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Key Trends and Regulatory Changes to Watch in 2022

Presented by Mid-Market Chicago

BDO BMO Harris Bank AON

Jack Lavin
President & CEO
Chicagoland Chamber of Commerce

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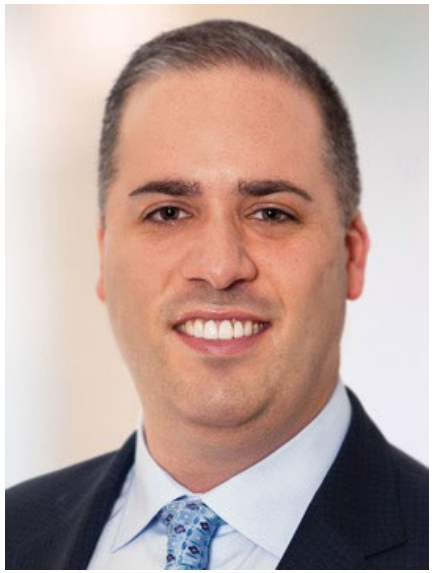

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BDO FALL BOARD PULSE SURVEY

December 2021

With You Today

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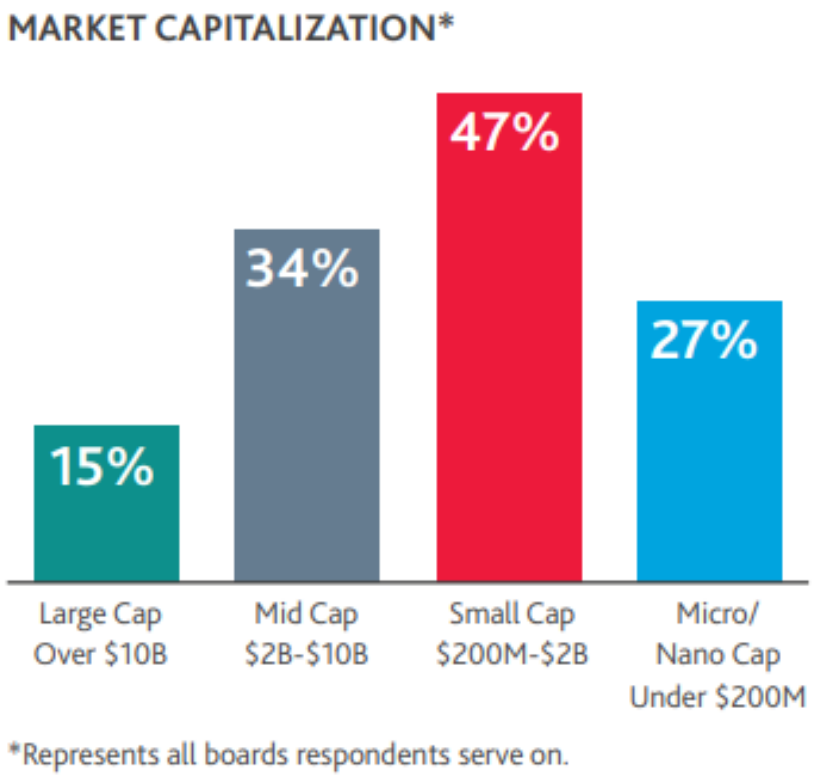
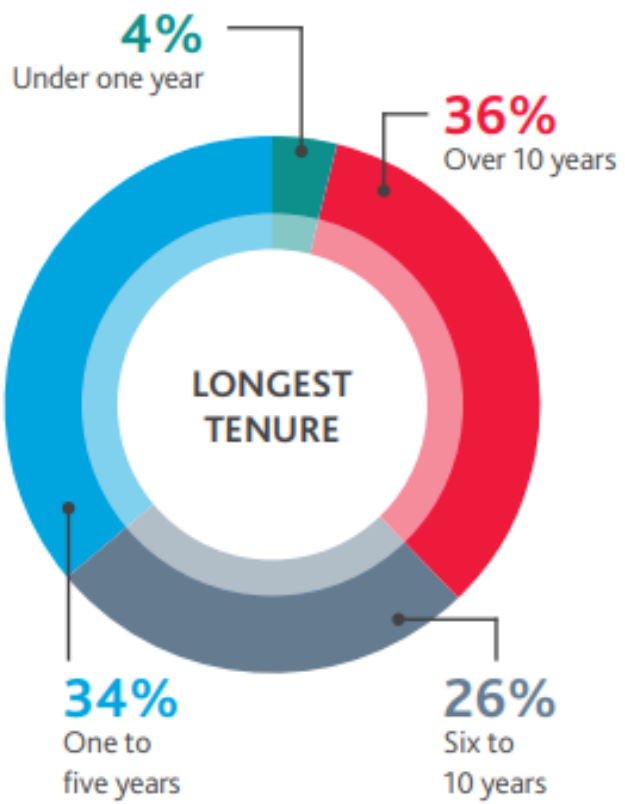
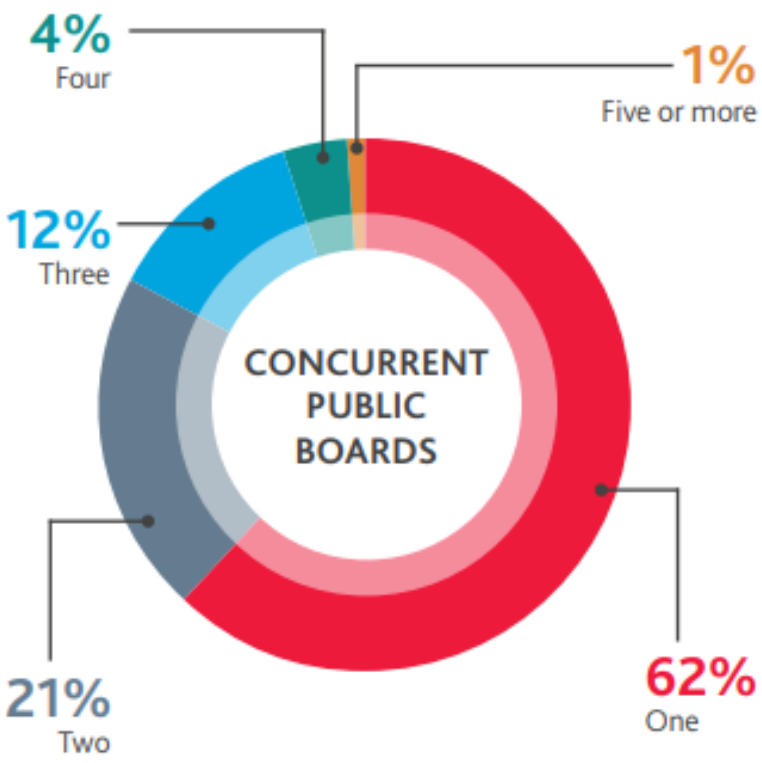
About the 2021 BDO Fall Board Pulse Survey







2021 BDO Fall Board Pulse Survey Key Findings

BDO has adapted our annual public company Board Survey by engaging directors in planned pulse surveys to reflect evolving actions and insights related to crisis response and strategic planning.

