

It Benefits You Your Employee Benefits Newsletter

April 2023

In This Issue:

- Cyber Liability – A McGriff Webinar
- Upcoming Compliance Deadlines
- What to Know Before You Offer a Stand-alone Supplemental Health Program
- DOL Issues Guidance on Telework and FMLA Eligibility
- EDI vs API Integrations for Ben Admin Tech
- Are You Still Filing Paper Reports with the IRS?
- Health Plans Must Submit Gag Clause Attestations by Dec. 31, 2023
- End of the National Emergency & COBRA
- McGriff Sponsored Mineral HR Q&A



In it for the Long Haul

On April 17, over 30,000 runners and nearly 500,000 spectators will gather for the 127th Boston Marathon! The athletes complete intensive training plans, dietary changes, and mental preparations to go the distance and cross that finish line. At McGriff, we realize our job is a marathon and not a sprint. We work year-round to ensure your benefit plan stays in the best possible shape to easily cross over the finish line during open enrollment and combat high-claim years using smart strategies and long-term planning.



Cyber Liability – A McGriff Webinar

April 20 – 2:00 pm ET – [Click here to register](#) – 1.0 SHRM CE Approved /1.0 HRCI Pending

Are you prepared for a cyber attack? With the growing threat of cyber crimes, organizations regardless of size realize no one is exempt from experiencing a cyber attack. During this session we will discuss best practices to mitigate cyber threat exposure that include: multi-factor authentication, how to track revenue following a loss, ransomware, FBI recommendations, recovering from an attack and claims impact. Presented by: McGriff Executive Risk Advisors and The Hartford.

Upcoming Compliance Deadlines

May



Summary Plan Description (SPD) (for new calendar year plans)

For new group health plans, welfare benefit plans, or pension benefit plans, the summary plan description (SPD) must be furnished within 120 days of the plan start date. For calendar year plans in 2023, the deadline is May 1, 2023. For existing plans, new participants must be provided an SPD within 90 days of becoming covered.

June



Reporting on Pharmacy Benefits & Drug Costs (Filing Deadline for 2022 Data)

Plan sponsors must report information about prescription drugs and health care spending to the CMS each year. Data for 2022 reference (calendar) year is due June 1, 2023. This reporting is required for fully-insured and self-funded group health plans of all sizes. The McGriff Compliance Team has prepared [a reference guide](#) that provides employers with practical steps to help them comply with this reporting obligations, and a Vendor Assistance Verification [email template](#) that contains questions employers should ask vendors in determining what they are doing to assist.

July



PCORI Fee Deadline

If an employer sponsors a self-insured health plan, including a level-funded plan or an employer-sponsored HRA, the ACA requires the employer to submit the annual Participant-Centered Outcomes Research Institute (PCORI) Trust Fund Fee. Plan sponsors must report and pay the PCORI fee using IRS Form 720. The fee amount for plan years ending on or after Oct. 1, 2022 and before Oct. 1, 2023 is \$3.00 multiplied by the average number of lives covered under the plan.

July



Form 5500 Filing Deadline for Calendar Year Plans

Generally, a Form 5500 must be filed no later than the last day of the seventh month after the end of the plan year for ERISA pension and welfare benefit plans. For calendar-year plans, the deadline is July 31. With few exceptions, an employer must file a 5500 if any of its ERISA benefit plans had 100 or more covered participants on the first day of the plan year.





What to Know Before You Go It Alone & Offer a Supplemental Health Program to All Employees

Has a vendor ever approached you about offering a medical or pharmacy benefit separate from your medical plan? When you offer a program to employees other than those who participate in your medical plan, we refer to it as a 'stand-alone' plan. These types of programs can be an inexpensive way to provide at least some health-related benefit to all employees. But the buyer must always beware of the potential compliance risks inherent in a stand-alone plan structure. Often when something sounds too good to be true...it is!

