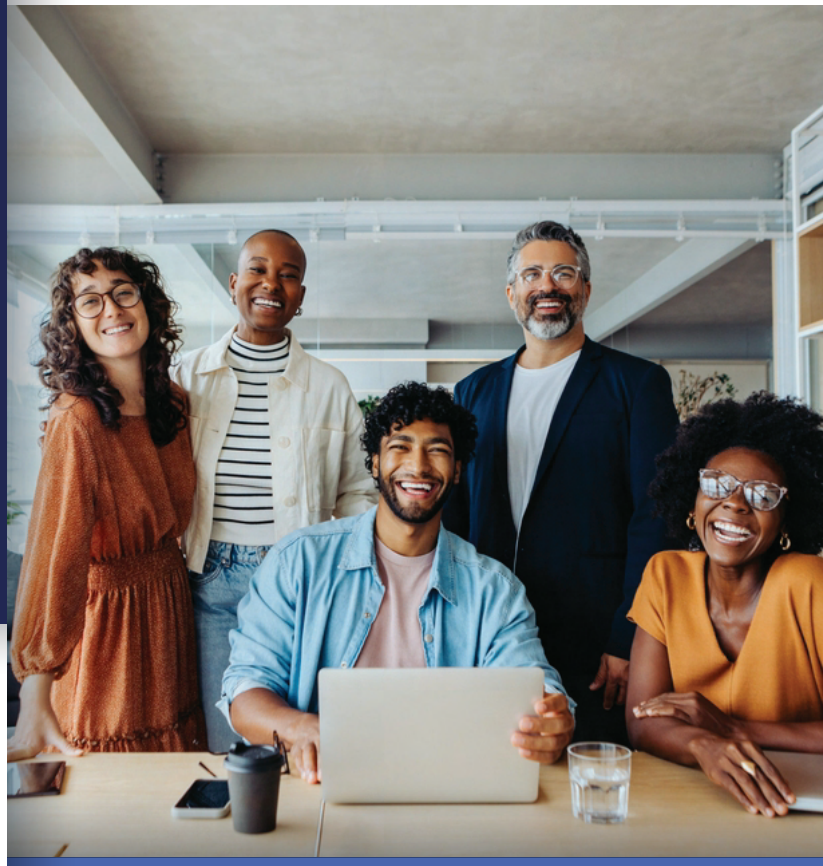
Medcom
BENEFIT SOLUTIONS



BENEFITS LEADER

Your Guide to Health & Welfare Compliance

QUARTER 2

2024

IN THIS ISSUE

IRS ANNOUNCES 2025 HSA LIMITS

On May 9, the IRS published Revenue Procedure 2024-25, which included the adjusted HSA contribution limits for 2025, along with other benefit limits.

Individual HSA limits will see a small rise to $4,300, up just $150 from 2024, while family HSAs will increase by $250 to $8,550. This adjustment follows a significant boost in 2024, marking the largest-ever increase in HSA limits. Employees aged 55 and older are granted catch-up contributions, allowing them to deposit an additional $1,000 into their HSAs in 2025. This amount remains the same from 2024.

We've provided a breakdown below of these and a few of the other limits released by the IRS.

	2024	2025
HSA Contribution Limits	$4,150 Individual $8,300 Family $1,000 Catch-Up	$4,300 Individual $8,550 Family $1,000 Catch-Up
HDHP Maximum Out-of-Pocket Limits	$8,050 Individual $16,100 Family	$8,300 Individual $16,600 Family
HDHP Minimum Deductible Limits	$1,600 Individual $3,200 Family	$1,650 Individual $3,300 Family
Excepted Benefit HRA Contribution Limits	$2,100	$2,150

HSAs have become an essential part of benefits packages over the past 20 years, offering valuable tax advantages to employees enrolled in an HSA-eligible health plan. They serve as a convenient financial tool to cover eligible healthcare expenses not only for the account holder but also for their spouse, eligible dependents, and even individuals they could have claimed as dependents. However, it's important to note that only employees enrolled in an HSA-eligible health plan (HDHP) can participate in an HSA, and an HSA card can only be used for qualified medical expenses.