Coming out of the 2021 proxy season, engagement of shareholders and investors is priority #1.

M&A is the top-ranked corporate strategy.

Cybersecurity and data privacy continue to be significant governance issues for all companies.

Risk of supply chain disruption challenges boards to tackle sourcing diversification head-on.

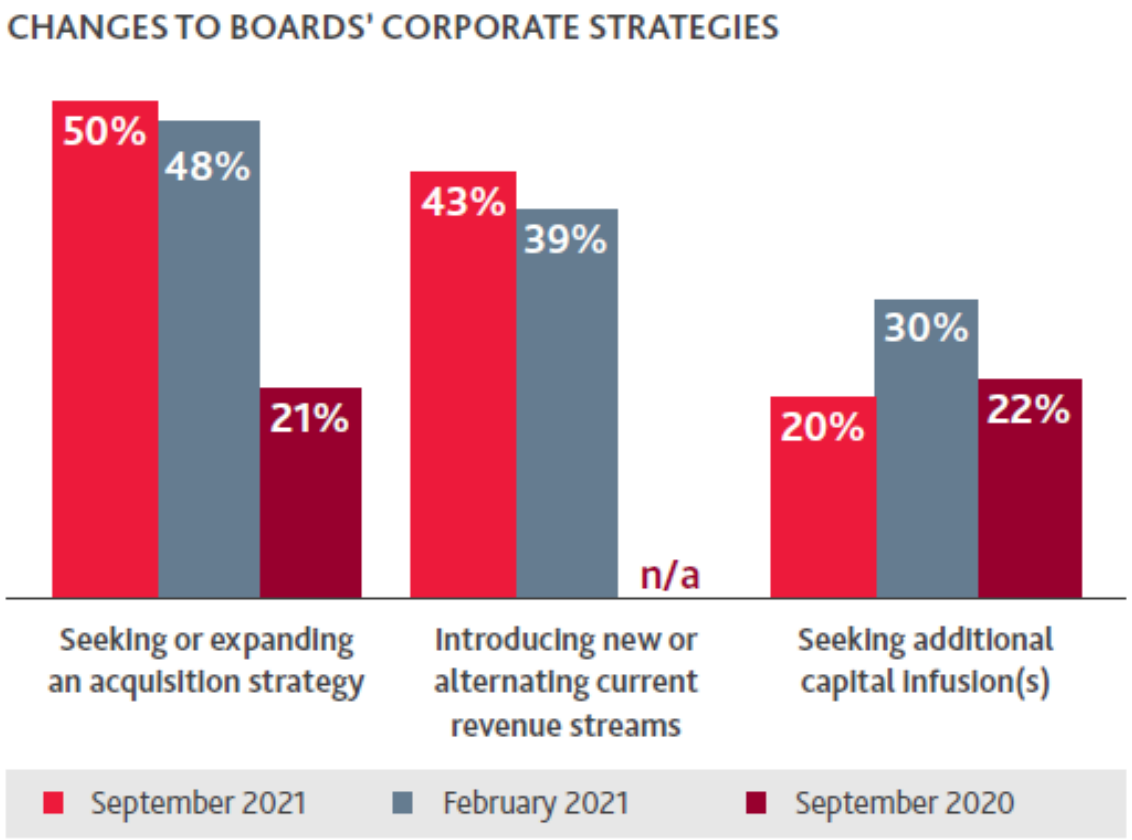
Labor shortages and scrutiny around board composition encourage more thoughtful talent recruitment and refreshment processes.

ESG issues remain high on boards' priority lists, as directors explore options on how best to comply with changing requirements and communicate their efforts publicly.

With annual reporting approaching, boards anticipate challenges around increasing disclosures and risks.

Source: 2021 BDO Fall Board Pulse Survey

Changes to Boards' Corporate Strategies



There's a renewed appetite for growth. Plans to explore acquisitions and new revenue streams have risen while needs for quick infusions of capital have dropped.

Workforce Challenges

To mitigate labor challenges, businesses are attracting and retaining talent by using the following strategies:

55% Re-imagining flexibility and remote work

51% Emphasizing diversity, equity and inclusion (DE&I)

46% Upskilling workforce

37% Enhancing employee benefits

32% Focusing on corporate social responsibility/philanthropy

Supply Chain Challenges

Boards see the supply chain as a top area of concern, and many are taking steps to address these issues:

32%

anticipate supply chain production/disruption will be their greatest business risk for the next 12 months.

31%

say supply chain challenges will be the biggest impediment to their organization's economic and operational success for the rest of 2021.

23%

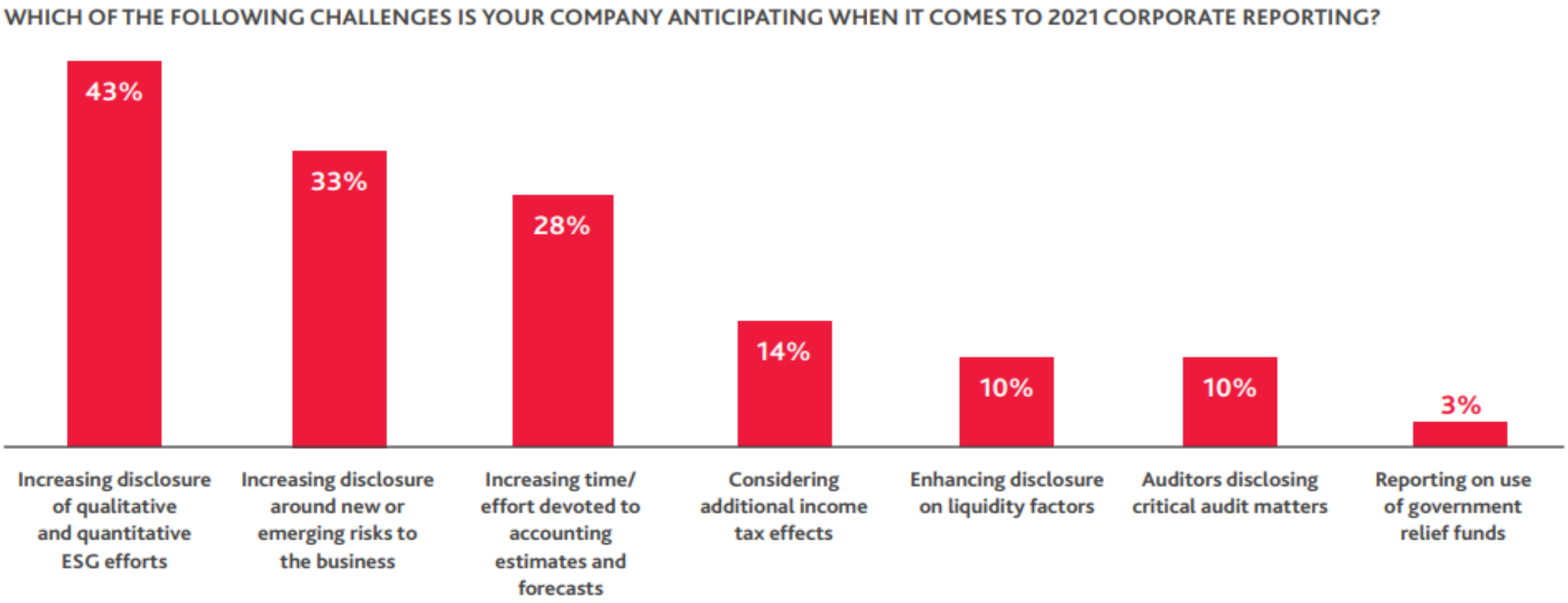
are considering expanding the diversification of their business' supply chain.

