# Basics of Employee Benefits Administration—Day 1

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## Housekeeping Items

- Silence cell phones
- Location of restrooms
- We're all adults here . . .
  - Sit, stand, move as you need to
  - Work still happens—Step out to make calls
- Breaks and lunch
- Instructor Feedback Report

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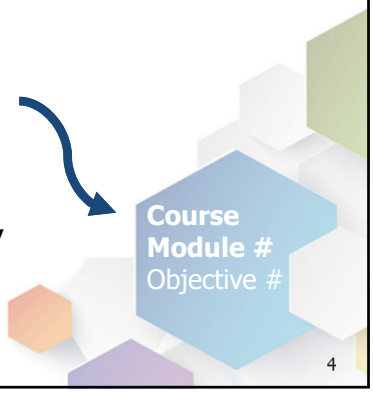
# The CEBS Program

The International Foundation's highest educational achievement is its Certified Employee Benefits Specialist (CEBS) designation.

The program is highly regarded by the industry and comprises five self-study courses (each with an exam) that provide deep technical knowledge of employee benefits. Most people complete the designation in about three years.

Many people are intimidated by the program, but we would like to take some of that fear away. The CEBS icon that you will see in the corner of some slides indicates that the following topics overlap with CEBS content.

While participation in employee benefits courses does not count towards getting the CEBS designation, this course may make the material feel more approachable if you decide to pursue the CEBS program in the future.

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# Introductions


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# Speaker: Ron Krupa

- 35+ Years in Employee Benefits
  - Held roles in just about every area of employee benefits
- Certified Employee Benefits Specialist (CEBS)
- ISCEBS Governing Council Member (2011-2015)
- ISCEBS Past President (2015)
- ISCEBS Hall of Fame Inductee (2024)
- Past President of the Greater Philadelphia and Tampa Bay Area Chapters of ISCEBS
- Local and national speaker
- Instructor for IFEBP—This course!

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## Introductions

- Introductions
  - Your name and where you're from
  - Your employer
  - Your current responsibilities at your employer
  - Share with us the **top two benefit issues** at your employer
- What are your expectations for the course?

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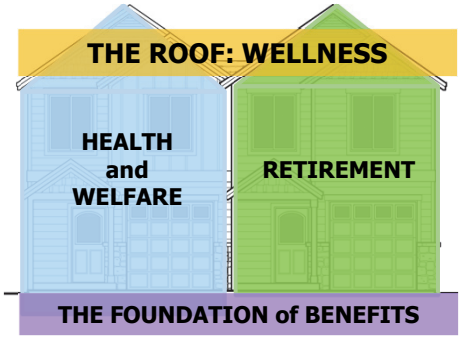
## Course Overview

- Learning Objectives
  - **The Foundation:** Core Laws
  - **The Framework:** Administration of Health and Welfare and Retirement Savings Plans
  - **The Roof:** Wellness
- Case Study

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# Focus of the Course

- My focus as an instructor
  - Provide a sound framework of resources for you in employee benefits and related areas
  - Provide ideas and protocols for your future career development
  - Discuss and explore best practices and new developments
  - Explore new areas of importance
  - Encourage feedback
  - Help you to get to know your colleagues
  - Share relevant and valuable experiences of your classmates
- Some of the topics that we discuss in this course may not affect your current job at this time, but **they could affect your career** later on . . .

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# The Foundation of Benefits

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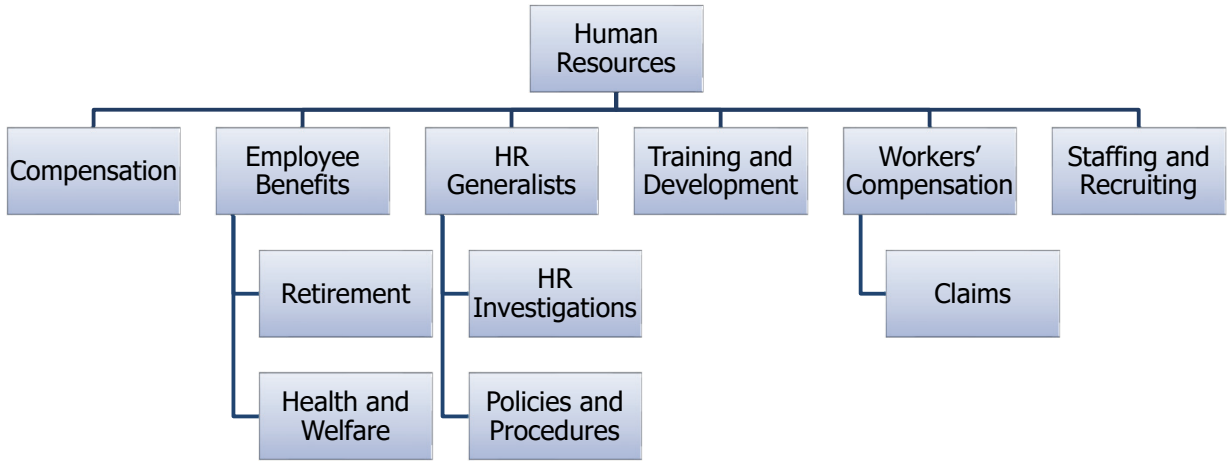
# The Org Chart of Human Resources

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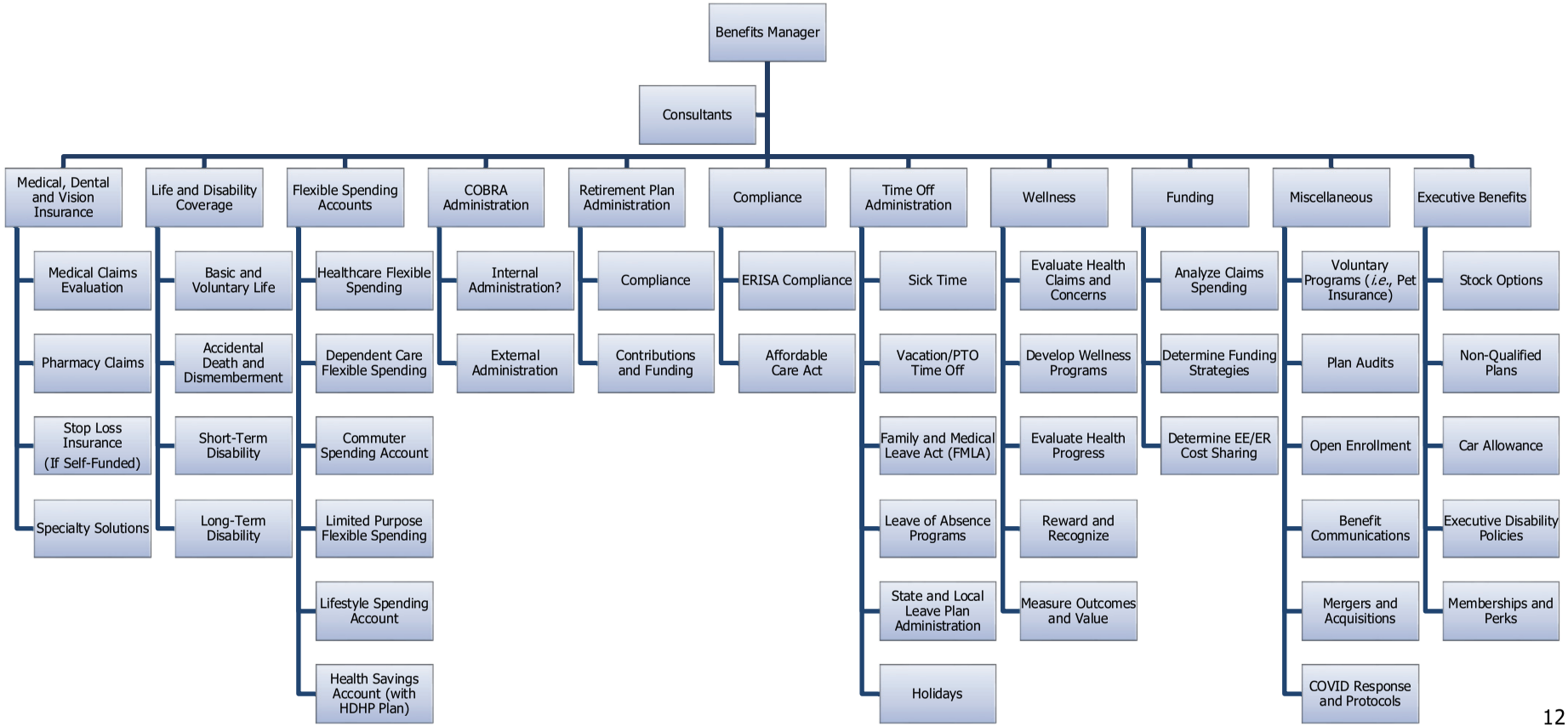
# The Org Chart of Employee Benefits



# Basic Terminology

- These next few slides will be covered later in the presentation when we talk about risk
- Knowledge of these terms are critical for our entire discussion, so they are being added here to kick off the course

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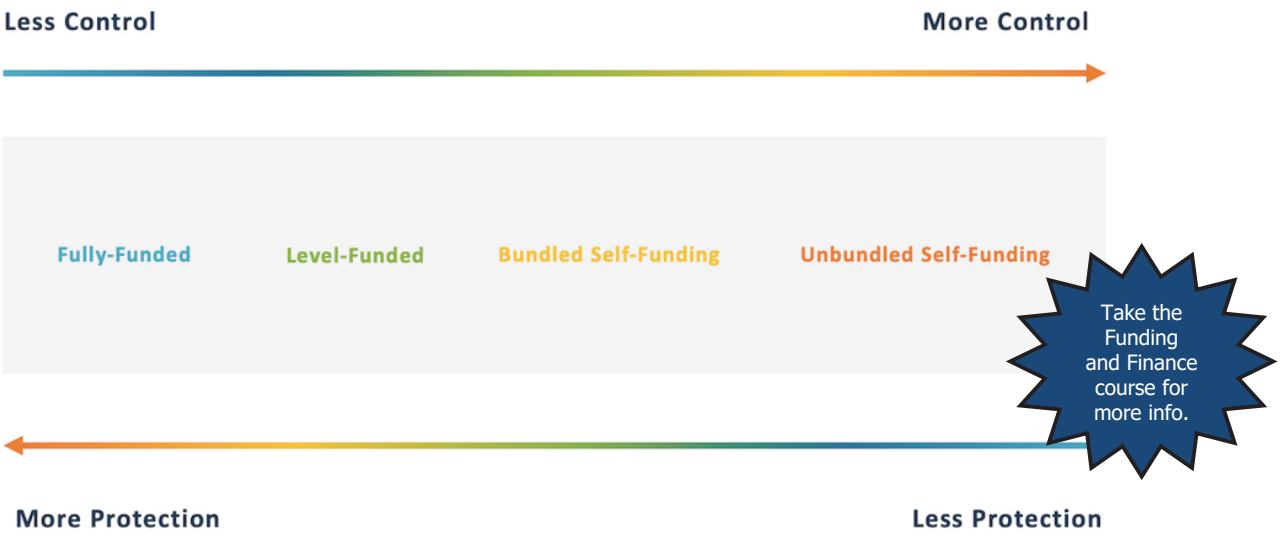
# Funding Degrees of Risk




Source: https://www.onedigital.com/blog/which-funding-model-is-right-for-your-employer-sponsored-health-plan/

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# Pre-Tax vs. Post-Tax

## PRE-TAX DEDUCTIONS

- Pre-tax deductions are taken out before calculating your taxable income, so you don't pay taxes on them.
- Pre-tax deductions reduce the amount of income that the employee has to pay taxes on.

## POST-TAX DEDUCTIONS

- Post-tax deductions are taken out after taxes, so you do pay taxes on them.
- Post-tax deductions have no effect on an employee's taxable income.

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# Pre-Tax vs. Post-Tax Examples

| Pre-Tax | Post-Tax |
|---|---|
| • The employer withholds deductions before taxes<br>• The employee might owe taxes on the withheld money in the future | • The employer withholds deductions after taxes<br>• The employee will not owe taxes on the withheld money in the future |
| **Common Deductions** | |
| • Some retirement plans<br>• Health insurance<br>• Disability insurance<br>• HSAs and FSAs<br>• Transportation Programs | • Some retirement plans<br>• Life insurance<br>• Disability insurance<br>• Garnishments<br>• Union Dues |
| **Effect on Taxable Income** | |
| • Pay less in taxes now | • No effect on taxable income |

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# Pre-Tax vs. Post-Tax Math Example

Annual Salary: $120,000 Disability benefit is 60% of Monthly Earnings
You have to pay taxes SOMEWHERE—either the PREMIUM or the BENEFIT

**PRE-TAX PREMIUM**
When you pay for LTD premiums on a pre-tax basis, you're paying taxes on the BENEFIT not the PREMIUM.
**Premium example: $50/month**
**Total Tax Savings: $50 x 30% = $15**

| PRE-TAX LONG-TERM DISABILITY EXAMPLE | | |
|---|---|---|
| Monthly Earnings | $120,000 / 12 | $10,000 |
| Disability Pay | 60% of Salary | **$6,000** |
| | | |
| 20% Federal Tax on Benefit | $6,000 x $20% | $1,200 |
| 10% State Tax on Benefit | $6,000 x 10% | $600 |
| Total Deductions | | **$1,800** |
| | | |
| Net Monthly Benefit | $6,000 - $1,800 | $4,200 |
| | | |

**POST-TAX PREMIUM**
When you pay for LTD premiums on a post-tax basis, you're paying tax on the PREMIUM, not the BENEFIT.
**Premium Example: $50/month**
**No tax savings—actual payment is $50/month**

| POST-TAX LONG-TERM DISABILITY EXAMPLE | | |
|---|---|---|
| Monthly Earnings | $120,000 / 12 | $10,000 |
| Disability Pay | 60% of Salary | **$6,000** |
| | | |
| Federal Tax on Benefit | None | $0 |
| State Tax on Benefit | None | $0 |
| Total Deductions | | **$0** |
| | | |
| Net Monthly Benefit | $6,000 - $0 | **$6,000** |
| **Total Tax Savings** | | **$1,800** |

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# Government Oversight

- IRS—Internal Revenue Service
- DOL—Department of Labor
  - EBSA—Employee Benefits Security Administration
- HHS—Dept. of Health and Human Services
- SEC—Securities and Exchange Commission
- OMG—Oh my God
- IKR—I know, right?

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# IRS—Internal Revenue Service

### Four primary IRS Divisions at-a-glance:

- Large Business and International
- Small Business/Self-Employed
- Tax-Exempt and Government Entities
- Wage and Investment

### Other principal offices:

- Appeals
- Communications and Liaison
- Criminal Investigation
- Equity, Diversity and Inclusion
- Office of Chief Counsel
- Office of Fraud Enforcement At-a-Glance
- Office of Professional Responsibility (OPR)
- Office of Promoter Investigations
- Privacy, Governmental Liaison and Disclosure
- Procurement
- Return Preparer Office
- Taxpayer Experience Office
- Whistleblower Office

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# DOL—Department of Labor

### Agencies

- Office Of The Secretary (OSEC)
- Administrative Review Board (ARB)
- Benefits Review Board (BRB)
- Bureau of International Labor Affairs (ILAB)
- Bureau of Labor Statistics (BLS)
- Centers for Faith and Opportunity Initiatives (CFOI)
- Chief Evaluation Office (CEO)
- Employee Benefits Security Administration (EBSA)
- Employees' Compensation Appeals Board (ECAB)
- Employment & Training Administration (ETA)
- Mine Safety & Health Administration (MSHA)
- Occupational Safety & Health Administration (OSHA)
- Office Of Administrative Law Judges (OALJ)
- Office Of The Assistant Secretary For Administration & Management (OASAM)
- Office Of The Assistant Secretary For Policy (OASP)
- Office Of the Chief Financial Officer (OCFO)
- Office Of Congressional And Intergovernmental Affairs (OCIA)
- Office Of Disability Employment Policy (ODEP)
- Office Of Federal Contract Compliance Programs (OFCCP)
- Office Of Labor-Management Standards (OLMS)
- Office Of The Solicitor (SOL)
- Office Of Inspector General (OIG)
- Office Of Workers' Compensation Programs (OWCP)
- Ombudsman For The Energy Employees Occupational Illness Compensation Program (EEOMBD)
- Pension Benefit Guaranty Corporation (PBGC)
- Veterans' Employment & Training Service (VETS)
- Wage And Hour Division (WHD)
- Women's Bureau (WB)

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## EBSA—
## Employee Benefits Security Administration

- Oversees Retirement, Health and Welfare, and other benefit plans
- Conducts civil and criminal investigations of employee benefit plans to ensure compliance with ERISA

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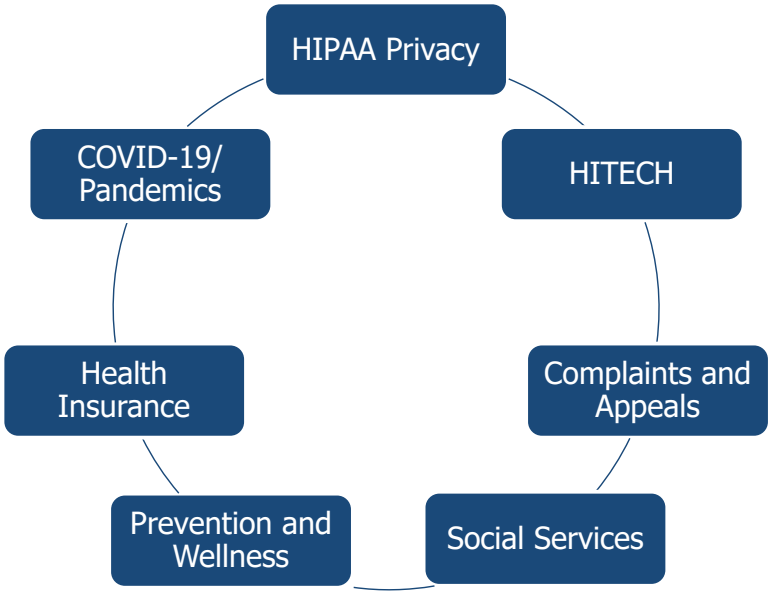
## HHS—Health and Human Services