So, what should you consider from a compliance perspective? It depends on the details of the program. This is one area where how the program is structured can make a big difference in terms of what laws and regulation apply. The kind(s) of benefits you offer as well as the depth and duration of coverage are important considerations.

In particular, ***if the program provides or pays the cost of medical care, then significant compliance obstacles may exist for providing the program on a stand-alone basis.***

That's because a program that provides or pays the cost of medical care will likely be considered a group health plan and therefore subject to the full complement of laws that regulate them (unless an exception applies). Typically, that would include laws such as the Employee Retirement Income Security Act (ERISA), the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Affordable Care Act (ACA), and the Health Insurance Portability and Accountability Act (HIPAA).

Let's take a closer look at some of the key compliance considerations for a stand-alone program that meets the definition of a group health plan, as well as some potential exceptions.

- **ERISA** – If ERISA applies, then the program will need its own written plan document and summary plan description. Depending on the size of the program, you may need to file a Form 5500. Other rules can present unique challenges, such as complying with ERISA-required claims procedures. And don't forget about the additional responsibilities (and potential liability) that apply with ERISA fiduciary duties.
- **COBRA** – If COBRA applies, participants who experience a qualifying event must be offered continuation coverage when they lose eligibility for the program, which means, among other things, that you must determine the applicable COBRA premium for the program. The program must also comply with all other notice, timing and other requirements under COBRA and that can get complicated without the assistance of a third party. Your current COBRA third-party administrator may or may not agree to take on these responsibilities for another program and if it does, you can expect to pay some additional cost.
- **ACA** – Group health plans generally must comply with market reforms under the ACA. This would require, for example, that a program not contain any annual or lifetime limits on benefits and cover preventive benefits with no cost sharing. As you can imagine, this can be a substantial if not insurmountable burden for most stand-alone plans and failure to comply means stiff penalties of \$100/day or \$36,500/year/ participant. Fortunately, some programs can satisfy an exemption, such as the one for excepted benefits, which would include on-site clinics and certain employee assistance programs (EAPs) that don't provide significant benefits in the nature of medical care. For example, it is common to seek to structure stand-alone telemedicine to fall under the EAP exception.

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- **HIPAA** – Depending on program specifics, it may need to comply with HIPAA portability, nondiscrimination, special enrollment, and privacy and security rules. These rules require careful consideration of plan design and may include a significant documentary burden that can add to program cost. Certain exceptions can prove quite useful. For example, an on-site clinic that qualifies as an excepted benefit would avoid most of these requirements as well as the ACA market reforms mentioned above.
- **HSA Eligibility** – If you also offer a medical plan that qualifies as a high deductible health plan (HDHP), then another trap for the unwary may appear. A stand-alone group health plan would have to ensure it does not provide zero or low-cost benefits below the IRS minimum deductible to preserve HDHP participant’s ability to fund a health savings account (HSA). We do have some limited time relief from this rule, most notably for certain telemedicine programs through HDHP plan years beginning in 2024. However, keep in mind that relief only impacts HSA eligibility...it does not exempt the program from the acronym soup of other laws that can affect group health plans!

The easiest way to satisfy the compliance obligations that apply to supplemental programs that are considered group health plans is to bundle the program with your major medical plan. That means that you can only offer the program to

medical plan enrollees and would need to take certain steps to include the program as part of your medical plan (e.g., add language indicating it is part of the medical plan, etc.). While not all the above key compliance obligations are non-starters, the ACA market reforms are difficult if not impossible for most programs to meet on a stand-alone basis.

Here are some practical tips you can follow to make sure the supplemental plan you are considering will not get you into trouble. Ask questions! Inquire about what laws apply to the program, how it complies with applicable laws and whether they have obtained a legal opinion along those lines. On the subject of legal opinions, keep in mind that a legal opinion is only as good as the source that provides it. If it comes from an attorney who does not practice in the area of employee benefits, it may not be trust-worthy. Remember, if a vendor tells you that none of their clients have gotten in trouble, that’s not the same thing as their program being compliant. There may still be significant risk. If possible, ensure your company’s employee benefits attorneys have reviewed the program and are comfortable with it.