Cybersecurity & Data Protection

TOP CITED GOVERNACE OVERSIGHT ISSUES

- Ensuring effective cybersecurity and data protection
- Specifically:
  - Ransomware threats are receiving considerable attention
  - Managing cybersecurity requires a layered, risk-based approach, and boards need to take an active role in keeping their organizations prepared

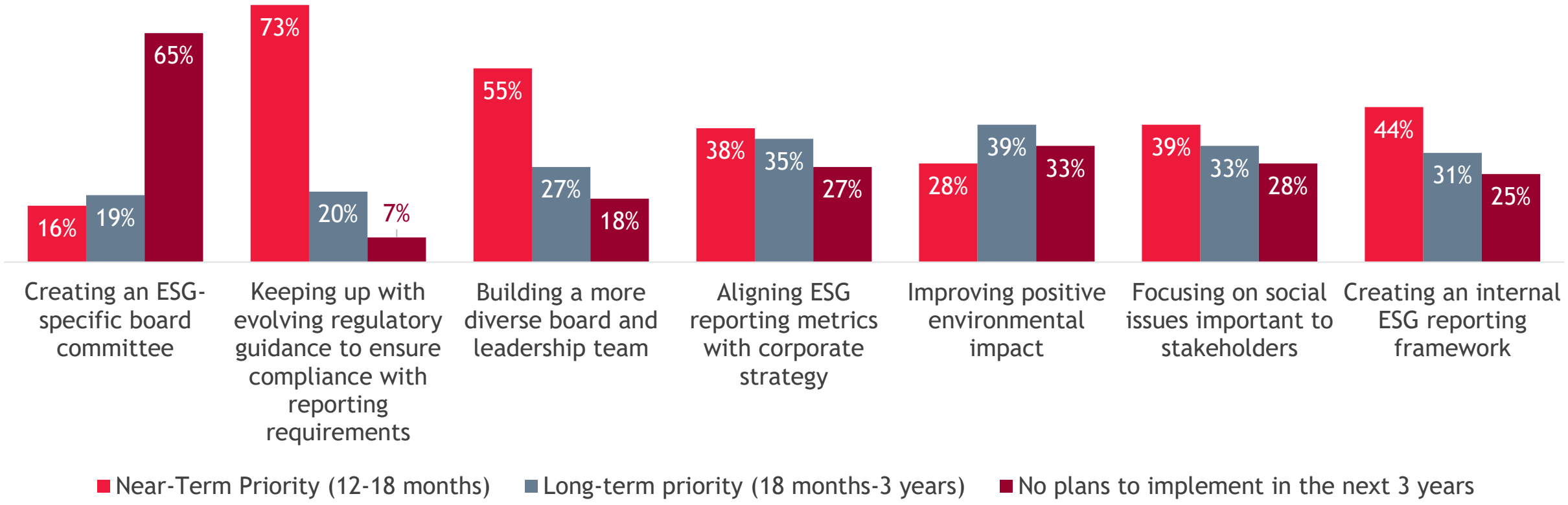
Reporting and Stakeholder Engagement



FROM THE *2021 BDO FALL BOARD PULSE SURVEY*

ESG Landscape: The Board Lens

PUBLIC COMPANY BOARD RECOGNITION OF THE NEED FOR ACTION AND TRANSPARENCY AROUND ESG




THANK YOU

Pratik Patel,
Managing Director, Family Wealth Strategies
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BMO Family Office

Tax update: how proposed tax changes could impact family business owners

December 2021

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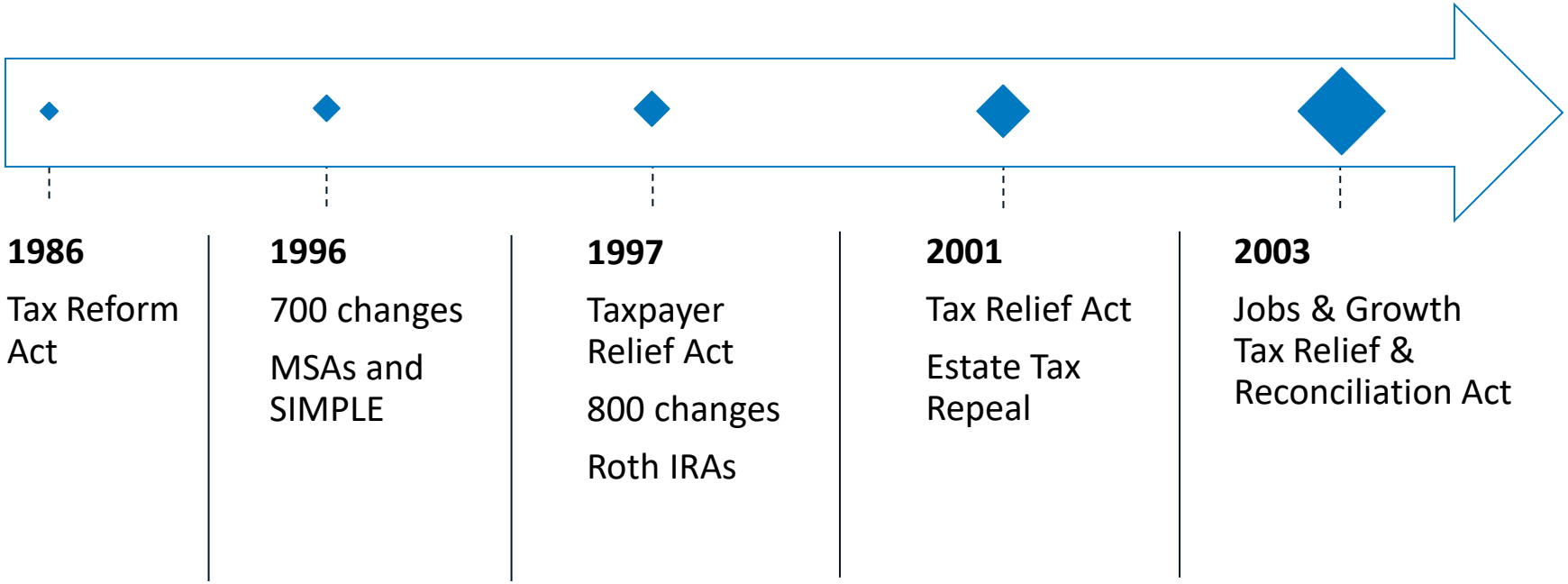
A part of BMO Wealth Management