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## SEC—
## Securities and Exchange Commission

- SEC Divisions Homepages
  - Corporation Finance
  - Economic and Risk Analysis
  - Enforcement
  - Examinations
  - Investment Management
  - Trading and Markets

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## SEC Offices

- EDGAR Business Office
- Office of Acquisitions
- Office of Administrative Law Judges
- Office of the Advocate for Small Business Capital Formation
- Office of the Chief Accountant
- Office of the Chief Operating Officer
- Office of Credit Ratings
- Office of Equal Employment Opportunity (EEO)
- Office of the Ethics Counsel
- Office of Financial Management
- Office of the General Counsel
- Office of Human Resources
- Office of Information Technology
- Office of Inspector General
- Office of International Affairs
- Office of the Investor Advocate
- Office of Investor Education and Advocacy
- Office of Legislative and Intergovernmental Affairs
- Office of Minority and Women Inclusion
- Office of Municipal Securities
- Office of Public Affairs
- Office of the Secretary
- Office of the Strategic Hub for Innovation and Financial Technology (FinHub)
- Office of Support Operations
- Regional Offices

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# SEC Disclosure

- Requires clear, concise disclosure on executive compensation
- Comprehensive overview of company's executive pay practices
  - Sets out total compensation provided to CEO, CFO, and three most highly compensated executive officers for the past three years
- Other information shared by the company:
  - Grants of stock options and stock appreciation rights
  - Long term incentive plan awards
  - Pension benefits
  - Employment contracts
- SEC does not dictate executive compensation practices, but does require certain disclosure

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# Regulations and Reporting

| Laws that govern benefits | |
|---|---|
| Section 125 | FMLA |
| 401(k) | GINA |
| ACA | HIPAA |
| ADA/ADAAA | MHPAEA |
| CAA | NMHPA |
| CHIPRA | USERRA |
| COBRA | WHCRA |
| ERISA | |

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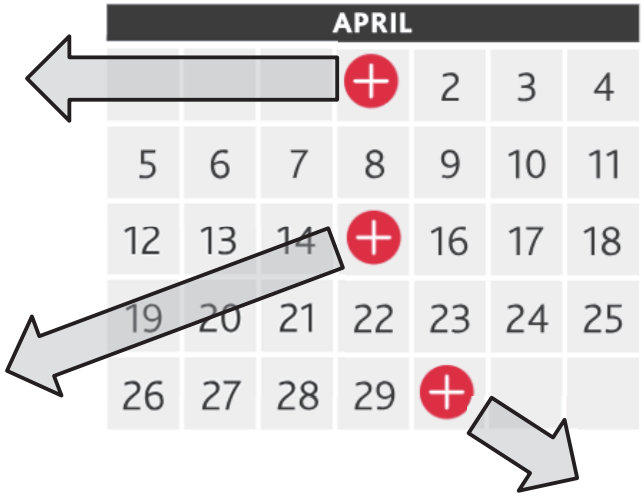
# Compliance Calendar Sample

**Action:** April 1 deadline for 5% business owners and terminated participants who turned 73 in 2025 to receive their required minimum distribution (RMD).

**Action:** File PBGC Form 4010, Notice of Underfunding for single-employer defined benefit plans with more than $15 million aggregate underfunding by **April 15**.




**Action:** Send annual funding notice to participants of single and multi-employer defined benefit plans over 100 participants by **April 30**.

For a 2026 Compliance Calendar visit https://www.bdo.com/insights/assurance/erisa-requirements-calendar

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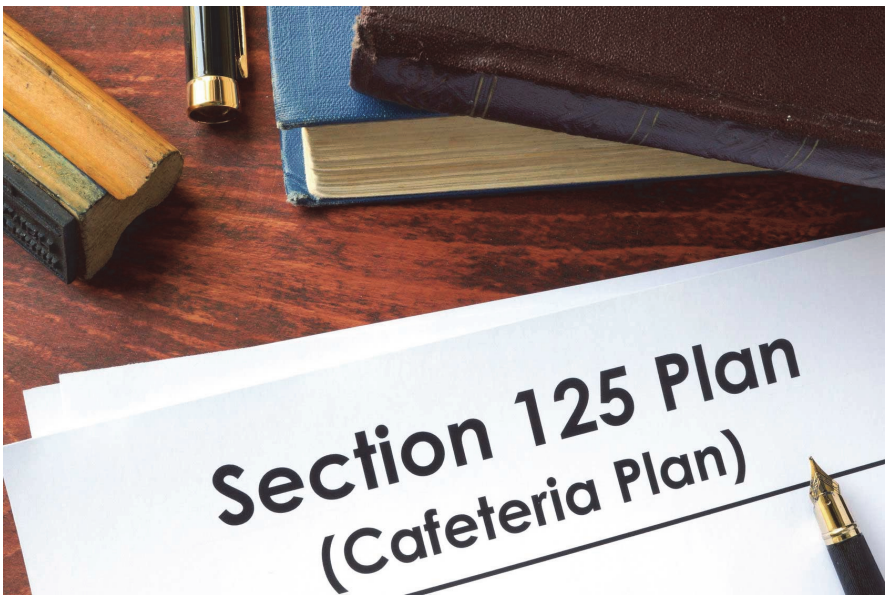
# Section 125 of the IRS Code

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## Section 125 and 132

- Section in the Internal Revenue Code—One place where you are permitted to defer compensation from the "Tax Man"
- Cannot discriminate in favor of highly compensated employees
  - Highly Compensated is defined as $160,000 in 2026
- Types of plans:
  - Premium only plans (POP)
  - Flexible spending accounts (FSAs)
    - Health Care
    - Limited Purpose
    - Dependent Care
    - Transportation (Section 132)
    - Parking (Section 132)

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## Section 125

- What is the benefit?
  - Saves employment taxes
  - Allows benefit to be used on a pre-tax basis
    - Valid medical costs reduce tax liability
- What is a Cafeteria Plan?
  - Term is used interchangeably with Section 125

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# Cafeteria Plan Regulations

## Key Provisions

**Written Plan Document**. The written plan document requirement is fleshed-out to require the document to include:

- *A description of the benefits available to participants;*
- *A description of the eligibility provisions;*
- *An explicit prohibition against participation by individuals who are not common law employees of the plan sponsor;*
- *Procedures for participants' elections among benefits;*
- *Procedures for making contributions through salary reduction or non-elective contributions;*
- *A stated maximum contribution per employee; and*
- *The plan year.*

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# Cafeteria Plan Regulations *(continued)*

Cafeteria plan sponsors, their administrators and advisors will want to examine the need to bring their cafeteria plans into compliance with the proposed cafeteria plan regulations

### Proposed Regulations Published in 2007

By issuing the new proposed regulations in August 2007, IRS effectively updated the previously existing proposed regulations which dated back to 1984. The new proposed regulations are published at *72 Federal Register 43938 (August 6, 2007) and 54716 (September 26, 2007)*. Taxpayers may rely on the proposed regulations pending the issuance of final regulations.

### Cafeteria Plans

- A cafeteria plan allows participants to choose between taxable benefits (*e.g.*, cash) and nontaxable qualified benefits (*e.g.*, employer-provided accident and health plan coverage). A number of different types of plans fall within the scope of §125, for example:
- "Flex" plans, which allow participants to choose among a variety of qualified benefits; Premium-only plans, where the only choice is between cash and pre-tax contributions to a health plan;
- Medical flexible spending accounts, which reimburse out-of-pocket medical expenses;
- Dependent care flexible spending accounts, which reimburse the costs of caring for employees' dependents.

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# HSA: Health Savings Account Paired With QHDHP

| Parameters | 2026 Health Plan Limits | 2026 HSA Contribution Limits |
|---|---|---|
| • Created in Medicare Modernization Act<br>• Tax-deductible savings account used to pay for qualified unreimbursed medical expenses and long-term care insurance<br>• Individually owned<br>• Money rolls over annually<br>• Can be used as a retirement plan<br>• Early withdrawals subject to 10% early withdrawal penalty | • Minimum deductible for single = $1,700<br>• Minimum deductible for family = $3,400<br>• Out-of-pocket Max for single = $8,500<br>• Out-of-pocket Max for family = $17,000 | • Maximum contribution for individual = $4,400<br>• Maximum contribution for family = $8,750<br>• Catch-up Contributions for age 55+ individuals is $1,000 per year eligible (no change)<br>• Maximums include employer contributions |

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# HSA Prorated Contribution Rules

- **OPTION 1:** Prorate your contribution limit based on the number of months you have HDHP coverage that year. This option results in a lesser contribution to the HSA Plan.
- **EXAMPLE:** You're covered under an HDHP for four months (September to December) in 2026, so you can contribute 4/12 of the total contribution limit for 2026. $4,400 / 12 = $366.67 x 4 = $1,466.68.

- **OPTION 2:** Contribute the full allowable amount as if you'd had HDHP coverage for the whole year. This option requires you to be covered by only an HDHP plan (remaining HSA eligible) for the entire following year. If you don't, you owe income tax and additional taxes on some of the funds contribute to your HSA
- **EXAMPLE:**
  - You start a new job in July 2026, and become eligible in September. Your employer offers an HDHP and you enroll in it as a single employee.
  - As long as you're HSA-eligible as of December 1, you can make the full-year HSA contribution, but the testing period applies. This is called the "last month" rule, because you have to be HSA-eligible as of the first day of the last month of the tax year in order to make the full-year HSA contribution.
  - Assuming you're still enrolled in the HDHP as of December 1 and you're participating in the health plan as an individual, you can go ahead and contribute up to $4,400 to your HSA for 2026—and you have until April 15, 2027 to make that contribution.

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# FSA: Flexible Spending Account Can Be Paired With Any Plan Design

| Parameters | Health Plan Limits Rules | 2026 FSA Contribution Limits |
|---|---|---|
| • Part of IRS Code Sec 125 Cafeteria Plans<br>• Tax-deductible spending account used to pay for qualified unreimbursed medical expenses<br>• Employer owned<br>• Use it or lose it<br>• Some rollover provisions or extensions allowed<br>• Four Types: Health, dependent care, transit, premium only | • No prescribed health plan design must be paired with FSA<br>• A limited FSA can be offered with an HSA and that would need to follow the health plan design of the HSA rules<br>• Needs a third-party administrator to set up plan summary plan documents, claim reimbursements, and billing to the employer | • Maximum contribution for individual = $3,400<br>• Maximum contribution for Dependent Care = $7,500<br>• Parking/Transit limits $340/mo.<br>• Rollover provision = $680 (The other option is the 2.5-month grace period)<br>• Contributions are subject to indexed discrimination testing **(Highly compensated individual limits change annually)** |

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# HRA: Health Reimbursement Arrangement Can Be Paired With Any Plan Design

| Parameters | Health Plan Limits | HRA Contribution Limits |
|---|---|---|
| • Part of IRS Section 105 Regulations<br>• Employer contributions pay for medical, dental, vision, Rx, and some OTC<br>• Rollover allowed at employer's discretion<br>• Portability allowed at employer's discretion | • No prescribed health plan design must be paired with HRA<br>• Needs a third-party administrator to set up plan summary plan documents, claim reimbursements, and billing to the employer | • No contribution limits<br>• Contributions can be made on behalf of current, former employees, their spouses and dependents, and spouses and dependents of deceased employees |

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## ACA—Affordable Care Act


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## Affordable Care Act

- Patient Protection and Affordable Care Act (PPACA)
  - ACA
  - Obamacare
- Signed into law March 23, 2010
- Health Care and Education Reconciliation Act of 2010
  - Companion bill to PPACA
  - Included many of the taxes associated with ACA

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# Little Known ACA Compliance Areas

## 60-Day Notice of Plan Changes

- A health plan or issuer must provide **60 days' advance notice** of any **material modifications** to the plan that are not related to renewals of coverage.
  - Notice can be provided in an updated SBC or a separate summary of material modifications.

## Employee Notice of Exchange

- Employers must provide all new hires and current employees with a written notice about ACA's health insurance exchanges (Exchanges).
  - In general, the notice must: Inform employees about the existence of the Exchange and give a description of the services provided by the Exchange.

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# Little Known ACA Compliance Areas

## Preventive Care Services for Women

- Non-grandfathered health plans must cover specific preventive care services for women without cost-sharing requirements.
- The covered preventive care services for women include: Well-woman visits; gestational diabetes screening; human papillomavirus (HPV) testing; sexually transmitted infection (STI) counseling; human immunodeficiency virus (HIV) screening and counseling; FDA-approved contraception methods and contraceptive counseling; breastfeeding support, supplies and counseling; and domestic violence screening and counseling.

## Medicare Tax Increases

- Employers are responsible for withholding the 0.9% Additional Medicare Tax on an individual's wages paid in excess of $200,000 in a calendar year, without regard to filing status. An employer is required to begin withholding Additional Medicare Tax in the pay period in which it pays wages in excess of $200,000 to an employee and continue to withhold it each pay period until the end of the calendar year.

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# Employer Action—Range of Possibilities

| Play | Play and Redirect | Selective Play | Pay and Exit |
|---|---|---|---|
| • Play by meeting PPACA requirements | • Play by meeting PPACA requirements | • Offer an employer-sponsored plan to only part of the population | • Discontinue employer-sponsored plan |
| • Optimally manage design and delivery to sustain an employer-sponsored plan | • Structure contributions to encourage low wage earner qualification for subsidies | • Direct ineligible employees to Exchanges | • Pay $3,340 for 2026 penalty for all FT employees |
| • Define contingencies for future exit | • Pay $5,010 for 2026 penalty for those who exit and are subsidized by new coverage from the Exchange | • Pay $3,340 for 2026 penalty for all FT employees | • Direct employees to Exchanges<br>• Provide no financial subsidy |

Note: penalty amounts are expressed as an annual amount above but are assessed on a monthly basis.

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# Key ACA Provisions

- Medicaid expansion
  - Subject to State approval
- Created health care exchanges
  - Federal and State-level (some states created their own, others did not)
- New regulations on health insurance plans
  - Cannot deny coverage
  - Cannot impose lifetime limits
  - Limit to how much can be charged based on age and gender
- Requires most individuals to have insurance, although the Tax Cuts and Jobs Act reduced the penalty to $0 beginning in 2019
- Requires Applicable Large Employers to offer insurance or pay a penalty (as noted on previous slide)
- Allows children to stay on parent's plan until age 26

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# Applicable Large Employer (ALE)

- Has 50 or more Full-time or Full-time Equivalent employees
- Determined each calendar year based on average size of workforce during the prior year
- Full-time employee
  - Determined monthly
  - Average 30 or more hours per week or at least 130 hours per month
- Full-time Equivalent (FTE) employee
  - Only applies in determining ALE status
  - Combine the number of hours of service for each non-full-time employee (max 120) and divide total by 120 to determine number of FTE
- Companies with a common owner or that are otherwise related under certain rules of section 414 of the Internal Revenue Code are generally combined and treated as a single employer for determining ALE status.

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# Employer Shared Responsibility

- IRC Section 4980H
- ALE must offer health insurance:
  - Minimum Essential Coverage (MEC)
  - Provides Minimum Value (MV)
  - Is affordable
  - To at least 95% of Full-time Employees (FTE)
- Affordability compares the percentage (9.96% in 2026, indexed each year) to one of three safe harbors
  - W-2 wages
  - Rate of Pay
  - Federal Poverty Level

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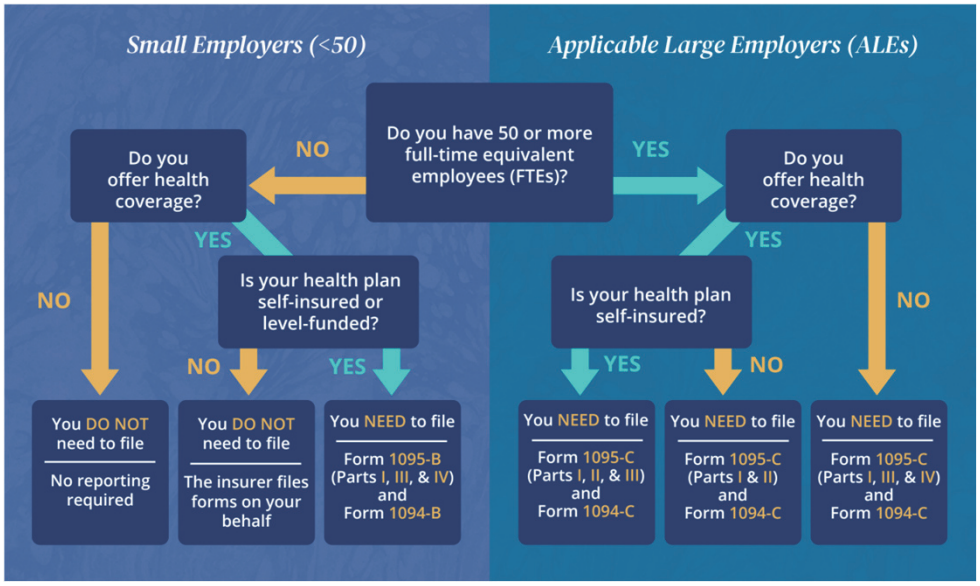
# ACA Reporting Workflow




Source: Ameriflex

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# ACA Reporting Requirements

- Reporting began with 2015 Tax Year
- Meant to assist the federal government in enforcing compliance with individual mandate and employer shared responsibility (employer mandate)
- Also assists with administration of the Premium Tax Credit (PTC)
- §6055—Information Reporting of Minimum Essential Coverage (MEC)
  - Enables the individual to prove and the IRS to verify the existence of individual coverage
- §6056—Information Reporting by Applicable Large Employers (ALE) on Health Insurance Coverage
  - Enables ALE to report compliance with ACA's shared responsibility requirements

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# ACA Reporting Requirements

- Different forms are used for different purposes
- Health care information for individuals is filed on the 1095 series
  - Form 1095-A: Marketplace sends this to individuals enrolled on the Marketplace
  - Form 1095-B: Health insurance providers send this to individuals they cover
  - Form 1095-C: Employers send this to employees and other participants in the employer sponsored plan
- Information is reported to the IRS on a corresponding Form 1094 (*e.g.*, Form 1094-C is submitted by employers that provide Form 1095-C), can be thought of as a cover sheet as the individual Forms 1095 are transmitted with the 1094

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# ACA Furnishing

- IRS Notice 2025-15 provided guidance on alternate ways of furnishing Forms 1095-B and 1095-C
- Allows reporting entities to ***only furnish*** these Forms upon request
- Notice of Form availability must be posted where it is accessible for all recipients (including terminated or inactive employees) and must be posted by deadline for furnishing Forms
- Requests for Forms must be fulfilled within 30 days of the request
- NOTE: states with reporting requirements still require Forms to be furnished to recipients

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# ACA Penalties

- There are two types of penalties related to ACA reporting
  - Sections 6721 and 6722 impose a penalty for failing to timely file/furnish an information return or for filing/furnishing an incorrect or incomplete information return.
  - Sections 4980H(a) and 4980H(b) impose an assessable payment if an applicable large employer fails to offer to its full-time employees health coverage that is affordable and provides minimum value if a full-time employee enrolls for that month in a qualified health plan for which the employee receives a premium tax credit.

