Model%20Notice%20Letters.asp#TopOfPage.

The second notice, stating your plan's creditable coverage status, must be filed electronically with CMS within 60 days of the beginning of the plan year. Completing the online notice does not take much time; the toughest part is remembering to do it. You can file the notice online at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/Creditable-Coverage/CCDisclosureForm.html.

STATE OF MICHIGAN UPDATES HARD CAP LIMITS FOR PUBLIC EMPLOYERS

Public Act 152 caps the amount public employers may contribute to employee health benefits. The act allows two possible funding approaches: a hard dollar cap or an 80/20 contribution split. The hard dollar caps are indexed annually for medical inflation. The limits for 2020 and 2021 are listed at the top of page 14.

The 2021 limits are 3.3 percent higher than the 2020 limits. The limits continue to be based on total plan cost rather than the actual paid amounts for each coverage level. The 2021 limits apply to coverage years beginning on or after January 1, 2021.

To opt out of these limits, a public sector entity must follow a specific process. The law does not apply to state civil service employees or to public universities.

HEALTH CARE REFORM – OUT-OF-POCKET MAXIMUMS

In 2014, the ACA required non-grandfathered group health plans to limit the maximum annual out-of-pocket cost for plan members. This limit applies to nearly all out-of-pocket costs including deductible expenses, coinsurance, office visit copays, emergency room copays and even prescription drug copays. It does not include the out-of-pocket cost for out-of-network expenses and employee contributions to pay for the coverage.

The limits are as follows:

Single:

2019: $7,900
2020: $8,150
2021: $8,550

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Family:
2019: $15,800
2020: $16,300
2021: $17,100

HEALTH CARE REFORM – ACA 4980H PENALTIES-EMPLOYER MANDATE

Employers may have to pay one of two penalties under the ACA employer mandate.

The "A penalty" applies if your organization does not offer 95 percent of your full-time employees and their dependent children minimum essential coverage (MEC). MEC is simply employer-sponsored health coverage that is not an excepted benefit. (There is no minimum value or affordability requirement tied to the "A penalty.") This penalty is triggered if a full-time employee purchases subsidized coverage in the Marketplace.

The "B penalty" applies if your organization does not offer some full-time employees and their dependent children minimum value (60 percent) affordable coverage and your employees then obtain subsidized coverage in the Marketplace.

The dollar amounts of these penalties are annually indexed. The last three years of annual penalty amounts are as follows:

"A" Penalty:
2019: $2,500
2020: $2,570
2021: $2,700
"B" Penalty:
2019: $3,750
2020: $3,860
2021: $4,060

State of Michigan Hard Cap Limits for Public Employers	2020	2021
Employee Only Coverage	$6,818.87	$7,043.89
Employee and Spouse Coverage or Employee Plus One Coverage	$14,260.37	$14,730.96
Family Coverage	$18,596.96	$19,210.66

GROUP TERM LIFE INSURANCE: SECTION 79

Employers should review their group term life coverage annually to determine whether employees need to pay taxes on it. In the following cases, employers will have to impute income for the value of these life insurance plans:

- Employer-paid life insurance exceeding $50,000.
- Life plan favoring key employees (only key employees will have to pay taxes).
- Employee-paid optional life plan with a rate table that straddles Table I rates (employees whose rates are below the Table I rates may have to pay taxes).
- Voluntary term life coverage that the employer allows to be paid with pre-tax dollars.

Our most recent *Benefit Advisor* (available on our website) explains when and how to calculate imputed income.

W-2 SHOULD INCLUDE SHORT-TERM DISABILITY BENEFITS

Organizations need to report disability benefits or earnings paid to disabled employees during the year. Although disability carriers pay the benefits in many cases, employers need to make sure those benefits are included on the employee's W-2.

The income from these benefits is generally reported in one of two ways:

- Disability carriers or administrators may issue W-2s directly to participants who received benefits during the year.
- Carriers or administrators may send the employer a quarterly or annual report with the information that the employer should include on each disabled employee's W-2.

Let your employees know if your disability vendor is issuing them a separate W-2. Usually, disability vendors inform employers of the amount paid in disability benefits, and employers then add the benefit income to the employee's W-2.

If your organization self-funds short-term disability benefits, you will need to include those benefits in the employee's 2020 W-2. If you use a payroll service to issue W-2s, your payroll vendor must include the additional compensation on the employee's W-2.

FORM 8928

The IRS requires employers to self-report excise taxes when there have been certain compliance failures. Employers should review their records annually to determine whether they have had these failures. If so, they need to submit Form 8928. Self-reporting has been required since January 1, 2010.

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The IRS publishes instructions on how to complete Form 8928 along with the specific compliance failures employers need to report. These failures include COBRA violations, HIPAA violations, and ACA market reform violations. The instructions and form can be found at https://www.irs.gov/forms-pubs/about-form-8928. The IRS does make exceptions for certain compliance failures. For example, no tax penalty is due if the failure was reasonable and not deliberate. To show that a failure was reasonable, employers must:

- Establish that no one liable for the penalty "knew or if he/she had exercised reasonable diligence would have known" that the compliance failure occurred.
- Correct the failure within 30 days of discovering the problem.