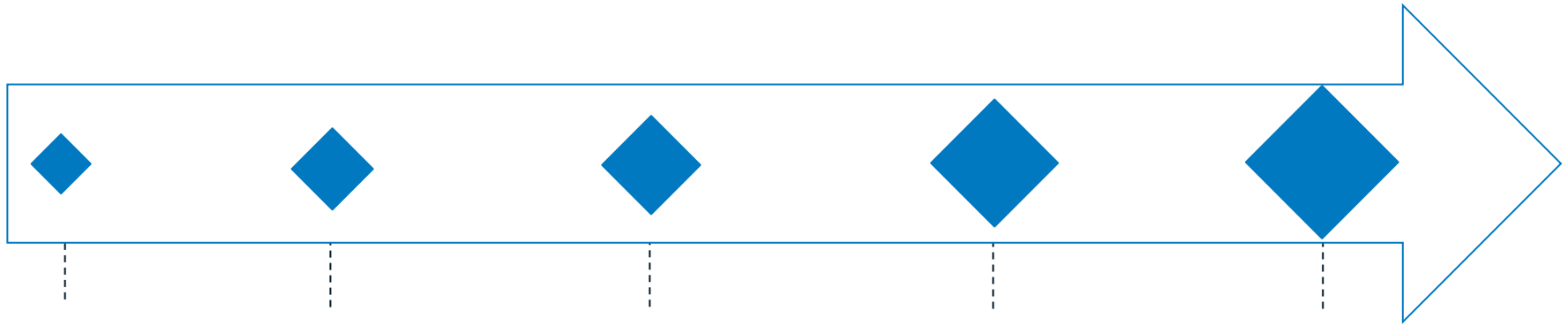
Evolving tax landscape

Tax code – growing bigger and more complex



Source: Important Dates in US Tax History, release 16
Wolters Kluwer Tax & Accounting US, 2015

…and keeps growing



2004

Working Families Tax Relief & Jobs Creation Act

2006

Three Laws

500 Changes to IRC

2010

Affordable Care Act & Legislation extending expiring tax breaks

2012

ATRA

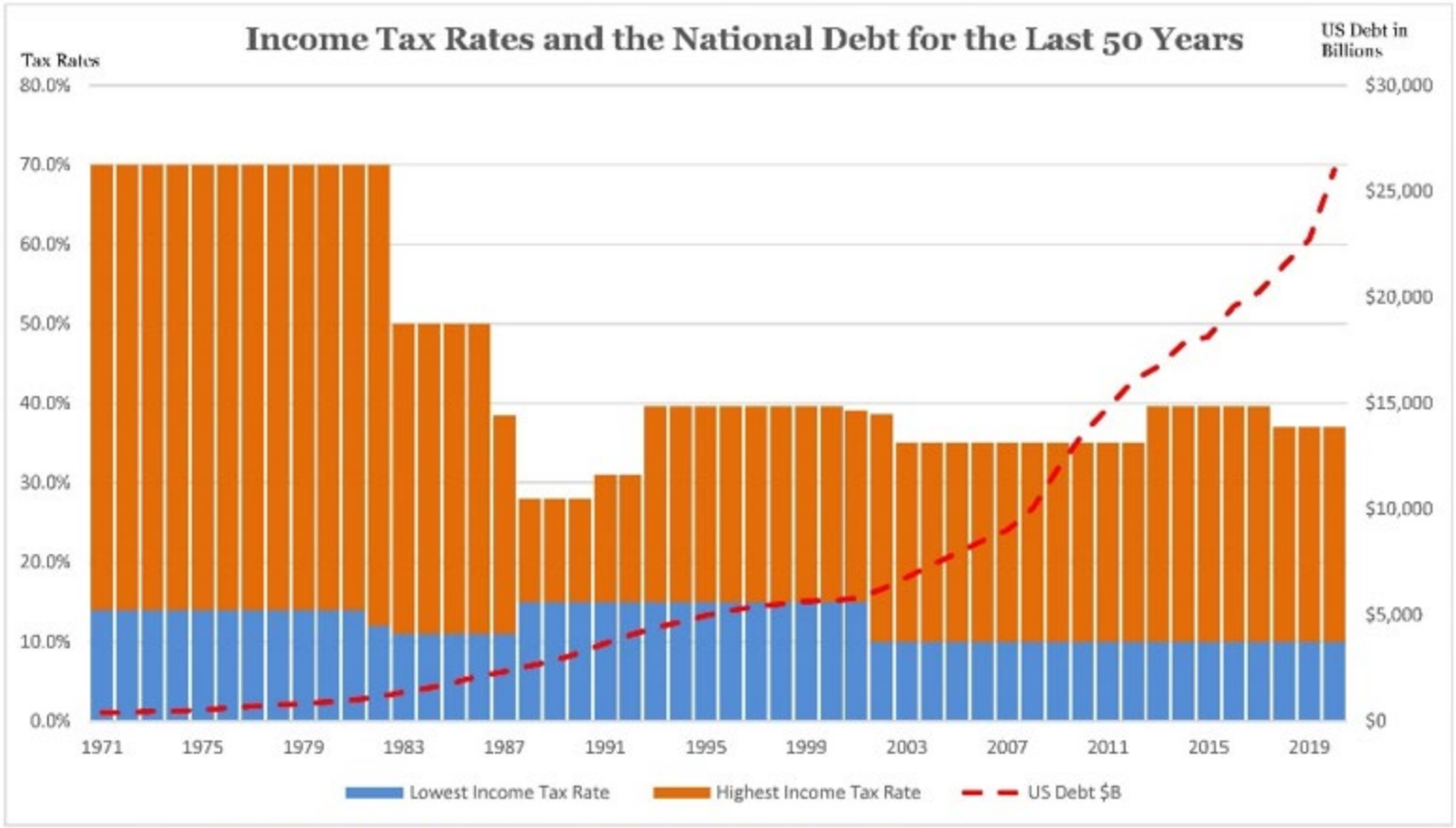
Estate Tax Exemption increased to $5.0M & Portability introduced

2017

Tax Cut & Jobs Act

Source: Important Dates in US Tax History, release 16
Wolters Kluwer Tax & Accounting US, 2015

Income tax rates and national debt



Source: http://www.taxpolicycenter.org/statistics/historical-highest-marginal-income-tax-rates
http://www.taxpolicycenter.org/statistics/historical-individual-income-tax-parameters
https://www.treasurydirect.gov/govt/reports/pd/histdebt/histdebt.htm
https://www.treasurydirect.gov/govt/reports/pd/pd_debttothepenny.htm

Business taxes

Considerations for businesses

Business tax changes

- **15% Corporate AMT**
  - 15% Tax on book income for companies with $1B> in profits
  - $325B in Tax Revenue

- **Stock Buybacks**
  - 1% surcharge on corporate buybacks
  - $125B in Tax Revenue

Considerations for businesses

Business tax changes

What was removed?