In the end, don’t despair! It may be that bundling the program with your major medical or making a few tweaks to the program parameters is all that’s needed to create a great new benefit that does not add potentially bank breaking liability to your bottom line.



This article was previously published in HR Professionals Magazine. For your free subscription, click [here](#).



Stacey Stewart, JD, LLM in Taxation
McGriff Senior ERISA & Employee Benefits Compliance Officer

Clickable Resources: DOL Issues Guidance on Telework and FMLA Eligibility

Watch a video:















Read the guidance:











EDI vs API Integrations for Benefits Administration Technology

EDI has long been the standard method used by benefits administration technology companies for transmitting data to third parties (carriers, FLEX providers, COBRA administrators, payroll platforms, etc.). However, APIs are beginning to emerge in this space. View the differences between the technologies below, as well as the transformational impact API will have on the experience of employees, HR administrators and third parties related to the administration of employee benefits.

	EDI - Electronic Data Interchange	API - Application Programming Interface
Connections		
Data Management	 <p>File-based, unidirectional: This solution stores a snapshot of data in a file and transmits to another party via Secure File Transfer Protocol</p>	 <p>Cloud-based, multidirectional: This solution allows for bidirectional data exchange via an interface over the internet</p>
Cadence	 <p>Weekly cadence: files are typically scheduled for weekly delivery</p>	 <p>Real-time cadence: interface allows for real time transfer of data</p>
Time	 <p>To establish each connection: 2-3 months</p>	 <p>To stand-up established connection: <14 days</p>
Impact of One Errant Record	 <p>Reject entire file of all employee records</p>	 <p>Reject only the errant record, updating all others</p>
System Implementation		
Configuration Accuracy¹	 <p>A human must interpret benefit plan designs and configure each one plan manually</p>	 <p>Plan build is standardized and automatically pulled in from carrier specifications</p>
Timeline^{2,3}	 <p>System implementation standard is 60-120 days due to EDI file feed development</p>	 <p>Reduced by 30-45 days by eliminating the EDI file feed development process</p>

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	EDI - Electronic Data Interchange	API - Application Programming Interface
Employee/HR Administration Impacts		
Billing Reconciliation ^{2,3}	 <p>Weekly, unidirectional EDI (snapshot) updates means the data in payroll, benefits administration and carrier systems are almost always out of sync, resulting in discrepancies</p>	 <p>Real-time, bi-directional API data exchange means data in payroll, ben admin and carrier systems are almost always in sync, reducing discrepancies</p>
Evidence of Insurability (EOI) Management ⁴	 <p>EOI processing requires the employee and HR Admins to manage a paper or electronic document process outside of the enrollment experience. HR Admin must manually update benefits administration system with carrier decision.</p>	 <p>API allows EOI application to occur within the enrollment experience and automatically update the benefits administration platform with carrier decision</p>
Access to Care ³	 <p>Annual Enrollment (AE), New Hire and QLE records updates can take weeks to reflect in the carrier system – meaning verification of coverage issues can arise for employees</p>	 <p>Once medical providers adopt API, AE, New Hire and Qualifying Life Event (QLE) records will update same day, greatly reducing delays in access to care</p>
Display of Third-Party Data	 <p>Limited to static documents such as benefits summaries, carrier links and videos</p>	 <p>Can pull in valuable third-party information such as employee deductible balances and spending account (FSA, HSA) balances into the employee's benefits administration portal experience</p>

¹ Plan Configuration API

² Demographic API

³ Enrollment/Eligibility API

⁴ EOI API

As API becomes more prevalent in benefits administration technology, the experience for all involved will become more seamless and efficient.

Kisha Moliere

McGriff National Benefits Administration
Technology Practice Leader



Are You Filing Paper ACA Reports with the IRS? Electronic Filing Required for Most Employers in 2024!