Register for Medcom's ACA Webinar Series!

ACA: Mergers & Acquisitions - What Employers Should Know
Tuesday, June 25, 2024 *11:30 AM - 12:15 PM EST*
Discover how mergers and acquisitions impact ACA compliance. Essential info for your clients!

ACA: Testing Your Knowledge
Tuesday, July 2, 2024 *11:30 AM - 12:15 PM EST*
Challenge yourself with our interactive session and ensure you're ACA-ready.

REGISTER HERE

MEDICAL VS. GENERAL HEALTH EXPENSES

The Internal Revenue Service (IRS) has issued a warning regarding the misrepresentation of certain expenses as eligible for tax deductions under health spending plans. The alert specifically addresses the misclassification of nutrition, wellness, and general health expenses as medical care for Flexible Spending Arrangements (FSAs), Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), and Medical Savings Accounts (MSAs).

So, what's the issue? The IRS is concerned about companies misleading taxpayers and health spending plan administrators by suggesting that personal expenses for general health and wellness qualify as medical expenses under the tax law. This misinformation can lead individuals to believe that they can use pre-tax dollars from their health spending plans to cover these expenses.

WHAT YOU NEED TO UNDERSTAND

Personal expenses for general health and wellness, such as food for weight loss or exercise equipment, are **not** considered medical expenses under the tax law. Therefore, they are not eligible for reimbursement or tax deductions through FSAs, HSAs, HRAs, or MSAs.

THE CONSEQUENCES OF MISREPRESENTATION

If individuals submit claims for non-medical expenses under their health spending plans, they risk having their claims denied. Furthermore, if a health spending plan is found to be non-qualified due to the inclusion of non-medical expenses, all payments made under the plan, even for legitimate medical expenses, may become taxable.

HOW TO AVOID BEING MISLED

Be cautious of companies that promise reimbursement for non-medical expenses through health spending plans. Remember that legitimate medical expenses must be related to a specific diagnosis or treatment and must meet the requirements outlined by the IRS.

WHERE TO FIND RELIABLE INFORMATION

If you have questions about whether a specific expense qualifies as a medical expense, consult the IRS website or review the frequently asked questions section related to medical expenses for nutrition, wellness, and general health. Additionally, FSA or HSA participants with Medcom, can check out the FSA Store or HSA Store websites for a list of eligible expenses.

Understanding the distinction between medical and non-medical expenses can help you avoid potential penalties and ensure compliance with IRS regulations. Always verify the legitimacy of claims and seek reliable information from authoritative sources when in doubt.

NAVIGATING COMPLIANCE CONSIDERATIONS IN LEVEL-FUNDED EMPLOYEE BENEFIT PLANS

__Michelle Barki__, RN, JD, Senior Legal Counsel; __Derek Ashton__, CEBS, Strategic Client Relationship Consultant; __Mary Catherine Waldron__, JD, Senior Compliance Advisor; __Meagan Hendrix__, Manging Senior Advisor, Health & Welfare Compliance

Level-funding has been a favored plan design, primarily by small groups, with larger groups opting for the more traditional "partially self-funded" type of program. Level funding is a type of self-insured plan. In level funding arrangements, the sponsor pays a fixed monthly fee. This fee covers the maximum claims liability, administrative fees, and stop-loss insurance. This protects against unexpectedly large claims and high utilization. If the costs of individual or aggregate medical claims exceed the plan's maximum, the plan covers the difference. Level-funded plans offer businesses a way to manage healthcare costs by setting aside money from their general funds instead of paying fixed premiums to insurance companies each month.

Unlike traditional fully insured plans, where the insurance company assumes the financial risk, level-funded plans offer a surplus refund. This refund, received by the employer at the end of the plan year if annual medical claims are lower than expected, can significantly impact a business's financial health. However, managing this surplus is one of the primary challenges for employers opting for a level-funded approach.

The management of surplus funds depends on whether they classify as plan assets under ERISA. In general, any portion of plan premiums paid with participant contributions, including COBRA premiums, is considered a plan asset. ERISA requires that plan assets be used exclusively for the benefit of plan participants, limiting employers' discretion over refunds. Depending on the plan's structure, a portion of the refunded amount may need to be returned to participants, similar to the way medical loss rebates are handled. Alternatively, all amounts may become plan assets, especially if held in trust.