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# Penalties for Failure to Meet Reporting Requirements (6721/6722)—2025 Forms

| Large Employer—Gross Receipts >= $5M | | | |
|---|---|---|---|
| Filing/Furnishing the correct ACA forms within 30 days after the due date | Filing/Furnishing between 30 days after the due date and August 1 | Filing/Furnishing on or after August 1 | Intentionally neglecting to file |
| **$60** per return or statement, Maximum **$683,000** | **$130** per return or statement, Maximum **$2,049,000** | **$340** per return or statement, Maximum **$4,098,500** | **$680** per return or statement, No maximum |

| Small Employer—Gross Receipts < $5M | | | |
|---|---|---|---|
| Filing/Furnishing the correct ACA forms within 30 days after the due date | Filing/Furnishing between 30 days after the due date and August 1 | Filing/Furnishing on or after August 1 | Intentionally neglecting to file |
| **$60** per return or statement, Maximum **$239,000** | **$130** per return or statement, Maximum **$683,000** | **$340** per return or statement, Maximum **$1,366,000** | **$680** per return or statement, No maximum |

Source: https://www.irs.gov/instructions/i1099gi#en_US_2025_publink1000287010

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# Employer Shared Responsibility Payments (4980H(a) and 4980H(b))

| | ESRP Amounts | | |
|---|---|---|---|
| | 2024 | 2025 | **2026** |
| 4980H(a) | $2,970 x the number of FTEs | $2,900 x the number of FTEs | **$3,340 x the number of FTEs** |
| 4980H(b) | $4,460 x the number of FTEs receiving a premium tax credit | $4,350 x the number of FTEs receiving a premium tax credit | **$5,010 x the number of FTEs receiving a premium tax credit** |

Note: penalty amounts are expressed as an annual amount above but are assessed on a monthly basis.

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# ICHRA

- Individual Coverage HRA (ICHRA)
- ICHRA is a federal ruling which allows businesses the option to offer employees a monthly allowance of tax-free money to buy health insurance that fits their unique needs.
- Along with provisions for out-of-pocket health insurance expenses, ICHRA also directly addresses ACA compliance for employers with more than 50 employees.

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# ICHRA

- HRA had been popular for businesses who wanted to reimburse their employees' health care expenses. The ACA significantly limited a business's ability to offer HRAs for individual policies.
- A 2017 Executive Order directed the Departments of Treasury, Health and Human Services, and Labor to expand business' use of HRAs. New ICHRA rules were released in 2019 for 2020 plans.
- An ICHRA can reimburse individual insurance premiums (whereas an HRA cannot)
- An ICHRA works with individual insurance plans, while an HRA can only be used with a group health plan.
- www.ichra.com

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# ADA—Americans With Disabilities Act


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## Provisions of the ADA

- Prohibits private employers, state and local governments, employment agencies and labor unions from discriminating against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions, and privileges of employment.
  - Covers employers with 15 or more employees, including state and local governments.
  - Applies to employment agencies and to labor organizations
- An individual with a disability is a person who:
  - Has a physical or mental impairment that substantially limits one or more major life activities;
  - Has a record of such an impairment; or
  - Is regarded as having such an impairment

55

## Provisions of the ADA

- A qualified employee or applicant with a disability is an individual who, with or without reasonable accommodation, can perform the essential functions of the job in question. Reasonable accommodation may include, but is not limited to:
  - Making existing facilities used by employees readily accessible to and usable by persons with disabilities.
  - Job restructuring, modifying work schedules, reassignment to a vacant position;
  - Acquiring or modifying equipment or devices, adjusting or modifying examinations, training materials, or policies, and providing qualified readers or interpreters.

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# Provisions of the ADA

- An employer is required to make a reasonable accommodation to the known disability of a qualified applicant or employee if it would not impose an "undue hardship" on the operation of the employer's business.
- Reasonable accommodations are adjustments or modifications provided by an employer to enable people with disabilities to enjoy equal employment opportunities. Accommodations vary depending upon the needs of the individual applicant or employee.
- Not all people with disabilities (or even all people with the same disability) will require the same accommodation. For example:
  - A deaf applicant may need a sign language interpreter during the job interview
  - An employee with diabetes may need regularly scheduled breaks during the workday to eat properly and monitor blood sugar and insulin levels
  - A blind employee may need someone to read information posted on a bulletin board
  - An employee with cancer may need leave to have radiation or chemotherapy treatments

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# ADAAA—ADA Amendments Act of 2008

- Aims to broaden the scope of "substantially limits" by directing courts to construe the Act "in favor of broad coverage of individuals under this Act, to the maximum extent permitted by the terms of this Act."
- The ADAAA clarifies that an individual is "regarded as" having a disability if the employee establishes that he or she has been discriminated against because of an actual or perceived physical or mental impairment. The "regarded as" prong does not apply to transitory and minor impairments where the impairment is expected to last less than six months. The ADAAA also clarifies that employers are not required to provide a reasonable accommodation to individuals who are regarded as disabled.

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# ADAAA—
# ADA Amendments Act of 2008 *(continued)*

- The ADAAA specifically prohibits courts from considering mitigating measures such as medication, prosthetics, and assistive technology in determining whether an individual is disabled. The ADAAA does, however, permit consideration of standard vision correction achieved through normal glasses or contact lenses. The ADAAA also expands the list of major life activities for courts to consider, including the following:
  - Caring for oneself;
  - Performing manual tasks;
  - Seeing and hearing;
  - Eating, sleeping, walking and standing;
  - Lifting and bending;
  - Speaking and breathing;
  - Learning, reading, concentrating, and thinking; and
  - Working.
- Under the ADAAA, major life activity includes the operation of major bodily functions including functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.

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# ADAAA Implications

**Implications**

- The ADAAA has made it more difficult for an employer to take the position that one of its employees is not "disabled."
- As a result, more reasonable accommodation requests and decisions, as well as more discrimination charges and lawsuits have occurred
- Employers should familiarize themselves with the standards imposed by the ADAAA to ensure that they are aware of their legal obligations and are able to handle accommodation requests accordingly

60

# FMLA—Family and Medical Leave Act (1993)


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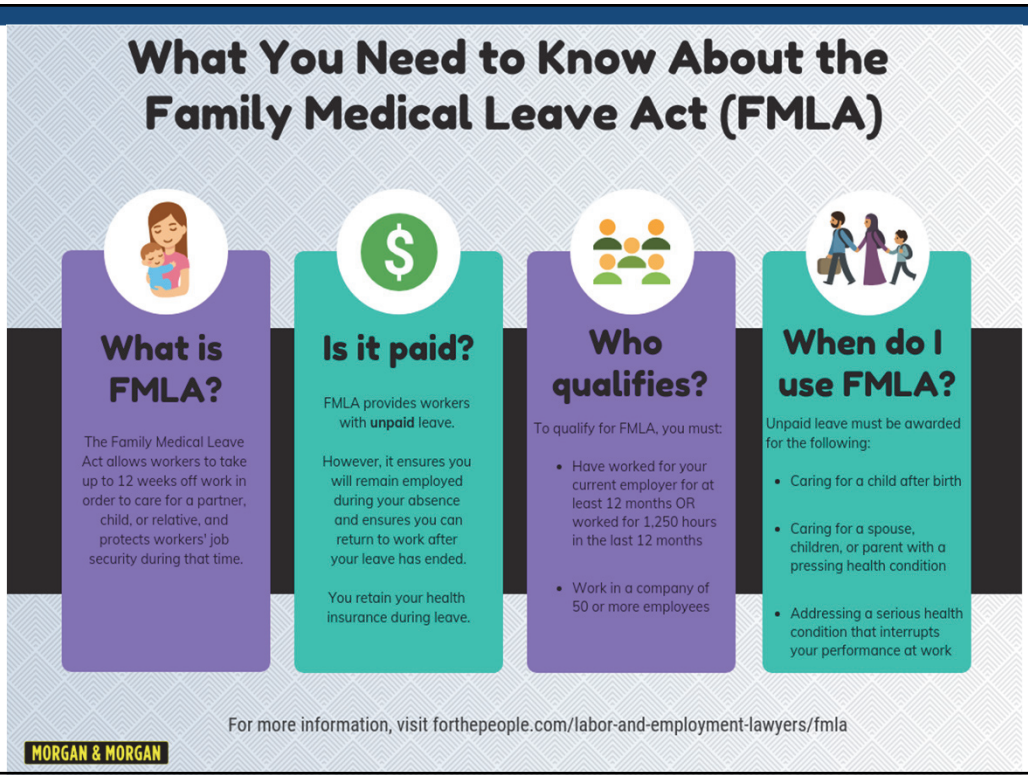



62

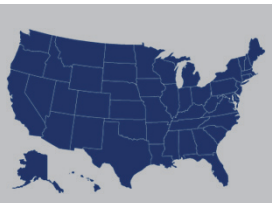
# FMLA Eligibility

To be eligible for FMLA benefits, an employee must . . .

Have worked for at least
**1,250 hours**
over the previous 12 months
before leave is to begin

Work for a
**covered employer**

Work in a location in the
**United States**
where **at least 50 employees** are employed **within 75 miles**



Have worked for the employer for at least
**12**
months
(needs not be consecutive)

Source: J.J. Keller® Leave Manager

63

# FMLA Eligible Employer

An eligible employer is one who is:

- A private-sector employer is covered by the FMLA if it employs 50 or more employees in 20 or more workweeks in the current or previous calendar year. An employee is considered to be employed each working day of the calendar week if the employee works any part of the week. The workweeks do not have to be consecutive.

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# Other FMLA Provisions

- Twelve weeks of leave in a 12-month period for:
  - The placement with the employee of a child for adoption or foster care and to care for the newly placed child within one year of placement;
  - Any qualifying exigency arising out of the fact that the employee's spouse, son, daughter, or parent is a covered military member on "covered active duty;" **or**
- Twenty-six workweeks of leave during a single 12-month period to care for a covered service member with a serious injury or illness if the eligible employee is the service member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

Don't forget about state and local leave laws!

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# FMLA + STD

## FMLA PROTECTS YOUR JOB

- If you qualify for FMLA, you must be allowed time off to take care of yourself or an immediate qualifying family member without retaliation
- Return to the same or equivalent job, benefits, responsibilities, and pay
- FMLA does not have a pay component, but some employers may have a paid leave policy.
- Employees may continue their benefits while on leave (and must pay for them)

## STD PROTECTS YOUR PAY

- Short-Term Disability provides you INCOME while you are taking care of yourself for your own personal medical condition.
- Short-Term Disability does NOT pay you when you are taking care of a covered family member.
- Additional pay may be available using Sick, Vacation, PTO, Workers Compensation or State Paid Leave benefits
- Some state leave programs may be more generous than FMLA

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# ADA Compared With FMLA

| FMLA | ADA |
|---|---|
| • Eligible only after 12 months and 1,250 hours | • Eligible day one, before eligible for FMLA and after FMLA expires |
| • Limited amount of leave | • Leave not limited unless "indefinite" |
| • Intermittent leave mandatory | • Not required to tolerate erratic, unreliable attendance |
| • Must maintain employer's share of health insurance | • May require employee to pay full insurance premium |
| • Restore to same or substantially similar position | • Restore to exact same position at end of leave |
| • If certified, must provide leave | • May not need to provide leave if it would be an "undue hardship" |

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# CAA—Consolidated Appropriations Act


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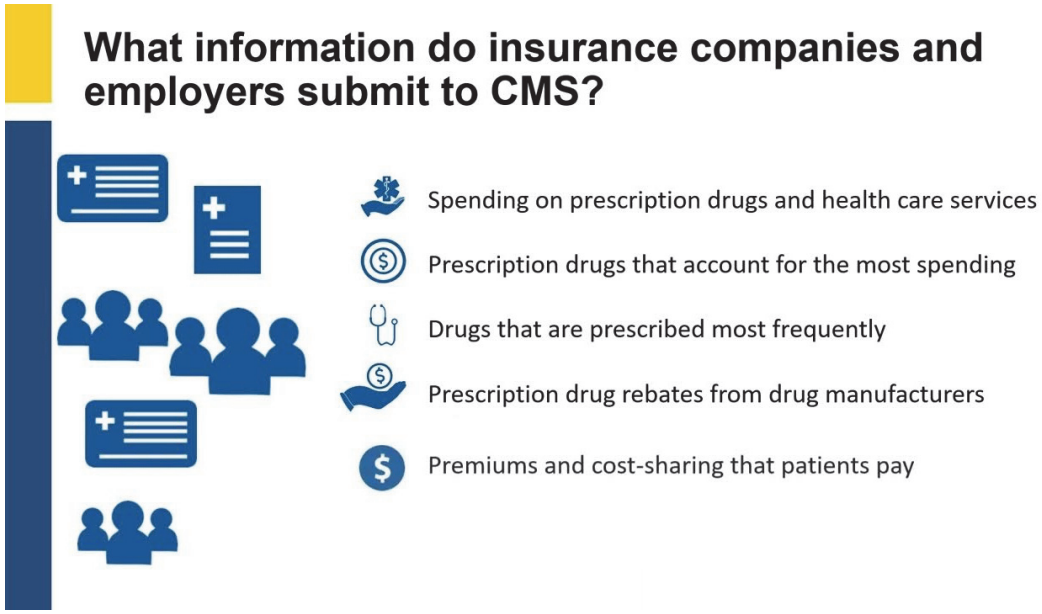
# Prescription Drug Data Collection (RxDC) Overview

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# RxDC

- Annual reporting due June 1 each year
- For self-insured plans, the plan sponsor is responsible for compliance and ultimately responsible for ensuring its data was submitted and documenting appropriate verification
  - Can delegate to TPA and/or PBM (a "reporting entity") which can submit some or all the required data on behalf of the group health plan on an aggregated basis;
  - Must enter into written agreement(s) with the TPA and PBM submitting the information
- For insured group health plans, the issuer is responsible for any noncompliance if there is a written agreement

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# Gag Clause Attestation

- Under the Consolidated Appropriations Act of 2021 (CAA), group health plans and health insurance issuers are prohibited from entering into agreements with service providers restricting certain information that the plan may make available to another party.
- Plan sponsors and issuers must make a Prohibition Compliance Attestation (GCPCA) annually.
- Group health plans (including ERISA plans, non-federal governmental plans, and church plans) and health insurance issuers are prohibited from entering into agreements containing gag clauses.
- The requirement does not apply to excepted benefits, health reimbursement arrangements (HRAs), or other account-based plans.
- Plan sponsors should review agreements with insurers, healthcare providers, network providers, TPAs, and other service providers to ensure there are no gag clauses.

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# Gag Clause Attestation

- A self-funded plan sponsor may contract with a service provider (such as a TPA, including an issuer acting as a TPA) who may complete the attestation on the plan sponsor's behalf.
- The plan sponsor remains legally responsible for compliance.
- Failure to provide the attestation may result in a civil penalty of $100 per day for each individual affected by a violation.
- Self-funded plan sponsors who intend to delegate GCPCA reporting responsibilities to a service provider should ensure the delegation is stated in a written agreement.

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# Other CAA Provisions

- **Cost Reductions**—The Act implements a number of budget offsets under the Medicare program. For example, the Act extends the current adjustment to the calculation of the hospice cap amount under Medicare through 2032, rather than 2031. Similarly, the Act reduces the Medicare Improvement Fund by over $7 billion.
- **Medicaid Improvement Fund**—The Act provides $7 billion in additional funding for the Medicaid Improvement Fund, which is intended to be used by CMS to improve management of the Medicaid program.
- The Act requires that States provide continued eligibility for benefits to qualifying children under both the Medicaid and CHIP programs. Specifically, under the Medicaid program, States must provide benefits to an eligible individual under the age of 19 until the earlier of:
  - The end of the 12-month period beginning on the date eligibility was determined;
  - The time the individual turns 19 years of age; or
  - The date the individual is no longer a resident of the respective State.
  - Under the CHIP program, eligible children must receive one year of continuous benefits eligibility, subject to being transferred to the Medicaid program.