Employers with no reportable failures within the year do not need to file Form 8928. Employers who do need to file Form 8928 should file it before the due date for filing the corporate tax return. They can submit Form 7004 if they need an extension. The most recent version of Form 7004 can be found at the above link.

HIPAA BREACH REPORTING

HIPAA Privacy and Security rules explain how to investigate and handle any potential breaches of Protected Health Information (PHI).

Covered entities must report breaches of unsecured PHI and take very specific action if, and when, a breach occurs. They must report breaches to anyone affected, the Department of Health and Human Services (DHHS) and possibly the media. The process for the DHHS reporting depends on the number of people the breach affects. If it affects 500 or more people, it must be reported to the DHHS promptly. If it affects fewer than 500 people, it needs to be reported within the first 60 days of the calendar year. Employers can file breach reports electronically at http://www.hhs.gov/ocr/privacy/hipaa/administrative/breachnotificationrule/brinstruction.html. If there are no breaches during the calendar year, no report needs to be filed.

W-2 REPORTING REQUIREMENTS

Employers need to report the value of employer-sponsored health coverage in Box 12 of each employee's W-2. This reporting requirement affects almost all employers, although the small employer exception still appears to apply for 2021. Employers issuing fewer than 250 W-2s in the preceding year need not report the health coverage value on employees' W-2s.

Employers must determine cost in good faith compliance with the COBRA rules. For example, organizations with fully insured plans would use insurance premiums less the 2 percent COBRA administrative fee. Self-funded plans should use the projected cost or illustrative rate less the 2 percent COBRA administrative fee.

The reportable cost is the total cost, and should include employee and employer contributions. It should reflect:

- Medical and prescription drug coverage.
- Dental and vision coverage only if they are **not "excepted"** under HIPAA (excepted benefits are provided under separate contracts or are elected separately).
- Medical FSAs only when the FSA annual election exceeds the employee's total salary reduction.
- EAPs that provide significant medical benefits. EAPs that do not provide significant medical benefits are considered an "excepted" benefit. Employers can exclude that cost when they report the value of the medical plan.

The reported value must also reflect mid-year changes such as changes in coverage or mid-year renewals. Employers can calculate reportable cost with the information they have as of December 31. Changes in January affecting the previous year's reportable cost do not need to be considered.

2021 INDEXED HSA LIMITS

The IRS annually releases indexed limits for health savings accounts (HSAs) and high deductible health plans (HDHPs). The limits for the last three years are shown in a table on page 16.

The maximum out-of-pocket limit for a qualifying HDHP is less than the maximum out-of-pocket limit the ACA allows.

2021 INDEXED PLAN LIMITS

A table on page 16 summarizes the 2020 and 2021 indexed plan limits.

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CONCLUSION

Just a reminder, our 2021 survey will begin collecting data early next year. If you participate, your organization will receive valuable benchmark data on Michigan's employer benefit plans.

This has been a year with a tremendous amount of stress and activity. This checklist will help you keep track of the ever-changing rules for employee benefit plans.

The Marsh & McLennan Agency | Michigan team wishes you and your family a happy and healthy 2021!

MMA

Health Saving Account Limits	2019	2020	2021
HDHP Minimum Deductible			
Self-Only Coverage	$1,350	$1,400	$1,400
Family Coverage	$2,700	$2,800	$2,800
HDHP Maximum Out-of-Pocket			
Self-Only Coverage	$6,750	$6,900	$7,000
Family Coverage	$13,500	$13,800	$14,000
HSA Statutory Contribution Maximum			
Self-Only Coverage	$3,500	$3,550	$3,600
Family Coverage	$7,000	$7,100	$7,200
Catch-Up Contribution (age 55 and older)	$1,000	$1,000	$1,000

Indexed Plan Limits		
Plan Limits	**2020**	**2021**
Section 401(k) or SAR-SEP	$19,500	$19,500
Section 402(g) maximum pre-tax contribution by employees for elective deferrals	$19,500	$19,500
Age 50+ Catch-Up Deferral Limit	$6,500	$6,500
Section 403(b) Plan	$19,500	$19,500
Section 408(p)(2)(E) Simple Plan Contributions	$13,500	$13,500
Section 457(b)(2) Limit	$19,500	$19,500
Key Employee Determination - Officers; Earning Threshold	$185,000	$185,000
Section 415 Limit for:		
Defined Contribution Plans (calendar year)	$57,000	$58,000
Defined Benefit Plans	$230,000	$230,000
Highly Compensated Employees		
Section 414(q)	$130,000	$130,000
Includible Compensation - Section 401(a)(17)	$285,000	$290,000
FICA Taxable Wage Base		
Social Security (Tax Rates 6.2%)	$137,700	$142,800
Medicare (Tax Rate 1.45%)	No limit	No limit

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