ERISA imposes trust requirements once a plan is deemed "funded," a term not directly related to the funding mechanism but rather the presence of plan assets. Notably, certain insured plans and self-funded arrangements with participant contributions routed through a cafeteria plan may receive non-enforcement relief or exemptions

from the trust requirement, especially when plan assets are held by an insurance company. However, employers must exercise caution and verify how these exemptions apply to their specific circumstances.

In addition, a level-funded plan considered funded may trigger Form 5500 reporting requirements, irrespective of the plan's size. A plan previously exempt under the small welfare plan exemption may lose eligibility upon transitioning to a level-funding arrangement. Determining the applicability of exemptions and understanding when a plan is deemed funded can be intricate and context-dependent.

It is known that an ERISA welfare plan covering fewer than 100 participants as of the first day of the plan year is exempt from the Form 5500 requirement if it is unfunded, fully insured, or a combination of the two. Thus, a small welfare plan must file Form 5500 only if it is funded, does not satisfy the conditions for the unfunded or insured

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plan exemptions, or is subject to Form M-1 requirements. In short, if the funds are segregated from general assets to a non-carrier TPA, a trust may be needed. However, an insurance carrier can hold funds segregated from general assets, and the Plan Sponsor would not need a trust.

Technical Release 92-01 clarified when the DOL will not enforce the requirement to hold plan assets in trust. These plans are also considered unfunded for the purposes of the Form 5500 filing rules.

TECHNICAL RELEASE 92-01 CONDITIONS INCLUDE:

1. Benefits are paid solely from the general assets of the employer (or employee organization) maintaining the plan

2. Benefits are provided exclusively through insurance contracts or through a qualified health maintenance organization (HMO), the premiums for which are paid directly by the employer (or employee organization) from its general assets or partly from its general assets and partly from contributions from its employees (or members), provided that contributions by participants are forwarded to the insurance carrier or HMO by the employer (or employee organization) within three months of receipt

3. Benefits are provided partly from the general assets of the sponsor and partly through insurance contracts or through a qualified HMO, as described in (ii). (See: sections 2520.104-20 and 2520.104-44 for specific relief and conditions).

Technical Release 92-01 then goes on to state that relief "is not available to any welfare plan with respect to which benefits or premiums are paid from a trust. Moreover, even in the absence of a trust, (e.g., where a cafeteria plan elects not to establish a trust in reliance on Technical Release No. 88-1), the exemptive relief would, in the absence of additional relief, be available only to those contributory welfare plans which apply participant contributions toward the payment of premiums in accordance with the terms of the regulations. For example, a welfare plan that applies participant contributions directly to the payment of benefits (or indirectly by way of reimbursement to the employer) would not qualify for exemptive relief because the benefits under such a plan could not be considered as paid solely from the general assets of the employer." *Article continues on next page.*

Form 5500 is a crucial document for maintaining transparency, ensuring compliance with rules, and staying on the right side of the law regarding employee benefit plans. It's a significant requirement under the Employee Retirement Income Security Act (ERISA), which is enforced by the Internal Revenue Service (IRS), and the Department of Labor (DOL).

At its core, Form 5500 provides a detailed view of a company's employee benefit plan's financial status, operations, and adherence to regulations. Form 5500 helps regulators, employees, and others assess whether the plan is financially sound and compliant by tracking aspects such as income, expenditures, covered individuals, and other vital details.

When reporting these plans on Form 5500, companies must understand how the funds are managed and whether they require additional documentation, such as a trust. Here are some specific matters to keep in mind:

Filing Form 5500:
Companies with level-funded plans typically need to complete Form 5500 annually and submit it to the Department of Labor (DOL) and the Internal Revenue Service (IRS). This form provides insights into the plan's finances, operations, and adherence to ERISA rules. Unless the small plan exemption applies.

Plan Details:
Form 5500 requires various information about the plan, including its name, identification number, and duration. For level-funded plans, it's crucial to indicate that it's self-funded on the form.