Key Healthcare Provisions of the Consolidated Appropriations Act, 2023 | Healthcare Law Blog

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# CHIPRA (2009)


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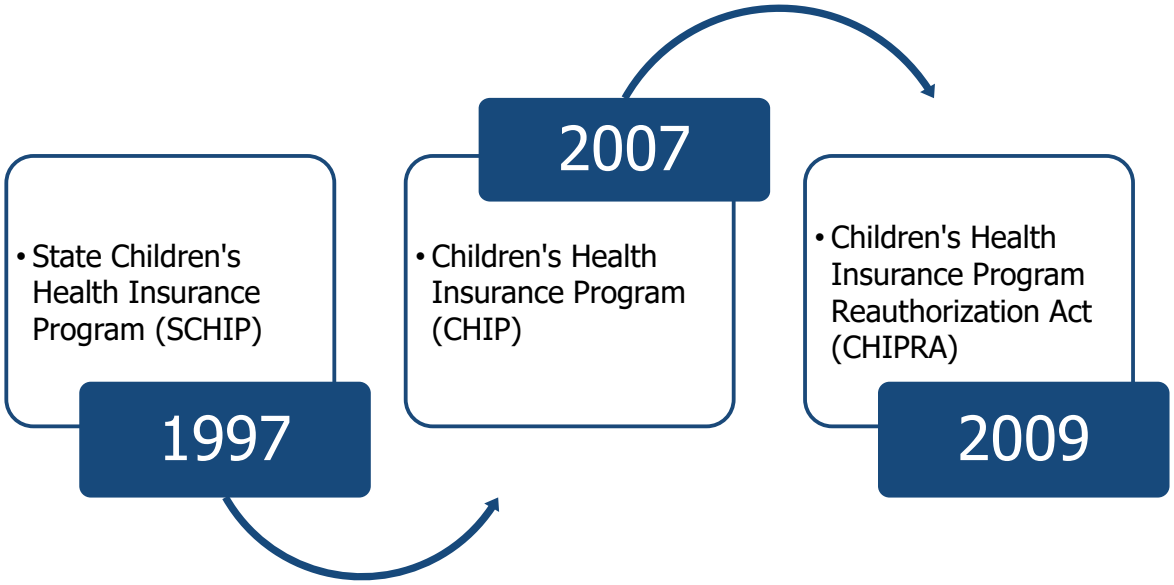
# CHIP (1997)/CHIPRA (2009)




75

# CHIP/CHIPRA Basics

- The Children's Health Insurance Program (CHIP) is a government assistance program that provides affordable health insurance and quality health care for children whose families don't qualify for Medicaid but still can't afford health coverage.
- CHIPRA—The CHIP Reauthorization Act—Was signed into law in 2009.
- In 2009, President Obama extended the Children's Health Insurance Program to cover an additional four million people including kids, expecting mothers, and even some who immigrated to the States.

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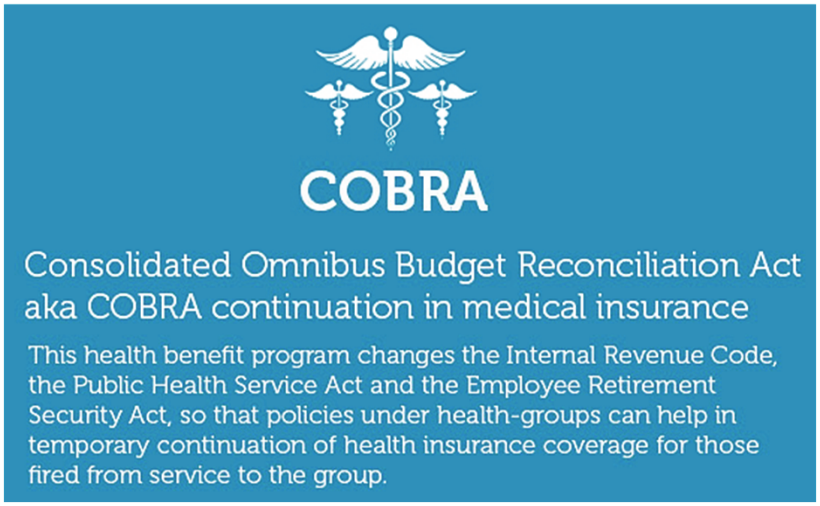
# COBRA (1985)

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# COBRA Eligibility

- COBRA gives workers and their families the right to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances:

Voluntary or involuntary job loss → Reduction in the hours worked → Transition between jobs → Death → Divorce

- Applies to group health plans with 20 or more employees in the prior year

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# When Is COBRA Communicated?

| | |
|---|---|
| SPD | Describes COBRA rights |
| COBRA General Notice | Sent to each employee and spouse who becomes covered |
| COBRA Election Notice | Provided when there is a qualifying event |
| COBRA Notice of Unavailability of Continuation Coverage | Issued if the plan denies someone's request for COBRA |
| COBRA Notice of Early Termination of Continuation Coverage | Issued if the plan terminates coverage early for a qualifying reason |

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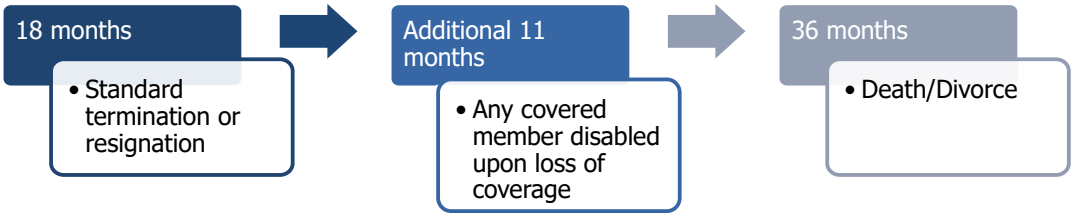
# Class Discussion

- How many of you have handled COBRA notices?
  - Does your welfare benefit plan consultant handle them?
  - Do you outsource them?
- Who is covered?
  - Beware of the gross misconduct exception

80

# COBRA Coverage Duration

- Lengths of coverage




- Second qualifying event could provide extension of coverage not to exceed 36 months from initial qualifying event

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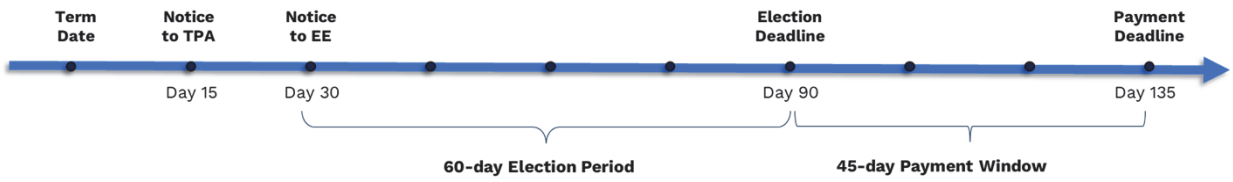
# COBRA Enrollment Timeline

- 15 Days to notify a TPA; maximum of 30 days to notify the employee
- 60 Days to elect coverage
- 45 Days from date of election to submit first payment
- First payment is retroactive to first date of coverage

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## COBRA Premiums and Enrollment

- COBRA premiums
  - 102% of cost for active employee for most situations
  - 150% for the additional 11-month disability extension
  - Payment short by $50 or 10% of the required amount counts has having made payment with respect to terminating COBRA coverage for non payment; participant still has to make up the difference
- 60 days to elect COBRA coverage, starting from later of date you lose coverage or are furnished notice

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## COBRA Termination and Penalties

- Terminating COBRA
  - End of coverage period—18, 29 or 36 months
  - Failure to pay premium in a timely manner
  - EE is covered under another health plan
- Penalties for non-compliance
  - Nondeductible excise tax of $100 per day
  - Civil penalty of up to $110 per day
  - Individual lawsuits for wrongful denial of COBRA coverage to recover all damages plus attorneys' fees

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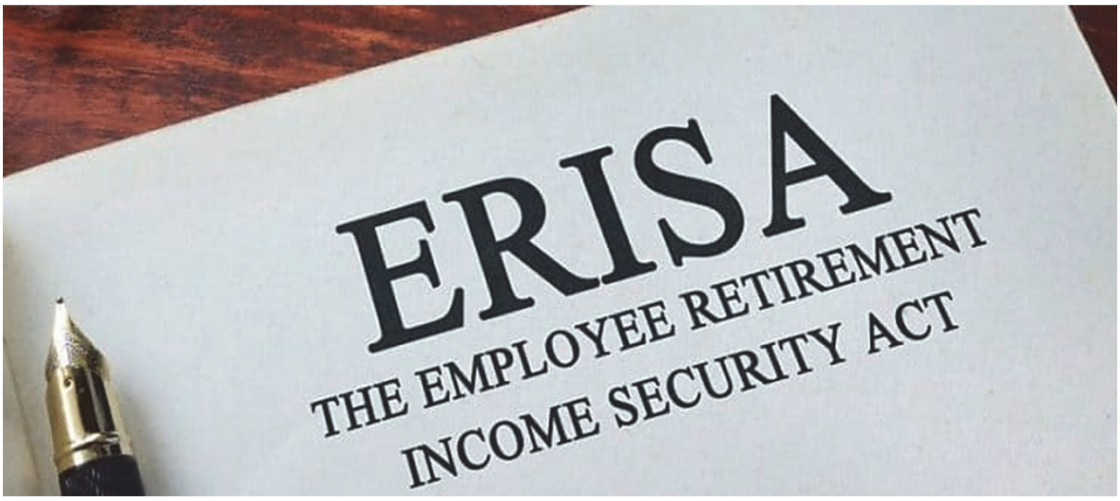
## ERISA (1974)




85

## ERISA (1974)

The Employee Retirement Income Security Act (ERISA) continues to be the single greatest influential force on the administration of employee benefit plans.

Its guidelines and penalties impact all parts of plan operations, including the recordkeeping requirements for disclosure documents.

**GBA/RPA 3**
**Module 1**
Objectives
1 and 4

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## Where Did ERISA Come From?

Employee Retirement Income Security Act of 1974

- Every Rotten Idea Since Adam

- To understand ERISA, it's best to start with examining what the problems were that Congress was trying to fix?
  - Studebaker (funding) problem
  - Security issue for long-time employees in DB plans
  - Fiduciary issues
  - Pension assets invested in imprudent investments
  - Circumventing the existing tax rules
  - Reporting issues

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## Employers Subject to ERISA

- Applies to virtually all private-sector employers
- Only two types of employers can be exempt from ERISA:
  - Church plan: Plan established or maintained by a church, convention or association of churches exempt from tax under IRC Section 501
  - Governmental employers: Plans maintained by federal, state, or local (city, county, etc.)
- Small employers are subject to ERISA unless they are a Church or Governmental plan

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# ERISA Basics

- Every "employee benefit plan" must have a Summary Plan Description written in a manner calculated to be understood by the average plan participant
- Plan document requirement
- Form 5500 may need to be filed with the U.S. Department of Labor for each plan year for which the plan is in existence
- Regulates the timing and communication of the benefits claims process
- Places duties and responsibilities on plan fiduciaries
- Gives plan participants the right to sue for benefits in federal court
- Punishes a plan sponsor for interfering with a participant's ERISA rights

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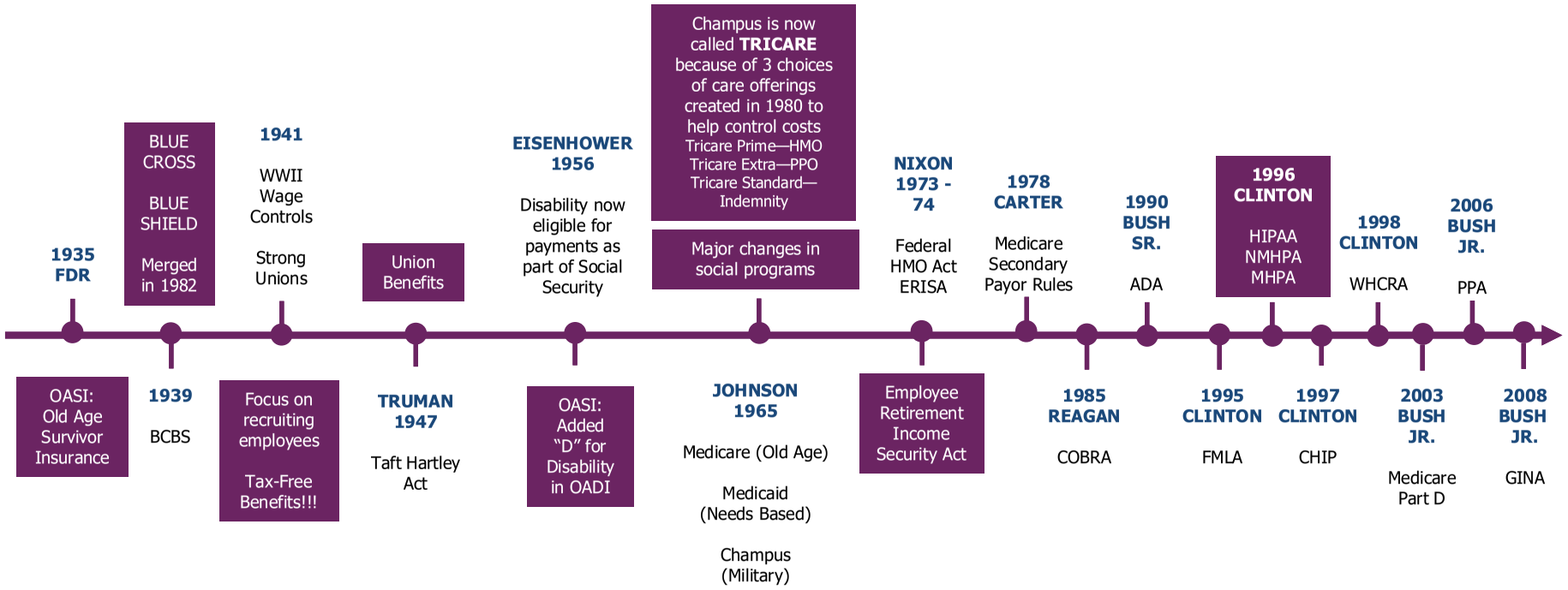
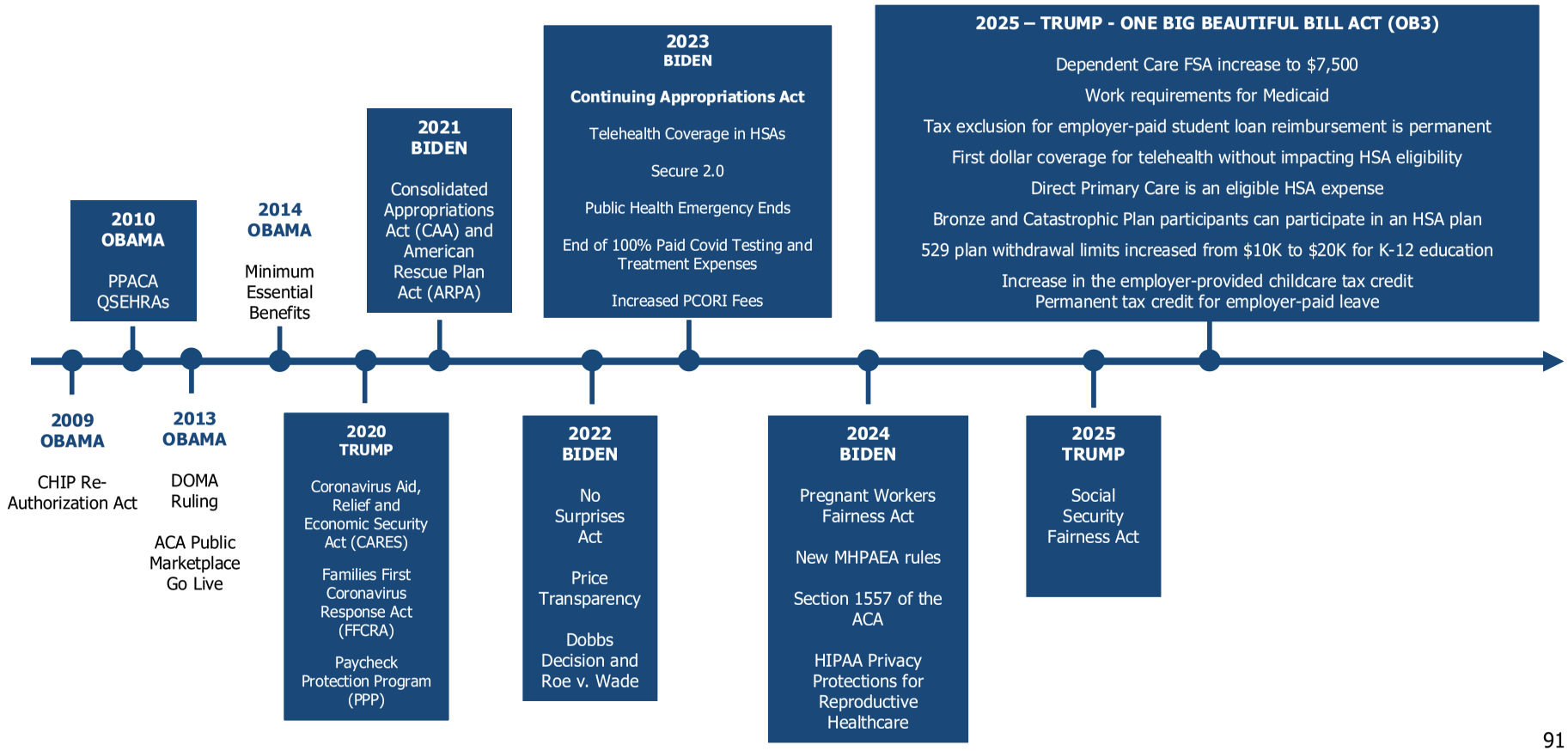
# The History of Benefits by President



# The Rapid Rise in Regulations



# The Rapid Rise in Regulations


**Workplace Violence**

**Worker Safety**

**Immigration**

**Labor Shortages**

**Privacy**

**Pay Equity**

**Gig Economy**

**Remote Workers/Return to Office**

**State/Local Paid Leave**

**Inflation/Affordability**

**Natural Disasters**

**Tariffs**

## What Is an Employee Benefit Plan?

- Under ERISA Section 3(3), it is:
  - An "**employee welfare benefit plan**" as defined in ERISA Section 3(1), or
  - An "**employee pension benefit plan**" as defined in ERISA Section 3(2)
- Many other plans, programs, or schemes inside and outside the U.S. are considered employee benefit plans, but not subject to ERISA

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## What Is an "Employee Welfare Benefit Plan"?