- No corporate tax increase (remains 21%)
- No increase in top rate for individuals (remains 37%)
- No increase in cap gains (remains 20%)
- No changes to estate and gift tax

Disclosure

Performance data is presented without deducting investment advisory fees and other applicable charges. While these fees and charges may appear small, over time they can have a major impact on the value of your investment portfolio. The deduction of such fees and other charges, and the compounding effect of these fees and charges over time, will reduce portfolio return. Unless otherwise indicated, traditional investment performance data generally represents a composite or representative portfolio return and is shown gross of the investment manager's advisory fees. Unless otherwise indicated, alternative investment performance data is shown as net of fund expenses, management fees, and incentive fees. Index performance data is shown as total return. You cannot invest directly in an index. Please contact us to obtain performance data that includes the fees and charges applicable to your account.

Past performance is not indicative of future results and current performance may be higher or lower than past performance. Investment returns fluctuate, and investments when redeemed, may be worth more or less than the original investment. Standardized performance data includes reinvestment of dividends, other income, and capital gains, which depict performance without adjusting for the effects of taxation or the timing of purchases and sales.

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This report contains our opinion as of the date of the report. We will not update this report or advise you if there is any change in this report or our opinion.

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Alternative investments, such as private equity and hedge funds, present higher risks than other securities. These risks include illiquidity, stock or sector concentration, financial leverage, difficulties in valuation, and short selling. Alternative investments have minimal regulatory oversight and alternative fund managers have the latitude to employ numerous investment strategies with varying degrees of risk.

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C11#13112153

Molly Iacovoni
Senior Vice President
Aon

Legislative Update

December 15, 2021

Prepared by Health Solutions

Chicago Chamber of Commerce

AON
Empower Results®

Affordable Care Act (ACA) Price Transparency

Two separate pieces of legislation address price transparency, but with some overlap: The Affordable Care Act (ACA) and Consolidated Appropriations Act (CAA)

The ACA required plans to address price transparency—final regulations in FR 11/12/2020; FAQs Part 49 (8/20/2021)

DELAYED until 7/1/2022 for medical (or later if PY is later); Rx until guidance

Plans and insurers must publicly disclose through machine readable files:

1. Negotiated rates for in-network providers for covered items and services;
2. Historical Allowed amounts and billed charges for out-of-network (OON) providers; and
3. Prescription drug file

1/1/2023 and 1/1/2024

Internet-based self-service tool that will disclose to participants upon request specific cost-sharing information for covered items and services from providers

1. Phased implementation beginning with PY on or after 1/1/2023 with respect to 500 items and services
2. Full implementation PY on or after 1/1/2024

ACA Transparency

Who Is Responsible for Disclosure of Cost-sharing Information?

The requirements apply to both group health plans and health insurance issuers

Fully Insured. If the group health plan is insured, the plan satisfies the requirements if the issuer offering the coverage is required to provide the information pursuant to a written agreement between the plan and the issuer.

- If the issuer fails to provide the required disclosures, then the issuer (not the plan) is liable for noncompliance

Self-Insured. Self-insured group health plans are technically liable for compliance with these requirements, specifically for provision of the self-service tool and the publication of the machine-readable rate files.

- Plans may enter into written agreements with a pharmacy benefit manager (PBM) or other vendor to provide the disclosures, but the plan is liable for noncompliance if the third party fails to comply
- Service agreements/contracts should be reviewed to determine if updated language is needed, including indemnification language if vendor agrees to provide and fails to comply
- Plans will also need to determine if service providers will charge additional costs for these services

Consolidated Appropriations Act of 2021 (CAA of 2021)

Consolidated Appropriations Act of 2021

- Enacted on 12/27/2020 with varying effective dates
- Health care topics included:
  - Additional flexibility for FSAs
  - Legislation on surprise medical billing
  - Price transparency and disclosure rules
  - Reporting rules on pharmacy benefits and prescription drug costs
  - Extension of student loan repayment programs
  - Mental health parity rules

CAA Price Transparency and Cost Disclosure Rules

Application to Grandfathered Health Plans

- FAQs Part 49 (issued 8/20/2021), No. 11
- Clarifies that the CAA, 2021 transparency and related provisions apply to grandfathered and non-grandfathered group health plans

CAA Price Transparency and Cost Disclosure Rules

Price Comparison Tool

- FAQs Part 49 (issued 8/20/2021), No. 3
- Initially effective as of Plan Year beginning on or after 1/1/2022 but now DELAYED
- Largely duplicative with ACA transparency requirement, except for mandate to provide transparency information over the telephone
  - Will now be aligned with the ACA transparency requirements that will be effective as of Plan Years beginning on or after 1/1/2023

CAA Price Transparency and Cost Disclosure Rules

In-Network and Out-of-Network (OON) Deductibles and Out-of-Pocket (OOP) Limits on Insurance ID Cards – Action

- FAQs Part 49 (issued 8/20/2021), No. 4
- Initially effective for plan years beginning on or after 1/1/2022 – good faith period
- For example, Departments will not deem a plan to be out of compliance with ID requirements if the plan includes on any physical or electronic ID cards the following:
  - Applicable major medical deductible and OOP maximum
  - Telephone number and website address for individuals to seek consumer assistance and access additional applicable deductibles and OOP limits
  - Additional deductibles and OOP maximum limits could also be provided on a website that is accessed through a Quick Response code (QR code) on the participant's card or through a hyperlink in the case of a digital ID card

CAA Price Transparency and Cost Disclosure Rules

Advanced Explanation of Benefits (EOB)

- FAQs Part 49 (issued 8/20/2021), No. 6
- Initially effective for plan years beginning on or after 1/1/2022 – DELAYED until regulations are issued
- Generally requires Advanced EOB to include:
  - Network status of provider or facility
  - The contracted rate for the item or service
  - Good faith estimate received from the provider
  - Good faith estimate of the amount the plan is responsible for paying and the amount of any cost-sharing for which the individual would be responsible for paying with respect to the good faith estimate
  - Disclaimers on medical management techniques

CAA Price Transparency and Cost Disclosure Rules

Prohibition on Gag Clauses & Price & Quality Data

- FAQs Part 49 (issued 8/20/2021), No. 7

- Initially effective as of 12/27/2020 – Good Faith Compliance until Agencies issue implementation guidance and require submission of attestations of compliance in 2022

- Prohibits plans and issuers from entering into an agreement with a provider, TPA, or other service provider offering access to a network of providers that would directly or indirectly restrict the plan or issuer from:
  - 1. Providing provider-specific cost or quality of care information or data to referring providers, the plan sponsor, participants, or otherwise eligible employees
  - 2. Electronically accessing de-identified claims and encounter data for each participant
  - 3. Sharing such information, consistent with applicable privacy regulations