Money Matters:
Employers must disclose the plan's financial details, such as contributions, expenses, and claims paid out (includes company contributions, employee contributions, and any claims settled by the plan)

Who's Covered:
Form 5500 necessitates information about plan participants, such as the number of individuals covered and their demographics

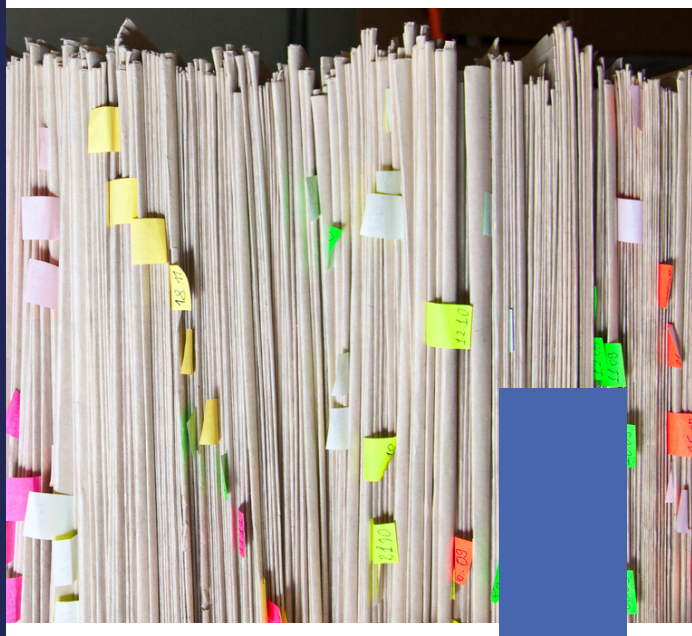
Service Providers:
Employers need to provide details about individuals or entities assisting in plan administration, like TPAs or insurance companies.

Following the Rules:
Companies must ensure compliance with ERISA regulations, including truthful reporting on the form, fulfilling fiduciary duties, and maintaining adequate funding for the plan.

Extra Details:
Depending on the plan's complexity, additional forms and documents may be required to explain how the plan operates, its financial performance, and its adherence to ERISA rules.

For companies providing level-funded plans, precise completion of Form 5500 is crucial. Neglecting this responsibility can lead to regulatory penalties and fines. Therefore, it is vital to verify that all information is accurately supplied and submitted promptly to prevent potential complications. Employers should diligently assess their plan funding decisions, seeking guidance as needed to comprehend the full scope of compliance implications.

Keeping all we've discussed here in mind, Medcom Benefits Solutions recommends that employers seek the advice of an ERISA Attorney or tax professional to make all determinations regarding subjection to trusting of assets and subjection to applicable rules. Medcom generally assumes that a level-funded plan is to be treated the same as a standard self-funded (non-trust) benefit unless the employer indicates otherwise.



COBRA LITIGATION: IS THE TIDE CHANGING?

Michelle Barki, RN, JD, Senior Legal Counsel

COBRA litigation has been on the rise since 2016. Over seventy class action lawsuits have been filed over the insufficiency of COBRA notices and, in certain cases, language that appears threatening. Typically, it starts with an employee seeking legal advice on what they perceive as a discriminatory or unjust termination, and the attorney will ask to see the COBRA notice. It can start with the COBRA notice being used for leverage to settle an employment or ADA dispute, but it can also morph into costly class action litigation under COBRA. Remember, under COBRA, failure to provide sufficient COBRA notices may result in a fine of $110 per day per qualified beneficiary. Under 29 U.S.C. §1132, authorization to sue for insufficiency does not only rest with the Department of Labor, but individual beneficiaries can sue as well.