- Any plan, fund, or program
- Which was established or maintained by an employer or employee organization, or both
- For the purpose of providing to its participants or beneficiaries
- Through the purchase of insurance or otherwise
- Medical, surgical or hospital care, or
- Benefits in the event of sickness, accident, disability, death, or unemployment or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services,
- Any benefit described in Section 302(c) of the Labor Management Relations Act of 1947

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## What Is an "Employee Pension Benefit Plan"?

- Any plan, fund, or program
- Which was established or maintained by an employer or employee organization, or both
- That by its express terms or as a result of surrounding circumstances such plan, fund, or program
- Provides retirement income to employees, or
- Results in a deferral of income by employees for periods extending to the termination of covered employment or beyond

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## Why Do We Care if a Plan Is an ERISA Plan?

- Pros
  - Preemption of state insurance laws
  - Tax advantages
- Cons
  - Reporting and disclosure to the U.S. Government and Participants
  - Discrimination rules in some cases
  - Plan filing for approval in some cases
  - Disqualification penalties in some cases
  - Increasing and costly lawsuits by employees and class action legal actions
  - Important and significant plan provisions may be required such as QJSA and QPSA

96

## Plan Administrator

- Plan Administrator is defined under ERISA Section 3(16)(A)
  - Person specifically designated under the terms of the instrument under which the plan is operated
  - If no person designated, then it is the plan sponsor by default,
  - If neither of the above can be identified, such other person as the DOL Secretary shall prescribe

97

## Plan, Fund or Program

- Guidelines for determining whether a benefit arrangement is a **"plan, fund or program"** subject to ERISA:
- If a reasonable person can ascertain:
  - The intended benefits;
  - A class of beneficiaries;
  - The source of financing; and
  - Procedures for receiving benefits.

[See the case of *Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir.1982).]

98

## Common Health Plan Mistakes

- Failure to timely amend and distribute the plan document, summary plan description, and summary of material modification for changes in the law
- Failure to enroll eligible employees/dependents and/or to exclude ineligible employees/dependents
- Failure to retain records and maintain internal controls regarding administration of the plan
- Failure to follow the terms of a Qualified Domestic Relations Order (QDRO) and Qualified Medical Child Support Order (QMCSO)

99

## Reporting and Disclosure

- What are the main reporting and disclosure requirements of ERISA?
- What are some best practices?

100

# IRS and DOL Reporting

- IRS and DOL
  - Form 5500 series reports (not required by government employers)
  - All plans required to file electronically
  - Audited financial statements for plans with >100 participants as of the beginning of the plan year
  - Due dates: Last day of the 7th month after the plan year ends
  - Extensions are available
  - Penalties for late filing
    - DOL—Up to $2,739 per day with no maximum for 2025
    - IRS—$25/day up to $15,000 up to 2019; after 2019 penalty is $250/day up to $150,000

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# EFAST

- Effective January 1, 2010, all Form 5500 Annual Returns/Reports of Employee Benefit Plan and all Form 5500-SF Short Form Annual Returns/Reports of Small Employee Benefit Plan and any required schedules and attachments, must be completed and filed electronically using EFAST2
  - Required for retirement and welfare plans
  - Also applies to 403(b) plans, except those not subject to Title I of ERISA
  - Form 5500-EZ is used by one-participant plans and foreign plans to satisfy annual reporting requirements under the Internal Revenue Code.

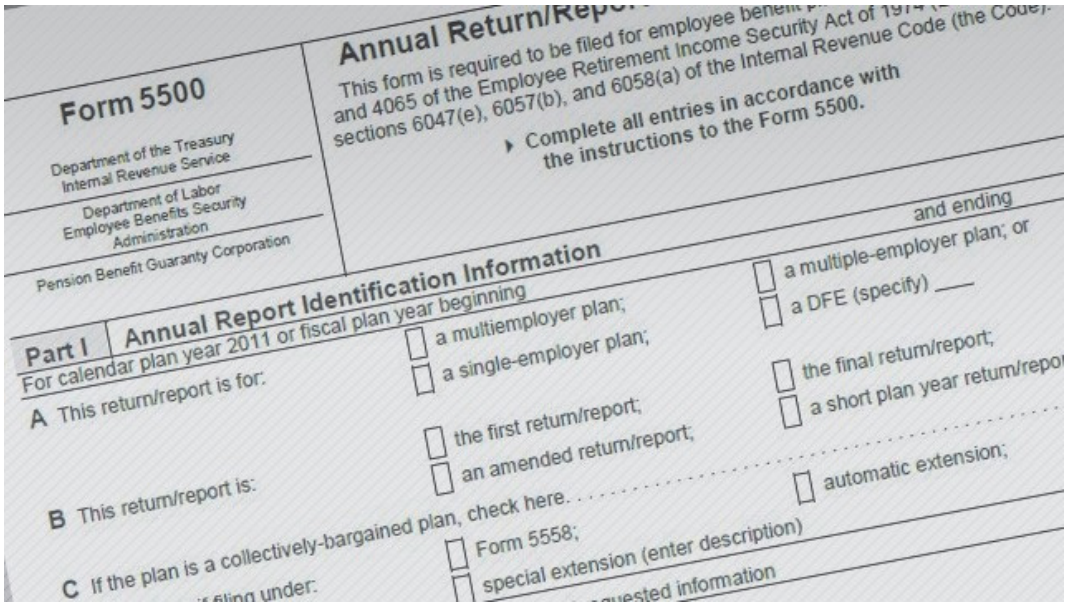
102

# Who Must File? When?

- Who must file?
  - All pension benefit plans covered by ERISA
    - Profit-sharing plans, stock bonus plans, 401(k) plans, annuity arrangements under Section 403(b), church pension plans, etc.
  - All welfare benefit plans covered by ERISA
    - Medical, dental, life insurance, scholarship funds, severance pay, etc.
- When to file?
  - Must be filed by the last day of the 7th calendar month after the end of the plan year (July 31 for calendar year plans)
  - Can request an extension of 2-1/2 months by filing Form 5558 with the IRS


103

# Form 5500 Annual Return




104

## ERISA Regulations

Further ERISA regulations apply differently to both health and welfare as well as retirement plans. We will discuss those differences in those respective sections.

105

## GINA (2008)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# GINA

- The federal Genetic Information Non-Discrimination Act (GINA), prohibits an employer from requesting an individual's genetic information and that of his/her family.
  - Applies to an employer's request for medical records and also applies to Independent Medical Examinations
- An employer may not request information about an employee's health status that is likely to result in the exposure of the employee's genetic information (includes relatives up to the fourth degree).
- "Genetic information" is classified as genetic tests, the manifestation of a disease or disorder, and participation in genetic testing. Clarifications regarding sex, age, and race are not considered genetic information. Family history is.
  - The definition of a 4th-degree relative is interesting: (1) parent, (2) grandparent, (3) great-grandparents, and (4) great-great grandparents. Assuming 30 years per generation, this could go back 120 years. Imagine the permutations through aunts, uncles and cousins. The fourth-degree relationship applies to spouses as well, so the genetic history of in-laws is covered.

107

# GINA Particulars

- Under GINA, an employer may not request, require, or purchase an employee's genetic information or that of the employee's family
- However, genetic information obtained "inadvertently" is not a violation of the Act. Such inadvertent acquisitions are not specifically defined, but examples are given where a conversation is overheard.
- In the medical exam scenario, to protect the company from genetic information received, the requesting party should direct the health care provider (in writing or verbally if the requester does not typically make requests for medical information in writing) not to provide genetic information.
- The inclusion of safe-harbor language, straight from the statute, in the employer's letter will render any disclosure of genetic information inadvertent.

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## More GINA Particulars

- If the employer does not provide the safe-harbor language, genetic information can still be classified as inadvertent if the request was not likely to result in the employer obtaining genetic information (*i.e.*, an overly-broad response from the doctor is received in response to your tailored request for medical information).
- If the above notice is given to a health care provider and genetic information is provided, the employer must "take additional reasonable measures within its control" to make sure that the violation is not repeated by the same health care provider.

109

## More GINA Particulars *(continued)*

- Finally, the **Act also applies to pre-employment health screenings,** regarding the potential employee or his/her family. In order to ensure compliance with GINA, employers may wish to implement the following measures:
  - Letters to physicians requesting medical records or an examination should include the safe-harbor language.
  - In the event that records are obtained which contain genetic information despite the safe-harbor language, employers may wish to redact the information prior to its transmission to a third-party.
- Failure to comply with GINA's mandates expose employers to potential claims for both compensatory and punitive damages, the threat of EEOC involvement and oversight, as well as penalties from the Department of Labor.
- **Fines can be as large as $50,000 for a first offense, and go to $100,000 for repeat violations. Punitive damages of up to $300,000 are available as well.**

110

# Under What Circumstances Do the ADA and/or GINA Apply to a Wellness Program?

| ADA | GINA |
|---|---|
| ADA applies to an employee's participation in a wellness program if the employee is asked to provide information on his or her past or current health status. | GINA applies to a spouse's participation in a wellness program if the spouse is asked to provide information on his or her past or current health status. |
| ADA does not apply to a spouse's participation in a wellness program. | GINA prohibits rewards or penalties for the provision of a child's health information. |

**How do the ADA and GINA limit the Rewards/Penalties for Participation/ Non-Participation in a Wellness Program?**

| ADA | GINA |
|---|---|
| Rewards/penalties for an employee's participation must be limited to 30% of the cost of single coverage. | Rewards/penalties for a spouse's participation must be limited to 30% of the cost of single coverage. |
| The cap applies to any combination of participatory and health-contingent wellness programs, plus any other workplace wellness programs which include inquiries as to the employee's health status. | The cap applies to any combination of participatory and health-contingent wellness programs, plus any other workplace wellness programs which include inquiries as to the spouse's health status. |
| | If the wellness program is available to both the employee and spouse, each may be offered a separate reward/penalty of up to 30% of the cost of single coverage. The cost of family coverage is not a factor. |

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# HIPAA (1996)


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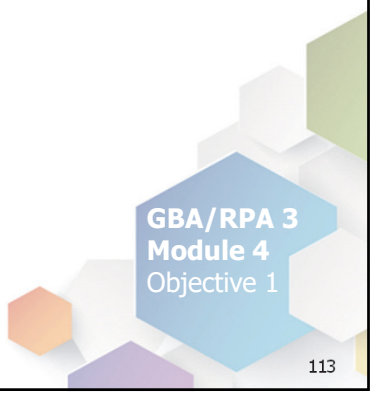
## HIPAA

A major part of understanding HIPAA is understanding the nature of data privacy problems as they relate to an employee benefit plan and its participants and beneficiaries.




113

## HIPAA

- Health Insurance Portability and Accountability Act
  - Privacy Rule published December 2000, modified in August 2002; compliance required by April 2003
  - Security Rule published February 2003; compliance required by April 2005
- An employer with a fully insured health plan that receives no Protected Health Information (PHI) has a minimal burden to comply with HIPAA.

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## Privacy and Security Rules

- Privacy Rule—"Set national standards for the protection of individually identifiable health information by three types of covered entities: Health plans, health care clearinghouses, and health care providers who conduct the standard health care transactions electronically"
- Security Rule—"Set national standards for protecting the confidentiality, integrity, and availability of electronic protected health information"

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## Maintain Privacy of PHI

- Employers who fully insure and receive some PHI—And employers who self-insure—Must take steps to maintain the privacy of PHI:
  - Appoint a privacy officer;
  - Train employees who come into contact with PHI;
  - Implement technical and physical safeguards to protect PHI;
  - Notify employees and inform them of their rights, and;
  - Establish and implement policies and procedures to handle PHI and retain records

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# Protected Health Information

- PHI consists of:

Any oral, written or electronic communication

That relates to the past, present, or future health of an individual

Includes any information that identifies an individual such as their name, DOB, or Social Security number

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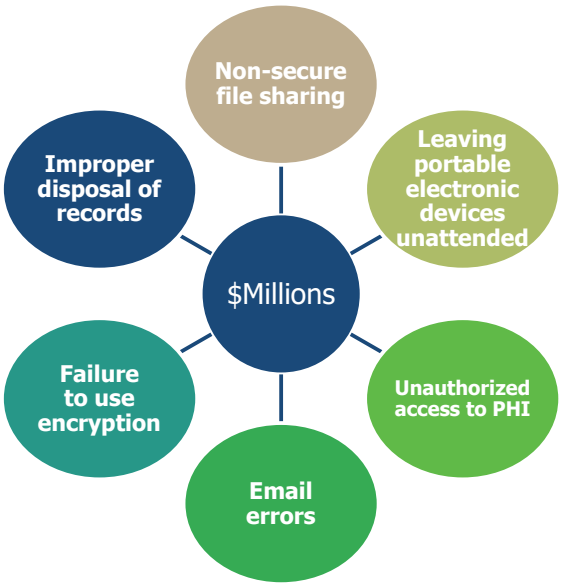
# Common Examples That Lead to HIPAA Violations




Source: https://www.hipaajournal.com/common-hipaa-violations/

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# HIPAA Compliance Considerations

- To bolster HIPAA Rule compliance, covered entities (CEs) and business associates (BAs) should consider:
  - Prioritize top-to-bottom compliance
  - If Office of Civil Rights (OCR) investigates Co.
  - Access rights matter
  - Perform an accurate, thorough, organization-wide Security Rule risk analysis
  - Address vulnerabilities and risks identified
  - Safeguard PHI taken off-site
  - Encrypt ePHI
  - Account for unconventional ePHI repositories
  - Protect paper
  - Evaluate internet applications
  - Support your software
  - Watch IT updates
  - Execute compliant Business Associate Agreements
  - Joint arrangements might mean joint liability
  - Privacy still counts
  - Terminating employment? Terminate access
  - Size doesn't matter (much)
  - No exceptions for the C-suite
  - Beef up breach notification
  - Public entities and government are not exempt
  - Research institutions are accountable
  - Mind your marketing

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# Health Care Claims and HIPAA

- As health care costs rise, employers should examine their claims and utilization data.
- Many human resource personnel, especially at smaller companies, do not know what data they can obtain cost effectively.
- Many vendors offer data for free or at little charge if HR professionals simply ask, but different vendors have different data available and different pricing schemes.
- Some vendors use the privacy rules in HIPAA to avoid providing data. In this case, the employer should call its broker to apply pressure.
- If HR does not have the expertise to analyze the acquired data, it can turn again to brokers or try to find the necessary skills among in house risk managers and financial officers
  - Make sure all involved parties are HIPAA trained

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# The Health Information Technology for Economic and Clinical Health Act of 2009 ("HITECH")

*HITECH Act Key Provisions:*

- Contains new rules for protection of personal health information held by providers, plans and other covered entities. Changes which may affect plans include:
  - Notice of Breach. Effective September 18, 2009, HITECH requires group health plans to provide detailed notice to affected participants and covered dependents of unauthorized acquisition, access, use or disclosure of their unsecured protected health information ("PHI") by the plan or a business associate.
  - If 500 or more people are affected, the plan is required to give immediate notice to the media and the Department of Health and Human Services ("HHS"), which will post notice of the breach on its website. In addition, plans must provide HHS with annual reports of all of their breaches each year, no matter the number.

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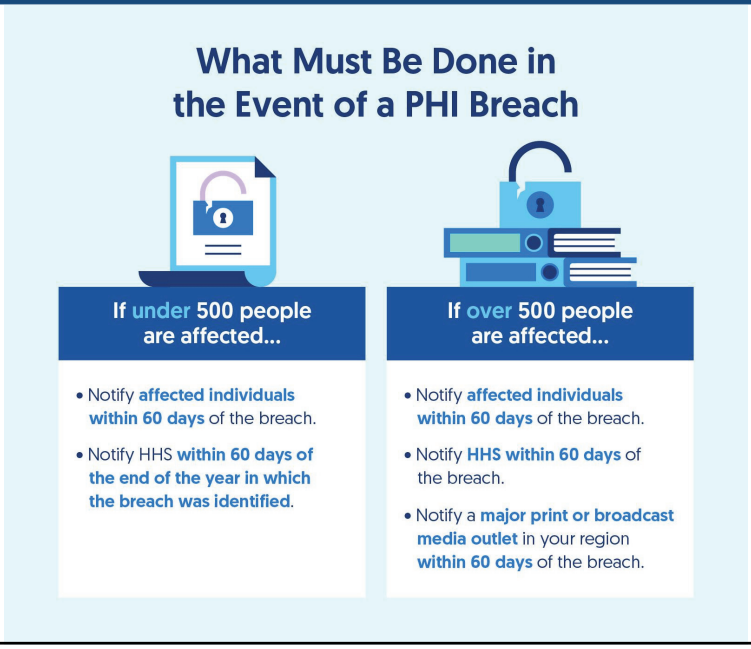
# HIPAA Breach Reporting




122

# Compliance Is the Key

- Covered entities (like health plans) are under an affirmative obligation to implement HIPAA Privacy and Security compliance policies, monitor and train employees and take steps to avoid breaches. There is a reporting obligation if a breach occurs and penalties can come into play not just for the breach, but for failing to comply to prevent the breach from occurring.
- At a time when plan sponsors are struggling to comply with the requirements of PPACA, other rules like ERISA and HIPAA Medical Privacy can get overlooked.