CAA Price Transparency and Cost Disclosure Rules

Protecting Patients and Improving the Accuracy of Provider Directory Information

- FAQs Part 49 (issued 8/20/2021), No. 8

- Initially effective for plan years beginning on or after 1/1/2022 – good faith period (i.e., plan/issuer must comply with information in blue)

- Plan and issuers must establish a process to update and verify the accuracy of provider directory information and to establish a protocol for responding to requests by telephone and electronic communication from a participant about a provider's network participation status
  - If participant receives assistance from an out-of-network provider and was provided inaccurate information in the provider directory or response protocol (i.e., that the provider was in-network when it was not), then the plan or issuer cannot impose cost-sharing amount that is greater than the cost-sharing amount that would be imposed for items and services furnished by a participating provider and must count such amounts towards the deductible and OOP maximum

CAA Price Transparency and Cost Disclosure Rules

Balance Billing Disclosure

- FAQs Part 49 (issued 8/20/2021), No. 9 (Surprise Billing)
- Initially effective for plan years beginning on or after 1/1/2022 – good faith period
  - See model notice & slide on Surprise Billing Notice requirements

CAA Price Transparency and Cost Disclosure Rules

Continuity of Care

- FAQs Part 49 (issued 8/20/2021), No. 10
- Initially effective for plan years beginning on or after 1/1/2022 – good faith period
  - If an individual has benefits under a group health plan, statute required ability to have coverage in-network for 90 days when provider or facility moves from in-network to out-of-network status
  - Agencies will issue regulations; industry will be given a reasonable amount of time to comply with any new requirements

CAA Price Transparency and Cost Disclosure Rules

Service Provider Compensation

- Health benefit brokers and consultants must disclose to plan sponsors any direct or indirect compensation received for referral of services

Reporting on Prescription Drug and other Health Care Costs

- FAQs Part 49 delayed from 12/27/2021 until 12/27/2022
- Interim Final Regulations issued in FR on 11/23/2021 – following slides address

CAA Prescription Drug and Health Care Spending Reporting

Overview

On 11/23/2021, the Departments of Labor, Treasury, and HHS (the Departments) posted the interim final regulations (IFR) with comment period on the CAA file intended to increase transparency on how prescription drugs contribute to the cost of health care coverage – data will be used in a report issued by government

- Different than the ACA machine readable file for Rx which is still delayed
- Unclear how the ACA file will intersect with the CAA Section 204 data submission

Section 204 data submission

Who must report?

- Group health plans that are subject to ERISA
- Non-federal governmental plans subject to the PHSA
- Church plans
- Individual health insurance coverage
- Student health insurance
- Federal employees' health benefits (FEHB)

CAA Prescription Drug and Health Care Spending Reporting

Which plans are excluded from the Section 204 data submission?

- Health reimbursement arrangements or account-based group health plans
- Excepted benefits (e.g., most dental/vision benefits)
- Short term limited duration insurance

- Too soon to tell if additional exclusions will apply

When must Section 204 data submission occur?

- Plan data is submitted for the “reference year”
  - “Reference year” defined as the calendar year before the data is submitted
- “Plan year” does not factor into timing even if plan uses a non-calendar year plan year
- Plan data for the 2020 and 2021 “reference years” must be submitted no later than 12/27/2022
- After 2022, plan must report by each June 1 thereafter
  - For example, for the 2022 reference year, submission must occur no later than 6/1/2023

CAA Prescription Drug and Health Care Spending Reporting

Who Is Responsible for the Section 204 data submission?

The requirements apply to both group health plans and health insurance issuers

Fully Insured. If the group health plan is insured, the plan satisfies the requirements if the issuer offering the coverage is required to provide the information pursuant to a written agreement between the plan and the issuer.

- If the issuer fails to provide the required disclosures, then the issuer (not the plan) is liable for noncompliance
- Cost for submission - ??

Self-Insured. Self-insured group health plans are technically liable for compliance with the data submission

- Plans may enter into written agreements with a medical plan administrator and PBM to provide the disclosures, but the plan is liable for noncompliance if the third party fails to do so
- A written agreement must be in place specifying which third party(ies) is/are handling the submission on behalf of employer/plan sponsor
  - Consider indemnification language if vendor agrees to provide and fails to comply
- Plans will also need to determine if service providers will charge additional costs for these services

CAA Prescription Drug and Health Care Spending Reporting

What must be included in the Section 204 data submission?

- Departments will be issuing additional instructions with more details
- Departments are also requesting comments on IFR

Plan Level Information

- Name, FEIN, and other relevant identification numbers of the plan, plan sponsor issuer/insurer, or any other reporting entity
- Beginning / end dates of the plan year that ended on or before the last day of the reference year
- The state in which coverage is offered

CAA Prescription Drug and Health Care Spending Reporting

Information for Each State and Market Segment / Aggregated Data

Prescription Drug Data (PBM)

- The 50 brand prescription drugs most frequently dispensed by pharmacies
- The 50 most costly prescription drugs
- The 50 prescription drugs with the greatest increase in expenditures between the year immediately preceding the reference year and the reference year
- For each such drug, additional information on spending and utilization including total annual spending by plan and participants and dosage units

Annual Health Care Spending (Medical TPA & PBM)

- Hospital costs
- Health care provider and clinical service costs, for primary care and specialty care separately
- Costs for prescription drugs, separately for drugs covered by the plan's pharmacy benefit and drugs covered by hospital or medical benefit
- Other medical costs, including wellness services

CAA Prescription Drug and Health Care Spending Reporting

Information for Each State and Market Segment / Aggregated Data

Prescription Drug Rebates and Fees (PBM)

- Prescription drug rebates, fees, and “other remuneration” paid by drug manufacturers to the plan or its administrators or service providers
- Amounts must be reported for each therapeutic class of drugs, as well as for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan from drug manufacturers during the plan year

Premium amounts (employer?)

- Average monthly premium amount paid by plan sponsors v. paid by participants
- Premium amount includes “premium equivalent” information for self-insured group health plans, representing total cost of providing and maintaining coverage, including claims costs, administrative costs, and stop-loss premiums as applicable

Surprise Medical Billing

IFRs with comment period issued on 7/13/2021 and 10/7/2021

- Generally effective for plan years beginning on or after 1/1/2022
- Proposed rule issued to help collect data on the air ambulance provider industry issued on 9/10/2021

Intent of "No Surprises Act" which was part of the CAA, 2021

- Prohibits participants from receiving surprise balance bills (a/k/a "balance billing"):
  - In certain emergency situations
  - When going to an in-network facility where certain services and procedures are performed by OON providers (e.g., OON anesthesiologists, radiologists, etc.)
  - Out-of-network air ambulances
- The Act establishes
  - What cost-sharing amounts participants can be charged in a surprise medical billing situation
  - The procedure for determining payment to providers from plans and
  - When notice and consent are required

Note: The Act replaces the emergency services provisions of the ACA and prohibits plans from placing certain restrictions on emergency services