JOHN G. BAJA V. COSTCO WHOLESALE CORPORATION

Case in point, John G. Baja (Baja)[1]. The named plaintiff worked for Costco for 11 years, during which time he and his wife were covered under the Costco medical plan. The plaintiff was terminated from his position when he had asked to be excused from heavy lifting due to a heart condition. The plaintiff then received an election notice for COBRA, and the allegations were that the notice did not follow the Model Notice 100% and claimed, among other things, that the notice was not written in a manner to be understood by the average participant.[2] It also failed to provide the name, address, and telephone number of the party responsible under the plan for the administration of continued coverage. Most importantly, the language in the election notice appeared threatening. The notice stated that when electing COBRA, "You certify that all information is complete and accurate to the best of your knowledge. Please note that any person who knowingly provides false, incomplete, or misleading information is considered to have committed an act to defraud or deceive the Plan Sponsor(s). The filing of any application for insurance or other claim for benefits based on false, misleading, or incomplete information is a fraudulent act and may result in criminal or civil penalties."[3] This language does not appear in the Model Notice.

Costco has since settled the lawsuit for $750,000, with each class action participant (38,818) receiving $9.72 after attorney fees, costs, and settlement administration fees. While individual participants do not reap much of an award, it appears lucrative to the law firms.

[1]While the complaint was titled John G Baja v. Costco Wholesale Corporation, further in the complaint there was a mention of the "Named Plaintiff" being Gabriel Green and the mention that the employee had worked for 11 years and been terminated when he asked to be excused from heavy lifting.

[2]Medcom Benefit Solutions did score the grade level for the Model Notice provided by the DOL and it scored over grade 13. Thus, even the Model Notice was written in a manner calculated to be understood.

[3]Amazon also recently settled a class action for allegedly using similar language. The amount of the settlement has not yet been released. See Theresa Lites v. Amazon.Com Services, Inc. The complaint also alleges that Lites was out on medical leave when she was terminated. In Blessinger, Nisku and Ferreira v. Wells Fargo and Company, a $1,000,000.00 settlement was reached. The allegations were the same. Blessinger and Ferreira were terminated from Wells Fargo though no reason given in the Complaint and Nisku had resigned.

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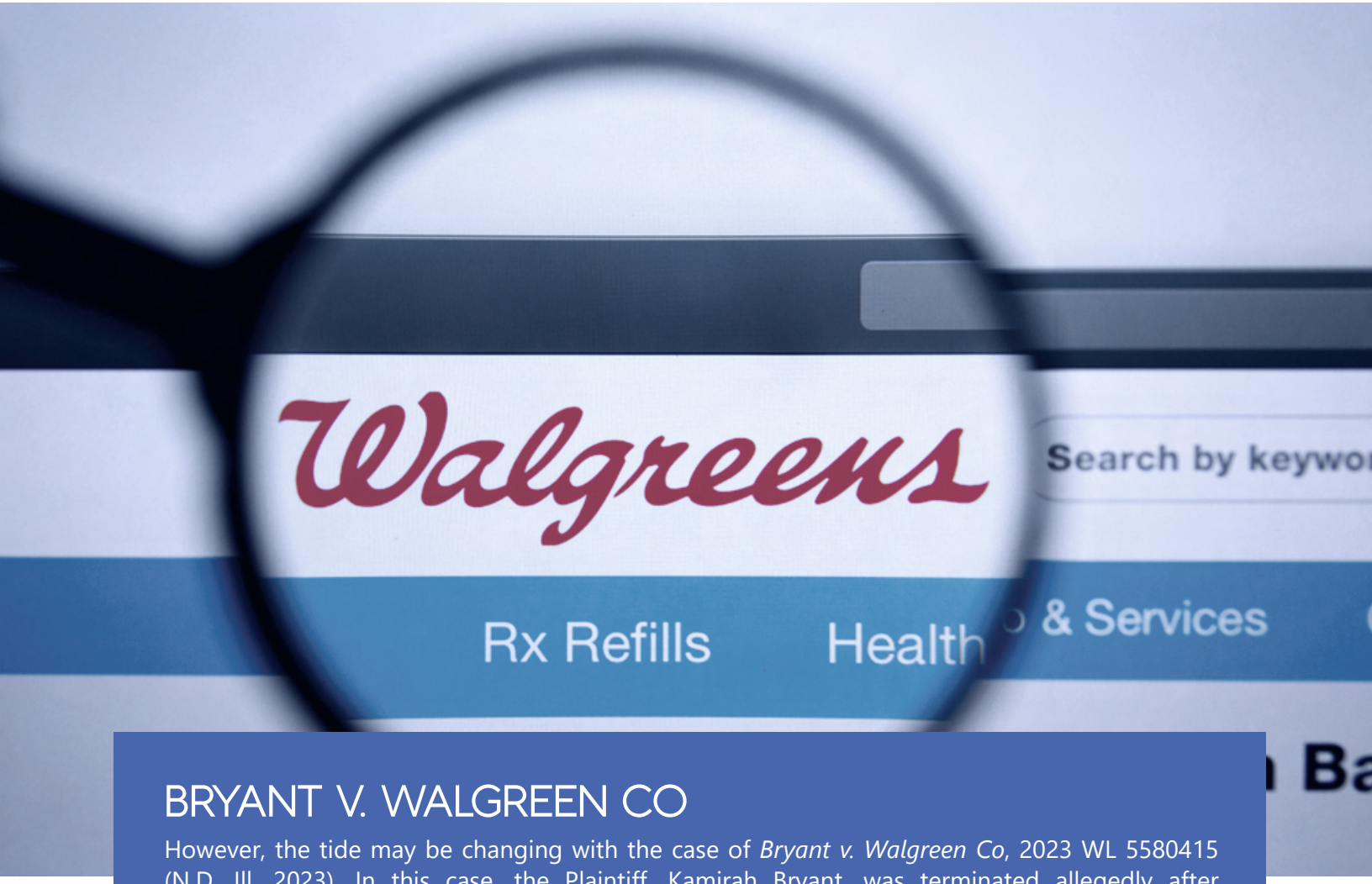