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# MHPAEA (2008)


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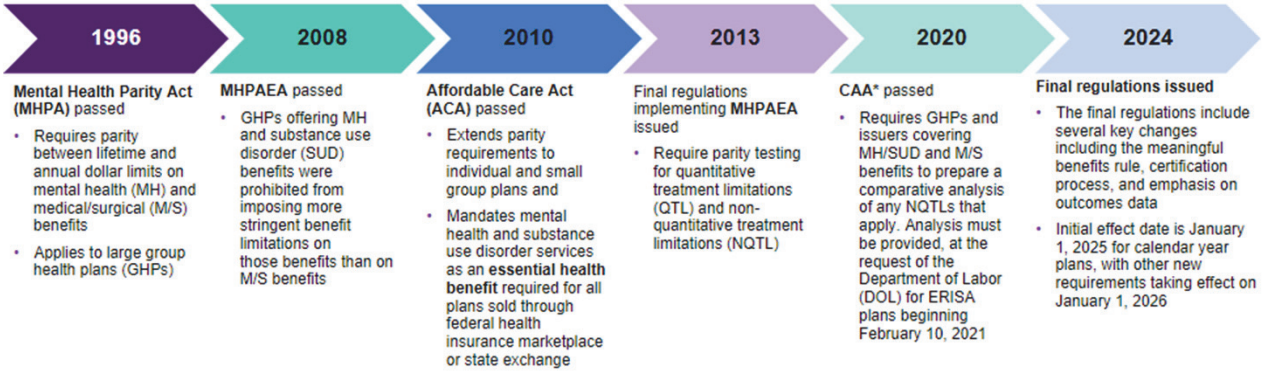
# A Timeline of Mental Health and Substance Use Disorder Parity




***CAA in a nutshell:** Adds to health plans' existing MHPAEA obligations: A comparative analysis and the duty to disclose this analysis and related information (two new requirements) to DOL on request.

Source: Willis Towers Watson, 2024

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# MHPAEA Rules

**Overview**

- Requires health plans providing Mental Health/Substance Use Disorder (MH/SUD) benefits to provide those benefits in parity with Medical/Surgical (M/S) benefits.

**Financial Requirement/Quantitative Treatment Limitations**

- Group health plans offering M/S benefits and MH/SUD benefits that impose **"financial requirements"** (*e.g.*, deductibles, copayments, coinsurances, out-of-pocket maximums) or **"quantitative treatment limitations" (QTLs)** (e.g., number of visits, days of coverage, days in a waiting period) must apply these requirements/ limitations to MH/SUD benefits no more restrictively than the **"predominant"** financial requirements or quantitative treatment limitations applied to **"substantially all"** M/S benefits in the same classification.

**Non-quantitative treatment limitations**

- Group health plans may not impose **"non-quantitative treatment limitations" (NQTLs)** (*e.g.*, prior authorization, utilization review) on MH/SUD benefits unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to M/S benefits in the same classification.

**MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA) which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.**

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## Why Conduct MHPAEA Analysis?


### MHPAEA Enforcement

Plans found to be out of compliance with MHPAEA can be subject to penalties and increased monitoring:

| | |
|---|---|
| **Lawsuits** | Participants, beneficiaries and the DOL may file lawsuits to enforce MHPAEA's requirements. The plan may be responsible for reprocessing unpaid or improperly paid claims |
| **Excise Taxes** | The IRS may impose excise taxes of $100 per day, per participant affected for a plan's failure to comply with MHPAEA |
| **Corrective Actions** | The plan may be subject to corrective actions including reprocessing denied claims, plan design modifications and amending and redistributing plan documents |

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# MHPAEA Audits

- Mental Health Parity and Addiction Equity Act (MHPAEA) updates require plans to comply with Non-Quantitative Treatment Limits.
- Health plans are being audited to ensure they are treating non-quantifiable mental health benefits similarly to non-mental health benefits.
- Contracting with a Third-Party Administrator (TPA) does not absolve your plan of it's need to comply with this law.
- Compliance for **Fully Insured** plans is generally handled at the plan level.
- Compliance for **Self Insured** plans is the responsibility of the Plan Sponsor.
- Plans are required to submit their NQTL comparative analysis to the DOL upon request
- Third-party audit firms are available to assist you with compliance.

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# NMHPA (1996)


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# NMHPA Basics

- Group health plans and health insurance issuers that are subject to NMHPA may NOT restrict benefits for a hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section.
- If you deliver your baby in the hospital, the 48-hour (or 96-hour) period starts at the time of delivery. If you deliver your baby outside the hospital and you are later admitted to the hospital in connection with childbirth (as determined by the attending provider), the period begins at the time of the hospital admission.

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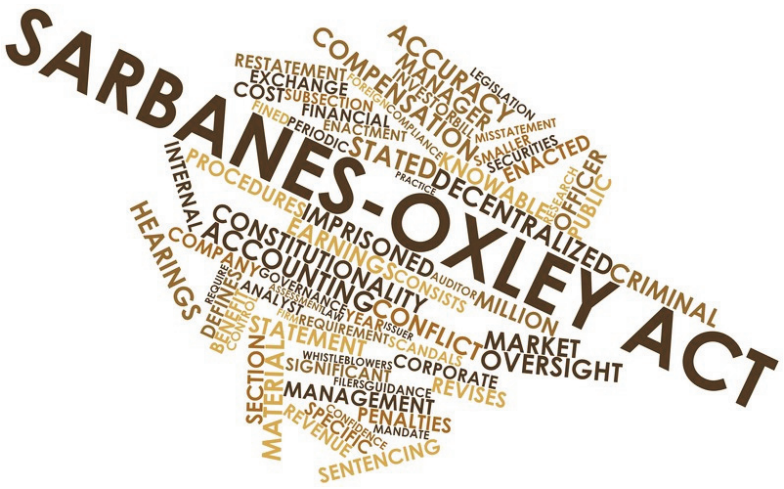
# Sarbanes-Oxley Act (2002)




131

# Sarbanes-Oxley Act (2002)

- The Sarbanes-Oxley Act (SOX) is a U.S. law to protect investors by preventing fraudulent accounting and financial practices at publicly traded companies.
- Passed in 2002 in the wake of a series of corporate scandals and the bursting of the dot-com bubble, Sarbanes-Oxley imposed a number of reporting, accounting, and data retention mandates to ensure that business practices at big companies remain above board.
- Mandated changes to accounting activities/financial practices and corporate governance
- Came about from corporate scandals such as Enron, WorldCom, and Tyco International

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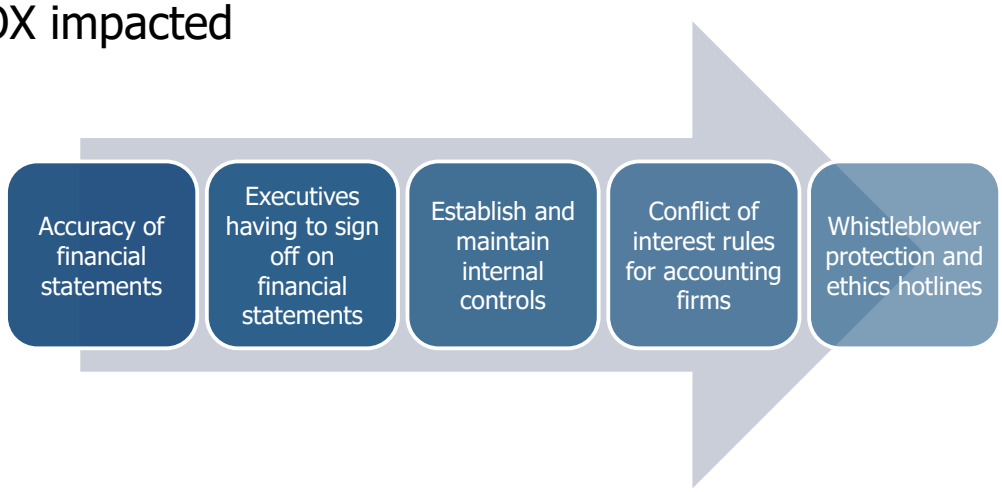
# Sarbanes-Oxley Act

- SOX impacted




- Established or increased criminal penalties for violations

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# USERRA (1994)


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# USERRA Obligations

- Uniformed Services Employment and Re-Employment Rights Act
- Prohibits discrimination against employees because of membership in the Armed Forces
- Individual who is reemployed following protected military service must be treated as not having incurred a break in service
- You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:
  - You ensure that your employer receives advance written or verbal notice of your service;
  - You have five years or less of cumulative service in the uniformed services with that employer;
  - You return to work or apply for reemployment in a timely manner after conclusion of service;
  - You have not been separated from service with a disqualifying discharge or under other than honorable conditions. If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

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# USERRA Reemployment Rights

- Upon reemployment, the plan must grant vesting and benefit credit for the period of time the employee was absent.
- For DC plans, must credit the employee with any allocations of employer contributions, but not earnings or forfeitures, to which the employee would have been entitled had there been no interruption of employment.

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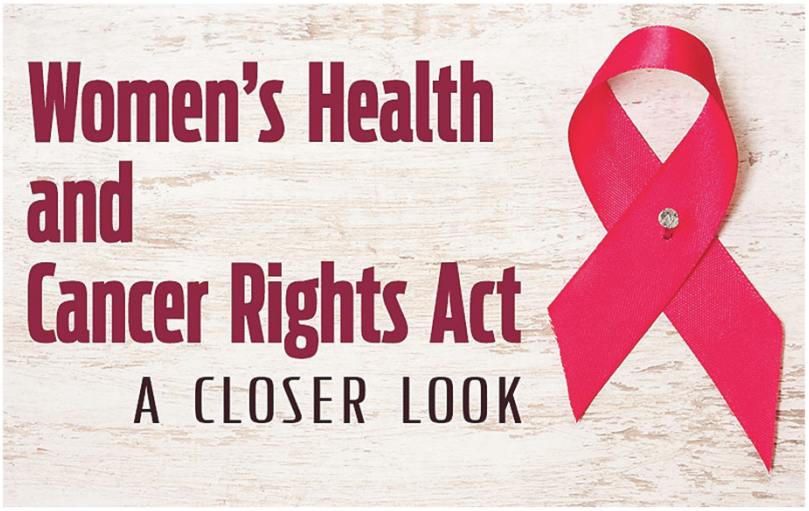
# WHCRA (1998)




137

# WHCRA Protections

- The Women's Health and Cancer Rights Act is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy.
- Coverage must be provided for:
  - All stages of reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - Prostheses and treatment of physical complications of all stages of the mastectomy, including lymphedema.

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# WHCRA Notification Requirements

- WHCRA requires group health plans and health insurance companies (including HMOs), to notify individuals regarding coverage required under the law. Notice about the availability of these mastectomy-related benefits must be given:
  - To participants and beneficiaries of a group health plan at the time of enrollment, and to policyholders at the time an individual health insurance policy is issued; and
  - Annually to group health plan participants and beneficiaries, and to policyholders of individual policies.

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# Laws That Govern Benefits


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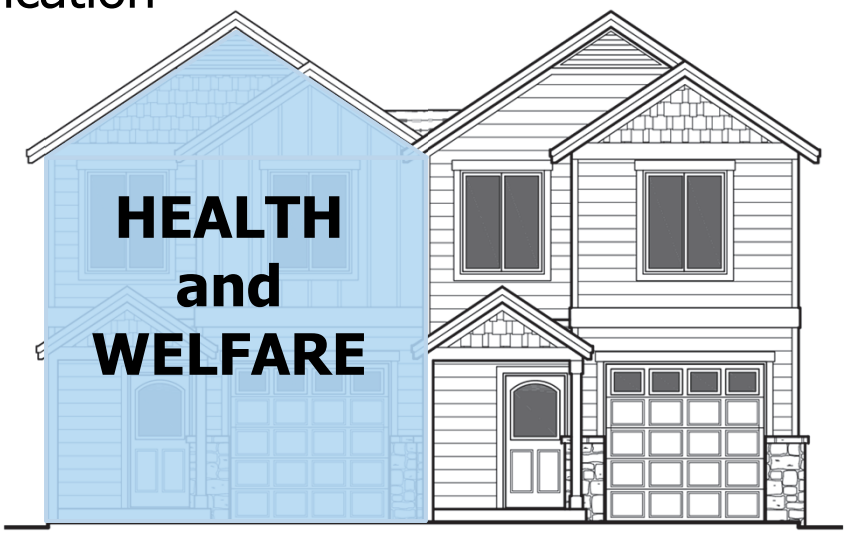
# Framework: Health and Welfare

The Practical Application of Health and Welfare Benefits in the Workplace

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# ERISA—A Review

- Employee Retirement Income Security Act of 1974
- Every "employee benefit plan" must have a Summary Plan Description written in a manner calculated to be understood by the average plan participant
- Plan document requirement
- Form 5500 may need to be filed with the U.S. Department of Labor for each plan year for which the plan is in existence
- Regulates the timing and communication of the benefits claims process
- Places duties and responsibilities on plan fiduciaries
- Gives plan participants the right to sue for benefits in federal court
- Punishes a plan sponsor for interfering with a participant's ERISA rights

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## Governance of ERISA Plans

- Under the Employee Retirement Income Security Act (ERISA), various roles are defined to ensure proper governance, administration, and oversight of employee benefit plans.
- These roles include fiduciaries, settlors, ministerial actors, named fiduciaries, plan administrators, investment fiduciaries, and service providers.
- Understanding the distinctions between these roles is essential for compliance and effective plan management.

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## Governance of ERISA Plans

- **Fiduciaries** exercise discretionary authority or control over plan management or assets. They are held to high standards of loyalty, prudence, and adherence to plan documents. This includes trustees, plan administrators, and investment managers.
- **Settlors** make business decisions related to the creation, amendment, or termination of a plan. These actions are not subject to fiduciary standards as they are considered corporate decisions.
- **Ministerial** roles involve routine, administrative tasks that do not require discretion, such as processing claims or maintaining records. These roles do not confer fiduciary status.

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## Governance of ERISA Plans

- A **named fiduciary** is explicitly designated in the plan document and is responsible for controlling and managing the plan. This role is central to ERISA compliance.
- The **plan administrator**, defined under ERISA §3(16), is responsible for ensuring the plan complies with reporting, disclosure, and operational requirements. This role may overlap with fiduciary duties.
- **Investment Fiduciary**—Section 3(21) fiduciaries provide investment advice without discretion, while Section 3(38) investment managers have full discretionary authority over plan assets and assume fiduciary liability for investment decisions.

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## Governance of ERISA Plans

- **Service providers** such as recordkeepers, third-party administrators (TPAs), and financial advisors perform essential functions. While many tasks are ministerial, discretionary actions may confer fiduciary status.

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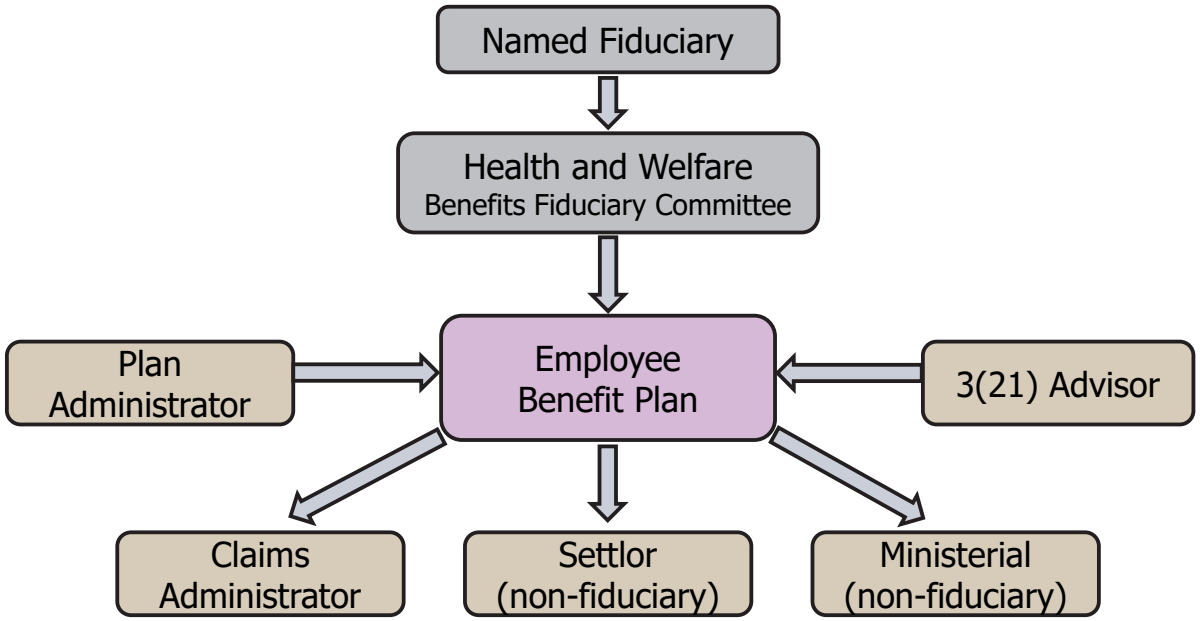
# Oversight Structure




147

# Strategies and Governance

- Governance means a role of ongoing oversight and monitoring:

| | | |
|---|---|---|
| Updating for new laws and new circumstances | Reviewing and Evaluating | Continuous improvement and questioning |
| Reporting to the right people | Communicating the right message | Repeat the process periodically |

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## Why It Matters

- How you achieve governance could depend on the type of organization
- Different types of organizations have different benefit needs and requirements

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## Discussion

- What is your organization doing for governance?
- Do you have a H&W committee?