Surprise Medical Billing

Plans to Which Requirements Apply

- Grandfathered and Non-Grandfathered Group Health Plans
- Non-federal governmental plans
- Church Plans

Plans Excluded

- Excepted benefits, e.g., most dental/vision/EAPs
- Retiree-only plans
- Health Reimbursement Arrangements (and other account-based plans)
- Short-term limited duration plans
- Additional comments requested by the Agencies

Surprise Medical Billing

Cost-Sharing Provisions

- Cost sharing for emergency services provided OON OR cost sharing for non-emergency services provided by OON providers at in-network facilities are generally calculated as if the total amount charged is equal to the “recognized amount” for these services
  - These amounts also must be applied towards any out-of-pocket (OOP) amounts
- “Recognized Amount” defined as:
  - An amount determined by an applicable All-Payer Model Agreement, set out in the Social Security Act
  - If there is no applicable All-Payer Model Agreement, an amount determined by state law; or
  - If neither is applicable, the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (the QPA), which is generally the median of the contracted rates by the Plan for the specific item or service in the geographic area
    - Most self-insured group health plans will utilize QPA unless they have voluntarily opted into state surprise billing laws

Surprise Medical Billing

Cost-Sharing Provisions

- Where neither the All-Payer Model Agreement or state law applies, the balance of the bill to be paid by the plan after the patient cost sharing and any initial payment from the plan is determined between the provider, facility, provider of air ambulance services, and the plan through a 30-day open negotiation period, and if the parties cannot agree on a payment amount the federal independent dispute resolution (IDR) process can be initiated
  - Regulations issued on 10/7/2021 outlines how this process initiates, what is eligible for this process, and how IDR entities should consider factors when determining a payment amount
  - $50 fee for 2022 (paid by each party) plus IDR fee paid by the “non-prevailing” party
  - Coverage decisions involving surprise billing are eligible for the external review portion of the “ERISA” Claims & Appeals process
    - May require an SPD update and even GF plans who are not normally subject to external review must provide external review for this purpose

Notice and Consent Procedures

- The specific procedures under the Act may not apply under certain circumstances to post-stabilization services or OON non-emergency services (other than air ambulance services or ancillary services at in-network facility) if the provider or facility provides notice to and receives consent from the participant
- Providers and facilities are required to notify plans when the notice and consent criteria have been satisfied so plans will know whether IFR requirements regarding cost-sharing and payments to plans apply
- Plans also will be required to publicly post a notice describing the prohibitions on surprise billing and who to contact if a violation is suspected
  - This information must be included on all EOBs to which protections apply
- Part 49, FAQ No. 9 highlighted that the Agencies may address the balance billing requirements in more detail in future guidance
  - Until then, a good faith approach is expected
  - A model notice was issued for this purpose: CMS-10780 | CMS

Illinois Disclosure Law

Illinois Disclosure Law

A new Illinois health care law requires Illinois employers to publicly disclose how an employer's group health plan stacks up against the Affordable Care Act's (ACA's) essential health benefits (EHBs) in the Illinois individual market

- This law may be preempted by ERISA for employers subject to ERISA
  - However, Illinois FAQs state that Illinois does NOT believe that ERISA preempts
  - Employers should review with ERISA counsel if they do not intend to comply

- The law is entitled the Consumer Coverage Disclosure Act (CCDA)
  - Technically effective 8/27/2021
  - Illinois recently issued FAQs clarifying

- An employer must either email or post on an intranet site an "easy-to-read" comparison of what the employer's group health plan covers v. the items and services within the 10 categories of EHBs that Illinois requires health insurance issuers to include in individual health insurance policies sold in Illinois
  - Model form issued by the Illinois Department of Labor (IDOL) that employers are permitted to use (but form is optional)

Illinois Disclosure Law

- Most self-insured employers are not required to offer EHBs
  - Illinois understands and acknowledges in FAQs – reiterates this is a “notice only” law
  - Of course, under ACA, an employer cannot impose a lifetime or annual dollar limit on EHBs

- Penalties for Non-Compliance
  - IDOL can request documentation demonstrating compliance going back to up to one year
  - Upon notice of non-compliance, the IDOL will give an employer up to 30 days to comply
  - If employer does not comply within 30 days, the IDOL may impose a penalty
    - For employers with 4 or more employees, the penalties are up to a maximum of $1,000 for first offense, up to $3,000 for a second offense, and up to $5,000 for a third or subsequent violation

Checklist of Recent Changes

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	▪ COVID-19 testing at no cost (in- and out-of-network), includes serological related tests during PHE ▪ If HSA/HDHP, COVID-19 testing paid before deductible	Required	FFCRA CARES Act FAQs Parts 42, 43, 44 Stay tuned for additional guidance 1/15/2022
	COVID-19 treatment paid before deductible in HSA/HDHP	Optional	IRS Notices 2020–15 & 2020–29
	Vaccine. Coverage of COVID-19 preventive care items and services, including vaccines and immunizations at no cost (within 15 business days of recommendation) [only non-GF health plans technically] & OON during PHE	Required	CARES Act and FAQs Parts 42, 43, 44
	HSA/HDHP to cover telehealth and other remote care services without a deductible or deductible below the minimum ($1,400 for individual and $2,800 for family in 2020 & 2021); temporary until **12/31/2021** *Monitor for guidance to expand or make permanent*	Optional	CARES Act and FAQs Part 42
	Student Loan Changes to allow for tax free reimbursement of student loans before 1/1/2026	Optional	CARES Act & CAA, 2021

FAQs means FAQs issued by DOL, HHS, and Treasury

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Over-the-counter drugs and menstrual products may be reimbursed by health FSA, HSA, or HRA for expenses paid on or after 1/1/2020	Optional	CARES Act
	COVID-19 personal PPE under a health FSA, HSA, or HRA for expenses paid on or after 1/1/2020	Optional	IRS Announcement 2021-7
	Deadlines Extended for COBRA, HIPAA special enrollment, and ERISA claims and appeals—employee communication should be considered with legal counsel **See EBSA Notice 2021-01 with modified guidance (lesser of 1 year or end of Outbreak Period)—individualized**	Required	EBSA Notices 2020-01 and federal register and 2021-01 IRS Notice 2021-58
	Additional health coverage midyear changes allowed in 2020 and 2021 for medical, dental, or vision coverage: ▪ Make a new health election on a prospective basis, if the employee initially declined to elect employer's health coverage ▪ Revoke an existing health coverage election & make a new election to enroll in different health coverage sponsored by same employer (benefit options such as HMO, PPO, HDHP) or coverage tier (single, family, etc.) ▪ Revoke an existing health election on a prospective basis, employee attests to enrollment in other coverage	Optional	IRS Notice 2020–29 CAA of 2021 & IRS Notice 2021-15