BRYANT V. WALGREEN CO

However, the tide may be changing with the case of *Bryant v. Walgreen Co*, 2023 WL 5580415 (N.D. Ill. 2023). In this case, the Plaintiff, Kamirah Bryant, was terminated allegedly after experiencing unbearable harassment at work. She sought legal advice, and COBRA notices were requested. The complaint states several areas where the notice was deficient and did not follow the Model Notice. In this case, Walgreens mailed two separate COBRA Notices. The allegation was the first notice was insufficient due to:

- Failure to include an address where COBRA payments should be mailed
- Failure to identify the plan administrator
- Failure to explain how to enroll in COBRA
- Failure to provide the correct election date
- Failure to be written in a manner calculated to be understood
- Did not bother to include a physical election form

The second notice had the same errors but did provide a payment address. The complaint also stated that receiving two letters added to the confusion (*Note: These notices did not include any of the alleged threatening language that appeared with Costco, Amazon, or Wells Fargo*).

This case went to a hearing on a Motion for Summary Judgement to throw the case out. The court dismissed all the claims except for the fact that the notices provided inaccurate deadline information. The court decided that for all the other claims, the plaintiffs failed to show how the inadequate notice caused or could have caused any harm. The Court also found that there was no prohibition in the regulations limiting the beneficiaries from receiving more than one notice.

As more cases are brought before the court, look for further clarification. COBRA lawsuits continue to dominate class action lawsuits when it comes to group health plan litigation. Notices should be reviewed for adequacies and to ensure that there is no threatening language. Continuation of Benefits is a right, and notices should be clear and concise.

CONFUSED ABOUT COBRA & MEDICARE?

The below graphic was developed by: ***Michelle Barki****, RN, JD, Senior Legal Counsel;* ***Derek Ashton****, CEBS, Strategic Client Relationship Consultant;* ***Missy Brown,*** *COBRA Director*

Employee is actively working and is enrolled in coverage for self and spouse/dependent(s), then attains age 65 and becomes entitled to Medicare*

Scenario 1

Employee continues actively working and voluntarily drops GHP coverage

This is not a COBRA QE for spouse/dependent(s). As a result, spouse/dependent(s) lose GHP coverage and are not offered COBRA.

Scenario 2

Employee continues actively working and remains on GHP coverage, then employment terminates**

Spouse/Dependent(s) may elect COBRA coverage for up to 36 months from the date the employee became Medicare-entitled (in this case, Medicare-entitlement is treated as a 2nd QE). Regardless of this, spouse/dependent(s) may elect at least 18 months of COBRA from date of 1st QE (termination of employment). Note that the chronological order of the 1st and 2nd QEs are reversed in this scenario.