On Feb. 23, 2023, the IRS released a final rule that significantly expands the requirement to file certain information returns electronically, including Affordable Care Act (ACA) reporting requirements under Internal Revenue Code (IRC) Sections 6055 (Forms 1094-B/1095-B) and 6056 (Forms 1094-C/1095-C).

Currently, employers who file fewer than 250 of the same ACA reporting forms are permitted to choose whether to remit their Forms 1094/1095 by paper or electronically. However, under the new rule, employers who file **at least 10 returns** during the calendar year must file their informational returns electronically, **beginning with returns due on or after Jan. 1, 2024**. This 10-form threshold is calculated by **aggregating the total number of forms** the employer must file with the IRS, including information returns (Forms W-2, 1094, 1095 and 1099), income tax returns, employment tax returns and excise tax returns. Accordingly, this final rule will effectively eliminate paper filings for most benefit plan returns for all but the smallest employers.

If you are an Applicable Large Employer (ALE) responsible for filing Forms 1094-C/1095-C or a non-ALE sponsoring a self-funded/level-funded health plan and responsible for filing Forms 1094-B/1095-B, you should be prepared to file your 2023 ACA Forms due in early 2024 electronically. Unfortunately, the electronic filing process is not as simple as uploading an Excel or CSV file to the IRS. Electronic files must be submitted directly through the IRS [Affordable Care Act Information Returns \(AIR\) System](#) and require a specific XML Schema, rules and testing. Employers preferring to engage a vendor to assist with electronic filing should begin their search as soon as possible to make sure their 2023 data is accurately captured. For assistance with finding an ACA reporting vendor, contact your McGriff account team.



Christy Showalter, JD
McGriff Senior ERISA & Employee
Benefits Compliance Officer

Health Plans Must Submit Gag Clause Attestations by Dec. 31, 2023

On Feb. 23, 2023, the Departments of Labor, Health and Human Services and the Treasury (Departments) issued FAQs on the prohibition of gag clauses under the transparency provisions of the Consolidated Appropriations Act, 2021 (CAA). These FAQs require health plans and health insurance issuers to submit their first attestation of compliance with the CAA's prohibition on gag clauses by Dec. 31, 2023.

Effective Dec. 27, 2020, the CAA prohibits health plans and issuers from entering into contracts with health care providers, third-party administrators (TPAs) or other service providers that would restrict the plan or issuer from providing, accessing or sharing certain information about provider price and quality and deidentified claims.

Plans and issuers must annually submit an attestation of compliance with these requirements to the Departments. The first attestation is due by Dec. 31, 2023, covering the period

beginning Dec. 27, 2020, through the date of attestation. Subsequent attestations, covering the period since the last attestation, are due by Dec. 31 of each following year.

Action Steps

Employers should ensure any contracts with TPAs or other health plan service providers offering access to a network of providers do not violate the CAA's prohibition of gag clauses. Also, employers with fully insured or self-insured health plans should prepare to provide the compliance attestation by Dec. 31, 2023. If the issuer for a fully insured health plan provides the attestation, the plan does not also need to provide an attestation. Also, employers with self-insured health plans can enter into written agreements with their TPAs to provide the attestation, but the legal responsibility remains with the health plan.



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End of the National Emergency and COBRA

The year was 2020. News outlets were beginning to report on a novel coronavirus appearing in countries across the globe. Little did we know we would soon be adjusting to lockdowns and social distancing. We expected the upheaval to last a few months at the most.

On April 29, 2020, the Department of Labor issued relief regarding extensions of various time periods related to COBRA timelines and employee benefit plan deadlines. Now we find ourselves in 2023 planning for the end of the relief timeline extensions.

No one thought the COVID-19 pandemic and relief efforts would continue for three years. We now find ourselves preparing to end the COBRA timeline extensions at the end of the Outbreak Period (July 10, 2023). Now we're tasked with explaining the change in COBRA timelines to a population of COBRA-enrolled members who have never experienced the standard strict timelines of COBRA. It will be a painful education for members who are used to the leniency of reinstatement to find there is no mercy for missing deadlines.