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## Group Health Plan Reporting and Disclosure Requirements

- Full list available at: https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing
- Annual Reports to IRS (samples)
  - Form 5500, Annual Return/Report of Employee Benefit Plan

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## Group Health Plan Reporting and Disclosure Requirements

- Notices to Participants (samples)
  - Marketplace Notice: Within 14 days of hire
  - Initial/General COBRA notice: Within 90 days of group health plan coverage start date
  - Summary plan descriptions: Within 90 days of becoming covered by the plan
  - Typically included in New Hire and Open Enrollment Communication:
    - Women's Health and Cancer Rights Act (WHCRA)
    - Medicare Part D Notice of Creditable or Non-Creditable Coverage
      - CMS Certification within 60 days of the beginning of plan year
    - Children's Health Insurance Program Reauthorization Act (CHIPRA)
  - HIPAA Notice of Privacy Practices: When a participant enrolls, upon request and within 60 days of a material revision to the notice

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# Summary of Benefits and Coverage (SBC)

- Employer health plans must provide a uniform "summary of benefits and coverage" (SBC) to all plan participants and beneficiaries
- Must be provided to all participants upon hire and at each open enrollment
- To comply with this requirement, an SBC must be included in any application materials provided as a part of the open enrollment process. If there are no such materials, the deadline for providing an SBC is the first day on which a participant is eligible to enroll.
  - Plans have additional time to provide an SBC to any special enrollee
  - The deadline in that case is 90 days after the participant's enrollment date (*i.e.*, the same as the deadline for providing a summary plan description).

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# SBC Compliance

- **These SBC rules apply to both insured and self-funded plans**
  - The TPA or insurance company will create the SBC and provide to the employer.
  - The employer is responsible for verifying the accuracy of the SBC and distributing timely to employees.
- **Grandfathered plans must comply**
  - The same is true for even stand-alone health reimbursement arrangements, as well as "mini-med" plans that have received a waiver from the prohibition on annual benefit limitations.
- **Certain employer plans are exempt** from this SBC requirement, however. These include HIPAA "excepted benefits," such as stand-alone dental and vision plans and most flexible spending arrangements. Health savings accounts are also exempt.
  - The agencies note, however, that even exempt FSAs or HSAs may need to be referenced in an SBC for a comprehensive medical plan, as a way of explaining that plan's deductibles and other co-payment features.

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## More SBC Compliance

- An **SBC need not disclose information concerning premiums**
- An **SBC may be combined with other plan materials, such as a summary plan description, so long as the SBC is prominently displayed**
  - In the case of an SPD, the agencies suggest that the SBC immediately follow the SPD's table of contents.
- Although the agencies continue to emphasize the importance of using the published template when preparing an SBC, they now acknowledge that **certain modifications are permissible**.
  - These might be needed to describe discounts available through provider networks, benefits that vary with the type of facility, multi-tier drug formularies, or incentives for participation in wellness programs.

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## Penalties for SBC Non-Compliance

- The penalty for failing to comply with this SBC requirement is **$1,443 for 2026 for each participant and beneficiary who fails to receive a timely and accurate SBC**. Plan administrators should therefore take immediate steps to prepare appropriate SBCs (one for each benefit option), well in advance of the upcoming open enrollment season.
- Administrators of insured plans will want to **coordinate with their insurers**, but **self-funded plans should familiarize themselves** with both the final regulations and numerous pieces of related guidance.

156

# Why Have a Benefit Plan Committee?

| Heightened Regulatory Scrutiny: | Shared Responsibility and Governance: | Risk Mitigation: |
|---|---|---|
| • Recent enforcement priorities (*e.g.*, price transparency, mental health parity, gag clause attestations) and litigation trends have increased fiduciary risk for welfare plans. A committee helps manage these complexities. | • A committee provides structured oversight, distributes fiduciary responsibilities among qualified individuals, and ensures decisions are documented and prudent. | • Lawsuits alleging fiduciary breaches (*e.g.*, failure to monitor prescription drug costs or negotiate reasonable fees) highlight the need for robust governance. A committee can implement monitoring, benchmarking, and compliance processes. |

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# Accountability

- Benefit Plan Committees
  - Specify the basis on which payments are made to and from the plan
  - Assuring that the plan does not act in a way that would constitute a prohibited transaction
  - Assuring that the plan serves the best interests of plan participants and their beneficiaries (including surrounding ourselves with the best vendors)
  - Interpret plan rules that inevitably arise using the background fiduciary standards

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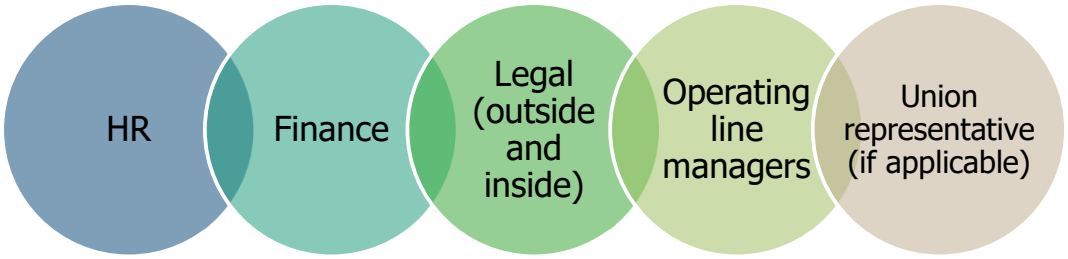
# Plan Oversight

- Board of Directors retains the authority over amending and terminating the plan
- Board will delegate the day-to-day operation of the plan (to administer and interpret) to a Benefit Plan Committee and to certain members of management or HR
- Who should serve on the Benefit Plan Committee?
  Consider an odd number of Committee members for voting purposes




159

# Core functions of H&W Committee

- Focuses on medical, dental, vision, disability, life insurance, and wellbeing strategy
- Deals with ACA requirements, HIPAA privacy/security rules, ERISA welfare plan obligations
- Oversees annual renewals, claims experience, plan design, stop-loss, and vendor performance
- Engages heavily in cost trend management and employee experience

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# Welfare Committee Best Practices

- Establish Appeals Committee
  - Odd number of participants for a tie breaker
- Review claims procedures (does CARRIER approve or does the EMPLOYER?)
- Ensure appeals procedures are in writing
- Ensure adequate attendance to make appeals decisions
- Provide Committee:
  - Claim detail
  - Reason for denial
  - Reason for appeal
  - Pros/Cons
- Track all decisions and ensure consistent application of decisions

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# Compliance Summary

**DON'T FORGET ABOUT COMPLIANCE**

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## Benefits for a Global Workforce

As more businesses seek to access a globalized workforce, it's important to recognize the major challenges that benefit plans and human resources departments face in multinational corporations.

GBA/RPA 3
Module 12
Objective 1

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## Globalization

- What about global organizations?
- Can you develop a benefits program that meets the employee and organization needs in every country?

- Can you develop that program in such a way that you meet compliance requirements in every country?
- What are some of the unique characteristics of U.S. benefit programs compared to other countries?

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# Global "Benefits"

- Start by defining "benefits"
- Multinational organizations face unique challenges in recruiting and retaining in each country
- Local laws and cultural differences may impact what may be offered to employees and what must be offered to employees

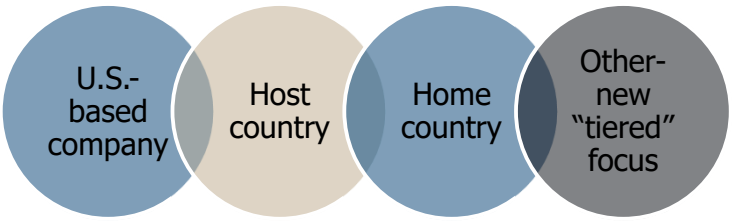
**CAUTION**

In some countries, once you offer a program or benefit, you may be legally required to continue that program forever.

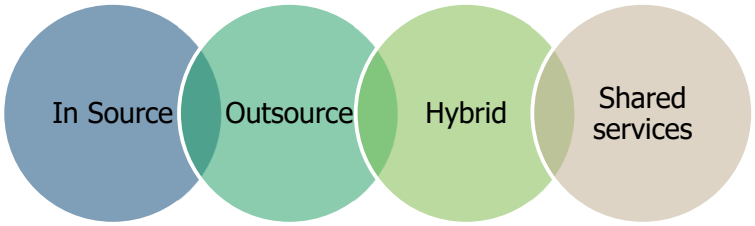
165

# Global Considerations

- Global or Multinational Considerations




- Service Delivery Model

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## Think Globally

- One approach may be to develop a global strategy that can then be applied in each country
- Has a consistent *approach* to offering benefits but allows customization in each country
- A global benefits policy should address the following:
  - Financial risk
  - Social program elements
  - Local compliance
  - Flexibility and competitive benefits

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## Get Global Input

- Developing the policy requires consultation with stakeholders tuned to the organization's current status and needs—Employees, managers, consultants knowledgeable in the specific country
- The policy should separately address retirement plans and health benefit plans and include topics common for all plans such as provider selection.

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# Multigenerational Workforce

**Traditionalists (1928-1945)**

- Motivated by money, but also want to be respected
- **Preferred recognition style:** subtle, personalized recognition and feedback

**Baby Boomers (1946-1964)**

- Prefer monetary rewards, but also value flexible retirement planning and peer recognition
- **Preferred recognition style:** acknowledgement of their input and expertise; prestigious job titles, parking places and office size are measures of success

**Generation X (1965-1980)**

- Values bonuses and stock as monetary rewards and workplace flexibility as a non-monetary reward
- **Preferred recognition style:** informal, rapid and publicly communicated

**Generation Y (1981-1996)**

- Wants stock options as a monetary reward and values feedback as a non-monetary reward
- **Preferred recognition style:** regular, informal communication through company or social networks

**Generation Z (1997-2009)**

- More interested in social rewards (mentorship and constant feedback) than money, but also is motivated by meaningful work and being given responsibility
- **Preferred recognition style:** regular in-person public praise

Source: https://www.shrm.org/resourcesandtools/hr-topics/behavioral-competencies/global-and-cultural-effectiveness/pages/motivating-generations-infographic.aspx

169

# Multigenerational Workforce Activity


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## Multigenerational Workforce Activity

1. Go to the poster that represents your generation
2. Write down one benefit that your company currently offers that supports the needs or preferences of your generation
3. Write down one additional benefit that could be offered to better support your generation
4. Repeat this process for each of the other generations

171

## Class Discussion

- What are your challenges related to changing demographics of your workforce?
- How is your organization addressing the needs of each generation in your benefits plans?

172

# Employee Engagement Through Benefits

Are your employees engaged in their work? Are your benefit programs impacting employee morale and engagement?

- Review turnover, reasons for low morale and lack of productivity
- Conduct employee surveys and exit interviews

Consider a three-step approach to see how outcomes might be improved.

- **Step 1: Continually Ask Employees (Including Senior Leadership) for Feedback**
- **Step 2: Focus on a Few Initiatives and Take Some Action Each Year**
- **Step 3: Communication Progress and the Effect of Efforts**
  Communicate, communicate, communicate should be the mantra.
- Ask what's wrong, share the results, commit to action, share progress, involve employees in solutions, measure results

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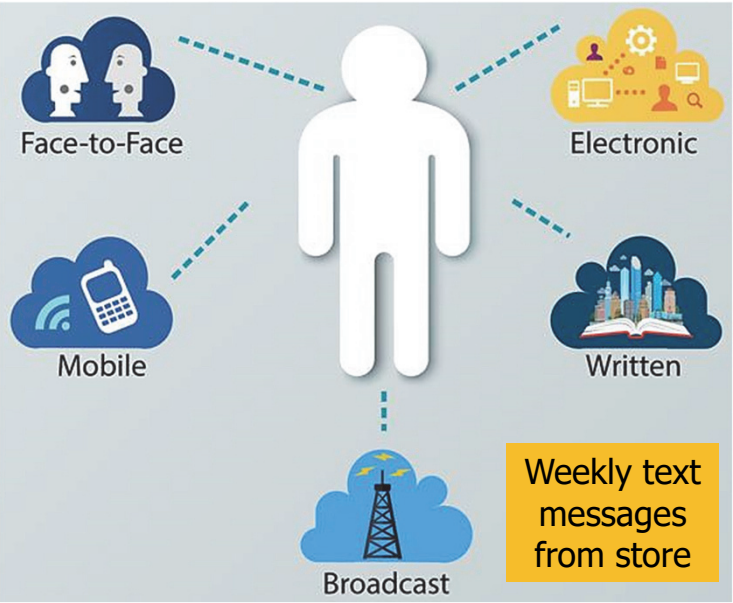
# Communication Channels

The check-out line with the store clerk

Ordering groceries online for delivery or quick pick-up




Self-scan check-out at the store

Reading the store's web site or ads for sales and coupons

Weekly text messages from store

174

## Ineffective Benefits Communications Harm Employee Engagement

- 70% of employees who received benefits information in their **preferred channels** very confident in their benefits selections vs. 57% for those who did not.
- Workers who were able to enroll via their **preferred channel** were significantly more *satisfied* with their overall benefits package (70%).

**CAUTION**

Over 60% of **EMPLOYERS** think their benefit communications are ineffective.
60% of **EMPLOYEES** agree.


175

## Evaluate the Employee Experience

- To increase benefits satisfaction, evaluate your employees' current benefits experience:
  - Identify ways to improve the process
  - Right communication channels?
  - Enough information?
  - Right benefits?


- Benefits have more perceived value, and satisfaction increases, when employees are given the right benefits-related information through the **channels they prefer**.

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# Change Management


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# Class Discussion

- What changes have occurred in your benefits program in the last 12 months?

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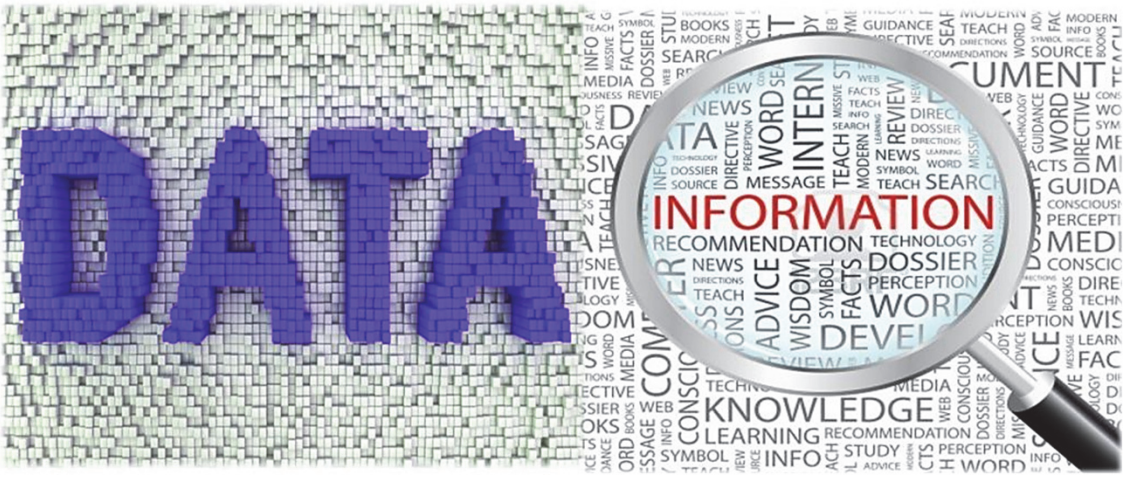
# Data Administration

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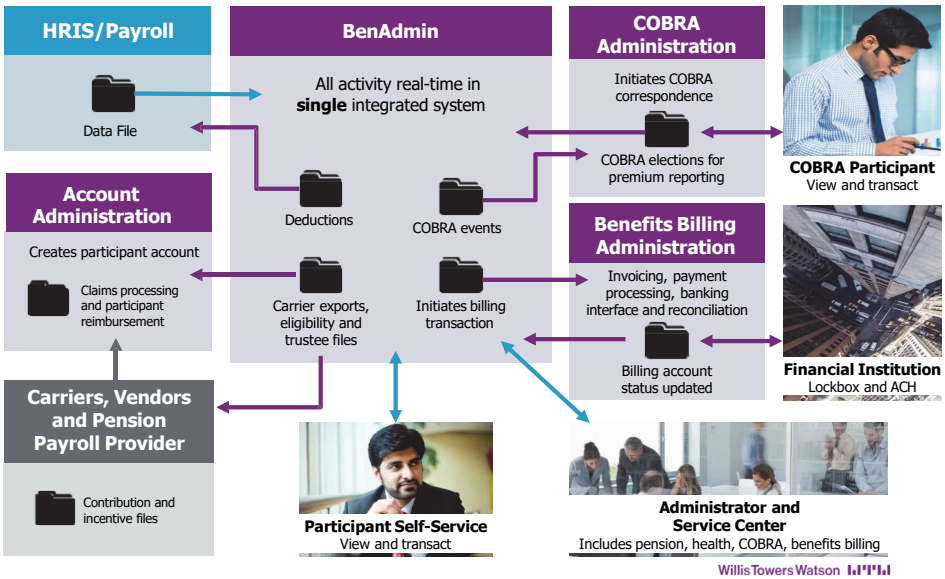
# BenAdmin System Overview

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## Data Administration

- Data and benefit plan administration
- Administrative issues in health and retirement plans
- Data Analytics
- Database needs, applications, implementation
- Management systems and disaster recovery
- HIPAA privacy and security
- Fraud and theft
- Recordkeeping

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## Total Benefits Outsourcing

- Total benefits outsourcing means the process of consolidating the management of increasingly complex retirement plans and health and wellness services/plans.
- Economies of scale can be created by bundling benefit services with a single vendor who provides administrative, transaction and employee support.
- This can free HR personnel to focus on more strategic problems and allow employees to participate more fully in managing their retirement plans and health care benefits.