Employee is actively working and is enrolled in coverage for self and spouse/dependent(s), has not attained age 65 and a COBRA QE occurs**

Scenario 3

Employment terminates and employee enrolls in employer's retiree* health coverage, then becomes Medicare-entitled and retiree coverage is terminated**

Spouse/dependent(s) may elect up to 36 months of COBRA coverage from the date the former employee became Medicare-entitled (as a 1st QE).

Scenario 4

Employment terminates, COBRA is elected, then Medicare entitlement Occurs

The plan may terminate COBRA coverage for any qualified beneficiary who becomes Medicare-entitled (this is not 2nd QE for spouse/dependent(s)

Notes

QE = Qualifying Event

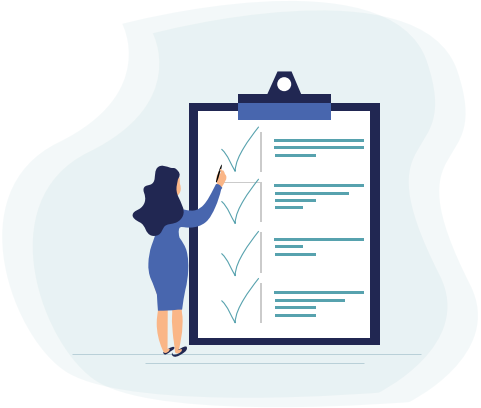
***Entitlement** to Medicare is actual enrollment in Medicare.

If QE is a **Reduction of Hours and not termination of employment, a 3-month "downshift" measurement period may be required (if employer is an ALE and employee is not in a stability period).

***An employee's **retirement** is treated as a termination of employment for COBRA purposes.

NOTE: This infographic is provided as a general reference and portrays typical scenarios as commonly encountered. It is provided as a guideline only and should not be taken as legal advice. Note that special rules may apply based each employer's specific circumstances. Different rules may also apply for non-ERISA plans. Employers should review specific facts and circumstances with legal counsel before taking action.

STAY AHEAD WITH MEDCOM'S COMPLIANCE CHECKLIST!



The Medcom Bridge was designed with the benefits broker in mind to help you gain business, while staying organized, and saving you time. Our Compliance Checklist tool ensures your clients' compliance by identifying weaknesses in benefit plans so you don't have to wait for the penalties to hit.

To learn more about the Bridge visit our website.

Watch our video to see the Compliance Checklist in action: Medcom Bridge - The Checklist is a Broker's Best Friend

Subscribe to Medcom's YouTube channel for more updates and resources!

UPCOMING DEADLINES

JULY 28

LAST DAY TO ISSUE SMM FOR THE PRIOR PLAN YEAR (CALENDAR YEAR PLANS)

- 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)
- Due date is 210 after the end of the plan year to which the change applies.

Note: For a material reduction, an SMM is required within 60 days of the adoption of the change.

JULY 31

PCORI FEE DUE & FORM 5500 FILING DUE FOR CALENDAR YEAR PLANS

- Patient-Centered Outcomes Research Institute (PCORI) fee is due for policy or plan years that ended in 2023
- Employers must file 5500s for plans with at least 100 participants (i.e., employees) at the start of the plan year
- Employers with plans that have fewer than 100 participants must file a 5500 if the plan is "funded" (i.e., the plan's assets are segregated from the general assets of the plan sponsor through a trust)

SEPTEMBER 30

SAR DUE FOR CALENDAR YEAR PLANS & MLR REBATE REPORTING DUE

- A Summary Annual Report (SAR) summarizes the Form 5500 and 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)
- Carriers are required to report prior year MLR data to HHS by July 31 but If the MLRs are not met, premium rebates must be provided to employers by the end of September

OCTOBER 15

5500 FILING DUE DATE (WITH EXTENSION) FOR CALENDAR YEAR PLANS

CONSUMER DRIVEN HEALTH PLANS

ACA EMPLOYER REPORTING

HIPAA PRIVACY & SECURITY

COBRA PREMIUM BILLING ADMINISTRATION

GOVERNMENT HEALTHCARE PROGRAMS

HEALTH & WELFARE COMPLIANCE

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