The Outbreak Period was originally described as a pause in time. COBRA timelines for the enrollment, initial payments and subsequent payments paused on March 1, 2020, when a National Emergency related to the pandemic was declared. The end of the Outbreak period was set for 60 days after the announced end of the National Emergency. The Outbreak Period remained in effect longer than anticipated so, on March 1, 2021, new guidance was released limiting the pause to a 12-month period per individual per instance. With the Outbreak Period scheduled to end July 10, 2023, the pause based on each individual will end at the end of the Outbreak Period or 12 months, whichever occurs first.

What does this mean to individual member timelines?

- Individuals offered COBRA on July 10, 2022 or later who

have not yet elected will have a 60-day period, until Sept. 8, 2023, to choose to enroll in COBRA coverage. The individual will have 45 days from their election date to pay the premium to cover the period from the COBRA start date to current.

- Individuals who had elected COBRA between July 10, 2022 and July 10, 2023 will have 45 days, until Aug. 24, 2023, to pay the premium to cover the period from the COBRA start date to current.
- Individuals enrolled in COBRA from July 10, 2022 to July 10, 2023 making monthly premium payments will be required to pay COBRA coverage current within 30 days grace, which will end Aug. 9, 2023.

COBRA coverage start dates of July 10, 2023 and after will be subject to standard COBRA timeline rules listed below:

1. The 60-day deadline to notify your group health plan administrator of a qualifying event;
2. The 60-day deadline for Qualified Beneficiaries to elect COBRA;
3. The 60-day deadline to notify the plan that a Qualified Beneficiary was determined by the Social Security Administration to be disabled; and
4. The 45-day deadline in which to make a first premium payment and 30-day deadline for subsequent premium payments.

Employers will need to work with their COBRA administrators to ensure that all necessary communications and notices are being prepared and sent to COBRA beneficiaries, as well as being prepared to properly administer the deadlines.

Joan Waddell

McGriff Flexible Benefits, COBRA Manager

Attention McGriff COBRA Administration Clients!

McGriff COBRA Administration will send a letter of notification of the end of the Outbreak Period to all COBRA members offered COBRA from July 10, 2022 to current. This correspondence will be mailed by March 31, 2023.

A supplemental notice regarding the Outbreak Period has been attached to the outgoing COBRA specific rights notices since March 2020. This supplemental notice has been updated to reflect the end of the Outbreak Period and the new timelines effective July 10, 2023.

McGriff Sponsored Mineral HR Q&A:

Q: An employee came to us with a harassment complaint but said they didn't want us to do anything about it. Do we have to do an investigation?

A: You should still investigate the complaint. Not investigating could expose you to legal risk if more employees come forward with complaints, if the employee later decides to take their complaint to a state or federal agency, or if the harasser continues to harass.

Aside from liability, creating a culture that feels safe, inclusive and firmly opposed to harassment requires action when these issues arise.

Let the employee who made the complaint know that you, as the employer, need to ensure a safe work environment for all employees that is free from harassment and that you must investigate situations that are brought to your attention. You can assure the employee that you will keep their name out of the investigation as much as possible and that any retaliation for bringing the situation to light won't be tolerated. If you think your employees will be deterred from submitting valid complaints due to potential repercussions, you might want to consider providing a way for them to report issues anonymously.

Did You Know?

As an employee benefits client of McGriff, YOU have access to Mineral Learn – a web-based learning management system with 250+ training courses that can help you successfully tackle your organization's learning initiatives. Through the Mineral Learn platform, you are able to not only assign employees training courses on topics ranging from compliance and workplace safety to customer service and professional development, but also track completion of those courses and capture training metrics.

Please join us on April 18 at 2:00 pm ET as we walk through all of the Mineral tools and resources available to you – simply for being a valued partner of McGriff!

[Click here to register](#)



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