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Health Care FSA midyear changes permitted on a prospective basis for 2020 and 2021: ▪ Revoke an election ▪ Make a new election ▪ Decrease or increase an existing election	Optional	IRS Notice 2020–29 CAA, 2021/IRS Notice 2021-15
	Dependent Care FSA midyear changes permitted on a prospective basis for 2020 and 2021: ▪ Revoke an election ▪ Make a new election ▪ Decrease or increase an existing election	Optional	IRS Notice 2020–29 CAA, 2021/IRS Notice 2021-15
	Health Care FSA. For unused amounts remaining as of end of a grace period or plan year ending in 2020 (e.g., a non-CY PY), a cafeteria plan may permit employees to apply those unused amounts to pay or reimburse medical care expenses incurred through 12/31/2020	Optional	IRS Notice 2020–29
	Dependent Care FSA. For unused amounts remaining as of end of a grace period or plan year ending in 2020 (e.g., a non-CY PY), a cafeteria plan may permit employees to apply those unused amounts to pay or reimburse dependent care expenses incurred through 12/31/2020	Optional	IRS Notice 2020–29
	Health Care FSA Carryover amount increased to $550 starting in 2020	Optional	IRS Notice 2020–33

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Carryover. Employers may amend Health Care FSA and/or Dependent Care FSA to allow employees to carry over unused amounts in their DC and HC FSAs from 2020 into the plan year ending in 2021 and from 2021 into 2022	Optional	CAA, 2021 IRS Notice 2021-15
	Grace Period. Employers may amend Health Care FSA and/or Dependent Care FSA to allow employees to extend grace periods through the end of 2021 and again extend in 2022	Optional	CAA, 2021 IRS Notice 2021-15
	Dependent Care FSA. Extend maximum age of eligible dependent from age 13 to age 14 for 2021 if dependent aged out in 2020 and employee was a DC FSA participant in 2020	Optional	CAA, 2021 IRS Notice 2021-15
	Spend Down Provision. Employer may amend Health Care FSA, like a Dependent Care FSA, to allow employees who terminate participation to continue to incur expenses and claim reimbursement during plan year	Optional	CAA, 2021 IRS Notice 2021-15
	Dependent Care FSA. Increase in reimbursement exclusion limit to $10,500 or $5,250 married filing separately	Optional	American Rescue Plan of 2021 IRS Notice 2021-26

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Updated Model COBRA Notices ▪ Model COBRA notices updated to consider interaction with Medicare ▪ *Additional COBRA model notices and FAQs for premium assistance (subsidies)*	Optional, but **strongly** recommended	Model Notices and FAQs issued on 5/1/2020
	COBRA subsidy. American Rescue Plan implements a subsidy of 100% for involuntary terminations/reduction in hours from 4/1/2021–9/30/2021; *many details apply.* Notice and related administrative requirements will impact TPAs and payroll.	Required	American Rescue Plan of 2021; Model Notices and FAQs issued on 4/7/2021; IRS Notices 2021-31, 2021-46; 2021-58
	Government Marketplace. Increase in subsidies for those earning more than 400% of the FPL should not affect affordability penalty, **but employers *should confirm***. If employer is using affordability safe harbor for all pay bands then, no issue (e.g., FPL, W-2, rate of pay).	Required	American Rescue Plan of 2021

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	HHS 2021 Notice of Benefit & Payment Parameters Final Rule ▪ Rx Coupons may or may not apply towards the ACA OOP maximum ▪ Coupons should never apply towards deductible under an HSA compatible HDHP ▪ State law?	Design Option for non-HDHPs	2021 HHS Final Rule
	Impact of Section 1557 2020 Final Rule & *Bostock v. Clayton County* HHS issued a notice of interpretation and enforcement that confirms that Section 1557 prohibits discrimination on the basis of sexual orientation and gender identity; this is consistent with the original 1557 rules and Bostock and reverses Trump administration final regulations. However, it does not appear that other requirements (e.g., notices) have been re-implemented under 1557 or the concept of a covered entity.	Required/Continue to Monitor	Section 1557 2020 Final Rule and U.S. Supreme Court Case and 5/10/2021 HHS Notice of Interpretation and Enforcement

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Mental Health Parity and Addiction Equity Act ▪ Not new: Complete QTL testing and work with TPAs on NQTL matters ▪ Monitor additional guidance as required by CAA of 2021 ▪ TPA contract considerations	Required	MHPAEA CAA, 2021 FAQs Part 45
	Affordable Care Act and Transparency ▪ Regulations under Trump Administration (ACA requirement) ▪ Requires group health plans to disclose cost-sharing information upon request to a participant, including an estimate of the individual's cost-sharing liability for covered items and services ▪ Not applicable to grandfathered plans or "retiree-**only**" plans ▪ Details apply—layered effective dates for different requirements 2022, 2023, and 2024 ▪ TPA contract considerations	Required	ACA and recent regulations; FAQ Part 49 Delayed Implementation
	CAA, 2021 and Transparency ▪ CAA, 2021 (e.g., advanced EOB, continuity of care, accuracy of provider directory updates, removal of gag clauses) ▪ TPA contract considerations	Required	CAA, 2021, FAQ Part 49 Significant re: Implementation Deadlines

Checklist of Federal Law/Guidance & Action Items

Check Box √	Description	Required by Law or Design Option	Legal Reference
	Surprise Medical Billing including air ambulance ▪ Generally effective for PY beginning on or after 1/1/2022 ▪ TPA contract considerations	Required	CAA, 2021; regulations issued 7/1/2021, 9/10/2021, and 9/30/2021
	Reporting on pharmacy and Rx costs ▪ TPA contract considerations ▪ Submit 2020 and 2021 reference years by 12/27/22	Required	CAA, 2021; IFR 11/23/2021
	If incentivizing or penalizing vaccine through group health plan, ensure compliance with wellness rules & monitor employer shared responsibility affordability	Required	FAQs Part 50
	Individual state mandates and related filings: ▪ Massachusetts ▪ District of Columbia ▪ New Jersey ▪ California ▪ Rhode Island ▪ Vermont	Required	State Mandates

Documentation Considerations

Check Box √	Description
	Plan Amendments May Be Necessary, for example: ▪ Mandatory and permissive changes under the law, e.g., COVID-19 testing at no cost, COVID-19 treatment before deductible ▪ Changes in eligibility as a result of continued coverage during an unpaid leave or furlough ▪ Cafeteria plan midyear changes and spending account changes require an amendment—deadline is 12/31/2021 or later for later changes, see IRS Notice 2021-15
	SPD Updates/SMM OR Related Communication May Be Necessary ▪ Mandatory and permissive changes under the law, e.g., COVID-19 testing at no cost, COVID-19 treatment before deductible ▪ Changes in eligibility as a result of continued coverage during an unpaid leave or furlough ▪ Cafeteria plan midyear changes and spending account changes ▪ Delays in deadlines for COBRA, HIPAA special enrollment and ERISA claims and appeals should be communicated to employees/retirees/participants pursuant to employer's role as fiduciary—additional communication likely required as a result of EBSA 2021-01
	SBC: Relief given but update if necessary and when possible (See FAQs)

Questions?

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Q&A