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# Pros and Cons for Outsourcing

## Reasons to Outsource

- Not our core business
- Not really a revenue-raising enterprise for us
- Don't have the requisite in-house knowledge or professional staff
- Limit our liability and legal exposure
- "They do it better than we can"
- May save time and money
- Allows you to focus on more strategic initiatives

## Reasons NOT to Outsource

- Putting protected and confidential information in a vendor's hands
- Cost of outsourcing may be prohibitive
- Managing multiple vendors and contracts
- Loss of historical data if switching vendors

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# Financial Issues in Employee Benefits Administration




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# Class Discussion

## Benefits Budgeting

- Has anyone developed a benefits plan budget?
- What is included?
- What's not included?
- Who was involved in creating, reviewing and approving the budget?

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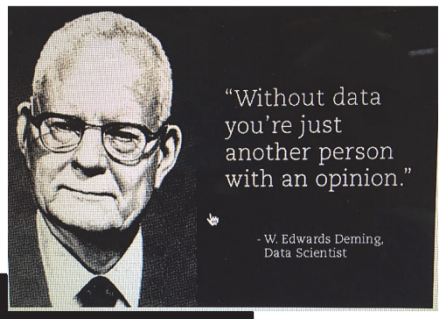
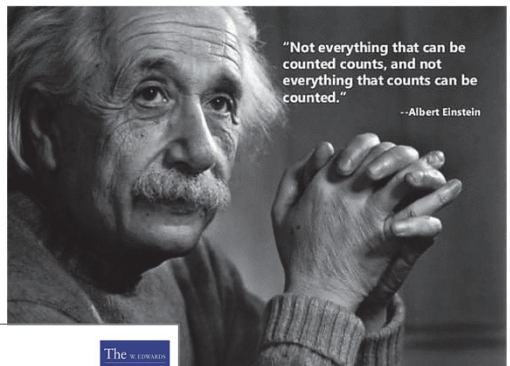
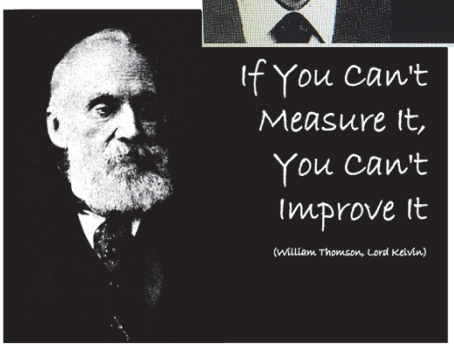
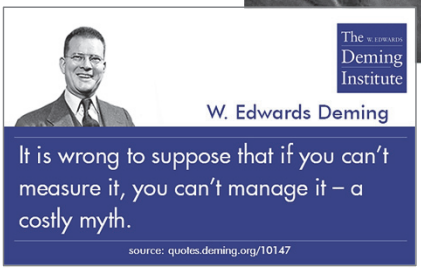
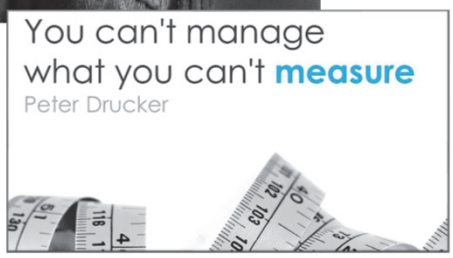
# Measuring the Value of Benefits



## Other Benefit Cost Considerations

- Creating a measurement framework for ROI
- Wellness programs
- Forecasting and budgeting
- Bankruptcy and employee benefits plans (PBGC)
- Compensation Issues
- Payroll
- Collections
- Risk management
- Contribution formulas
- Audits (DOL, IRS, Internal)

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## Forecasting and Budgeting

- Key factors to be aware of:
  - Cost of living
  - Benchmarking
  - Market-pricing situation for company
  - Pay structures
  - Indexes that are relevant—
    - U.S. Chamber of Commerce
    - Peer group
    - Some consulting firms
    - Survey data
    - Other benchmarking sources

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# Forecasting and Budgeting

- Key metrics
  - Dollar cost per employee
  - Percentage cost of base salary
  - Overall Payroll cost
  - Overall Benefits cost
  - Cost of health plans
  - Cost of retirement plans as a percentage of salary or as a dollar amount per employee
  - Cost of direct compensation, indirect compensation and total rewards


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# Don't Go It Alone!

- Benefit regulations and concepts are complex and ever changing
- Choose partners that will help you succeed and aren't in it just for their income
- Advisor:
  - Choose a benefits advisor (brokers/consultants) with a broad and deep knowledge base and service infrastructure in several key areas including state and federal regulations
  - Can explain DOL and IRS compliance and reporting regulations in easy-to-understand language
  - Can provide support in all areas you want: Plan design, employee education, mergers and acquisitions, benchmarking, vendor evaluation, technology, etc.
- Vendors:
  - Choose vendors that can solve the problem you're trying to solve
  - Is flexible enough to accommodate your specific situation


Make sure your advisor is providing Ongoing regulatory updates!

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# Attract and Retain Talent

## Drivers of attraction and retention

| | Attraction | |
|---|---|---|
| 1 | Pay (including bonus) | 67% |
| 2 | Health benefits | 40% |
| 3 | Job security | 36% |
| 4 | Flexible work arrangements (working remotely, flexible working hours) | 35% |
| 5 | Retirement benefits | 29% |
| 6 | Paid time off and broader leave policies | 27% |
| 7 | Working environment (location, facilities) | 26% |
| 8 | Career opportunities | 23% |
| 9 | Work which gives me a sense of purpose | 22% |
| 10 | Benefits to help day-to-day financial situation | 18% |

| | Retention | |
|---|---|---|
| 1 | Pay (including bonus) | 48% |
| 2 | Job security | 41% |
| 3 | Health benefits | 36% |
| 4 | Flexible work arrangements (working remotely, flexible working hours) | 31% |
| 5 | Working environment (location, facilities) | 30% |
| 6 | Relationships with co-workers and managers | 28% |
| 7 | Work which gives me a sense of purpose | 24% |
| 8 | Paid time off and broader leave policies | 22% |
| 9 | Retirement benefits | 22% |
| 10 | Career opportunities | 17% |

**Q: Which of the following are the most important reasons you stay with your current employer? If you were looking to move to a new job at a different employer, which of the following would be most important to you?**
Sample: Full-time employees only.
Source: 2024 Global Benefits Attitudes Survey, United States

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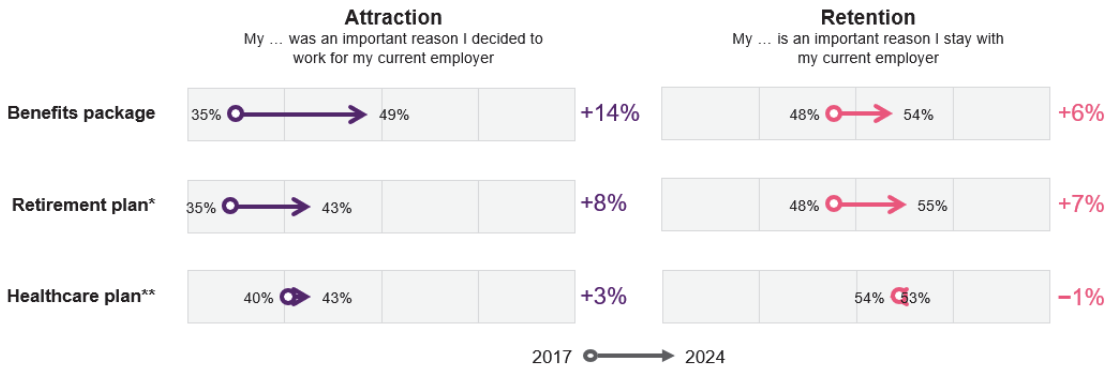
# Attract and Retain Talent

## Benefits are as important as ever for attraction and retention

The desire for security is rising




Note: Percentages indicate "agree" or "strongly agree".
Sample: Full-time employees only. * Employees with employer-provided retirement plan. ** Employees with employer-provided health care plan.
Source: 2017 and 2024 Global Benefits Attitudes Survey, United States

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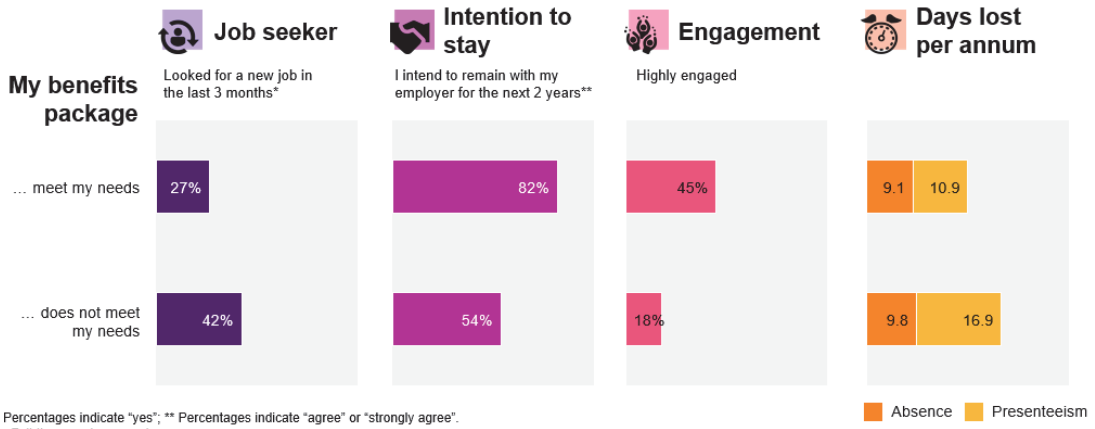
# Attract and Retain Talent

## Why do benefits matter?

Benefits appreciation is positively linked to retention and engagement




Note: * Percentages indicate "yes"; ** Percentages indicate "agree" or "strongly agree".
Sample: Full-time employees only.
Source: 2024 Global Benefits Attitudes Survey, United States.

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# Return on Investment (ROI)

- There <u>used to be</u> just **two** types of expenses in benefit plan administration:
  - Claims
  - Administration costs
- Don't forget to measure cost of recruiting and retaining employees—Both pieces factor into ROI!
- There are just a few more expenses to consider . . .

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# Expenses in Employee Benefits

| COST OF PLAN AND COMPLIANCE | | COST OF NON-COMPLIANCE |
|---|---|---|
| Medical Claims | Flexible Spending Admin Fees | COBRA Violations |
| Medical Admin Fees | 401(k) Matching Contributions | HIPAA Violations |
| Stop Loss Insurance | 401(k) Administrative Expenses | 401(k) Corrections |
| Stop Loss Reimbursements | 401(k) Forfeitures | 401(k) Fee Lawsuits |
| Dental Claims | Health Plan Consultant Expenses | Discrimination Claims |
| Dental Administrative Fees | Retirement Plan Consultant Expenses | Bankruptcy |
| Vision Claims (maybe) | Auditor Expenses | Penalties |
| Vision Administrative Fees | System Administration Fees | Plan Disqualification |
| Basic Life Insurance | Wellness Expenses | Bad Press |
| Short-Term Disability | Executive Disability Insurance | Negative Employee Engagement |
| Long-Term Disability | Time Off Programs | Loss of Employees |
| COBRA Admin Fees | Statutory Benefits (WC, SS, Taxes) | Turnover Costs |
| Executive Life Insurance | Leave of Absence Fees | ACA Penalties |
| Flexible Spending Plan Losses/Gains | Lost Productivity | |

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# Measurement of ROI

- Return on Investment (ROI)
  - What does it mean? **The cost we're paying versus the payback we're getting over a certain period of time**
  - Strong employee benefit programs can impact recruitment, loyalty, retention and productivity and help to differentiate an organization from its competitors. Employees have come to appreciate benefits more during times of economic stress. Employers must be sure they get full value from their benefit spending.
- Examples to consider when compiling metrics to determine ROI


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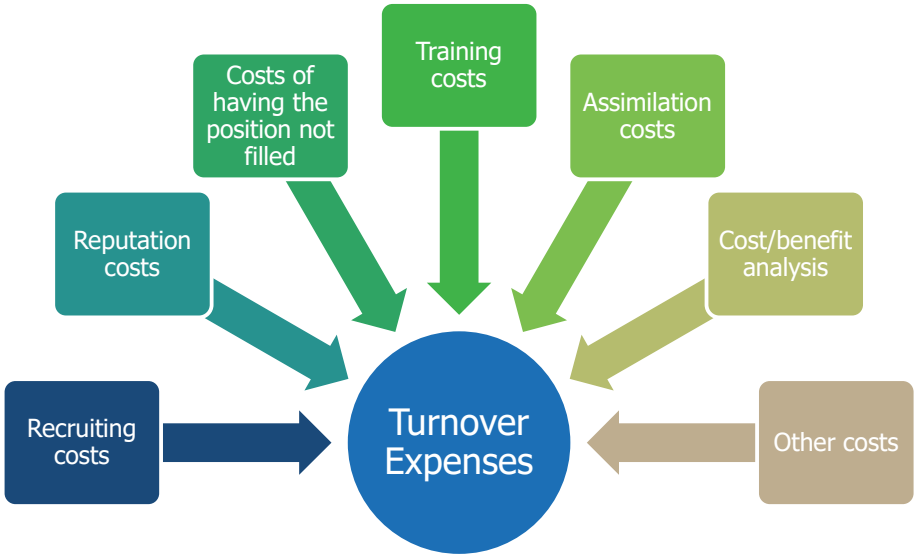
# Measuring ROI Example

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# Discussion: What About VOI?

**ROI**
Return On Investment

- Cost savings

**VOI**
Value On Investment

- Increased productivity
- Elevated employee morale
- Improved retention
- Enhanced organizational culture
- Better employee engagement
- Fewer safety incidents
- Decreased absenteeism

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## Risk Management

- **Identify and Assess Risks**: Understand potential financial, operational, and compliance risks that can impact benefit plans and participants.
- **Mitigate and Transfer Risk**: Use strategies like insurance, diversification, and plan design to reduce exposure and protect plan assets.
- **Monitor and Adapt**: Continuously review risks and adjust policies to respond to regulatory changes, market volatility, and evolving participant needs.

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## Risk Management

- Risk can take many forms including


- Organizations can take steps to mitigate risk

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# Mitigate Risk


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# Health Plan Risk

- Financial risk in a health plan could occur if a catastrophic claim hits the plan and funding is not there to cover the claim
- Risk borne by the insurer when fully insured
- Risk borne by the employer when self insured
  - Employer risk can be mitigated with Stop Loss insurance

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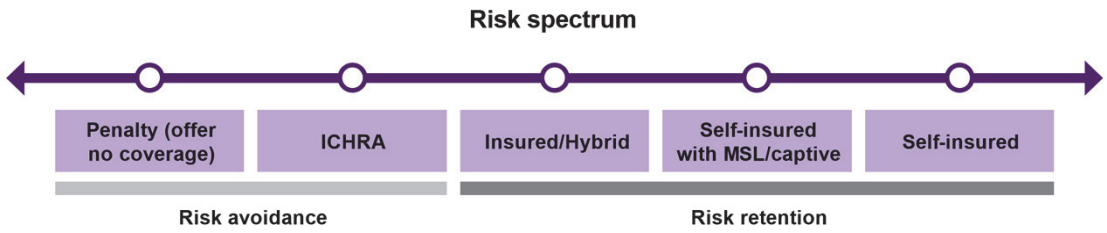
# Plan Funding Mechanisms

Will employers reevaluate their healthcare cost risk decision?

Managing the healthcare conversation




Note: Hybrid includes levelfunded, minimum premium
MSL = Medical stop loss.





# Plan Funding Mechanisms

- **Self-Insured/Self-Funded—**You pay your own claims; you assume the risk
  - Stop Loss is usually purchased with this option
  - Usually must be a group of at least 50-100 to purchase this option
  - Only subject to federal ERISA standards, although some recent areas like prescription drugs are challenging this
- **Fully-Insured—**Transfer of risk: Paying insurer to pay your claims; a safe bet for a small groups under a few hundred lives
  - No access to your claims data or the health status of your employees, leaving you with no ability to drive change through plan design
  - Plan is subject to individual state laws

## Plan Funding Mechanisms *(continued)*

- **Partially Self-Funded—**A portion of your premium paid into claims fund; claims paid out of that fund up to aggregate deductible, then the insurer takes over. You are paying for your worst-cast scenario, but benefit if you have a good claims year. No risk, some reward. Plan still subject to underwriting. Young and healthy groups have an advantage. Available to groups as small as five employees in some states.
- **Level Funded—**A flat fee to include the maximum amount of claims, stop loss, admin fees and other fees; you get a refund if your payments exceed claims
- **Graded Funded—**You pay a fixed cost each month plus actual claims, up to stop-loss thresholds. If claims are low during a particular month, you benefit immediately with lower cost and you keep ALL unused claim dollars to use later in the year or as immediate plan savings

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## Stop Loss Insurance

- Insurance for your Insurance
- Stop Loss=Your Losses Stop
- You pay to protect your organization against large claims
- **Individual (specific) Stop Loss:** You receive a refund for any claim over a specific dollar amount
  - Example: If a single claim exceeds $100,000, insurance covers the claims expense over $100,000
- **Aggregate Stop Loss:** You receive a refund for annual claims that exceed an aggregate amount
  - Example: If your claims exceed 125% of your projected claims for the year

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## Review of Day One

Strategies and Governance

Legal Environment

Data Administration

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## Case Study—Introduction


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# Key Takeaways

- All the Acronyms
- Laws, Rules, Regulations
- ACA Reporting Penalties
- Benefits Communication
- The Importance and value of data in the employee benefits landscape
- Risk Management

**Your Feedback Is Important. Please Scan This QR Code.**

Session Evaluation

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