ZIMON LLC

Compliance for Health and Welfare Plans
The Basics are Still Not Optional

Protecting Your Customers and Clients in an Ever-Changing Environment!

Are Your Clients and Customers Ready??
Will you be thanked? Or will you be blamed?

NEOHUA

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Health and Welfare Plan Basics – ERISA Fundamentals Are not Changing

Review Outline

I. The Basics – Health and Welfare Plans - ERISA Fundamentals

II. The Need and the Consequence

III. DOL Enforcement Process – Same for Now

IV. HIPAA – Employer Risk and Another Fundamental Requirement

V. Change Will Happen – But the Fundamentals Are NOT Changing

VI. Practical Considerations – Employer and Provider Considerations

I. The Basics – Health and Welfare Plans - ERISA Fundamentals

A. What is an "Employee Welfare Benefit Plan?"

ERISA Section 3(1): The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise,

(a) medical, surgical, or hospital care or benefits, 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, or

(b) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

I. The Basics – Health and Welfare Plans - ERISA Fundamentals

B. Basic Documentation Law

1. ERISA Requires a **Plan Document** for Every Plan!

(1) Every employee benefit plan shall be established and **maintained pursuant to a written instrument.** Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(ERISA §402(a); 29 U.S.C. 1102(a))

I. The Basics – Health and Welfare Plans - ERISA Fundamentals

B. Basic Documentation Law

2. ERISA Requires A **Summary Plan Description**

(a) A summary plan description of any employee benefit plan **shall be furnished to participants and beneficiaries** as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b), shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan….

(ERISA §102; 29 U.S.C. §1022)

I. The Basics – Health and Welfare Plans - ERISA Fundamentals

B. Basic Documentation Law

3. Insurance Documents **Do Not** Meet These Requirements

- Insurance documents are not issued by the Employer or the Plan to the Participant, they are issued by the insurance carrier
- Insurance documents have no protection for the Employer, or potential internal plan fiduciaries
- Insurance documents do not contain all required information and notices, including –
  - Eligibility and Termination
  - Employer EIN number
  - Agent for Service of Process
  - Fiduciary identification
  - And more!

II. The Need and The Consequences

A. Why Do We Need the Basic Documentation?

1. Law Requires It – ERISA §402 and §102
2. DOL Enforces It – Rights Under ERISA §502 and §504
3. Participants Can Request It – Rights Under ERISA §502
4. Their Lawyers Can Request It – Rights Under ERISA §502

II. The Need and The Consequences

B. If I Don't Have the Required Documentation - What Happens?

1. DOL Can Require It – Penalty (up to $110/day, plus notice penalties)

2. Participants Can Request It – Penalty (up to $110/day, plus notice penalties)

3. Their Lawyers Can Request It – Penalty, or Liability for Subrogation Amounts (Subrogation amounts $$$$$, and $110/day)

4. Affects the Business Compliance and Enterprise Value (Why risk it?)

5. Allows Easy Documentation of Changes and The Effective Date of Changes (*Think: Repeal/Replace*)

III. The DOL Enforcement Process

A. DOL's Investigative Rights Under ERISA §504

(a) Investigation and submission of reports, books, etc. The Secretary shall have the power, in order to determine whether any person has violated or is about to violate any provision of this subchapter or any regulation or order thereunder—

(1) to make an investigation, and in connection therewith to require the submission of reports, books, and records, and the filing of data in support of any information required to be filed with the Secretary under this subchapter, and

(2) to enter such places, inspect such books and records and question such persons as he may deem necessary to enable him to determine the facts relative to such investigation, if he has reasonable cause to believe there may exist a violation of this subchapter or any rule or regulation issued thereunder or if the entry is pursuant to an agreement with the plan.

III. DOL Enforcement Process

B. Who To Investigate? DOL Conducts Investigations Based Upon:

- Strategic National Audit Initiatives
- Local Initiatives
- Form 5500 Flags and Errors
- Participant Complaints
- IRS Referrals for Audit

C. What Type of Investigations Are There?

- Civil and Criminal
- Limited or Random Reviews
- Fiduciary Conduct Investigations
- Prohibited Transaction or Actor Investigations

III. DOL Enforcement Process

D. Audit Risk and Result Statistics

- Audit risk covers all employee benefit plans
- FY 2016 Closed 2,002 Pending Investigations
- 67.7% with monetary penalties
- 144 cases referred for litigation
- 333 Criminal Investigations
- $777.5MM of monetary recovery damages
- Average Damage recovery exceeds $573,000!!

III. DOL Enforcement Process

E. Process of Audit

- ✓ Document Request Letter
- ✓ Document Production
- ✓ On-Site Interviews!!
- ✓ Decision Letter of No Action or Violation
- ✓ Closing Letter
- ✓ One Way Closing Letters and/or Settlement Agreement
- ✓ Civil Litigation Referral or Criminal Investigation

III. DOL Enforcement Process – Other Penalties

Compliance Item	Rules	Penalty
Form 5500 Filing	Generally Health and Welfare Over 100 Participants	Up to $2,063 per day for failure. DOL will assess $50.00 per day - common ($30,000) a year
Plan Document and Summary Plan Description	Required under ERISA §402 and §102	Court Action, up to $110 per day for failure to respond to written request. Willful violation $5,000. DOL is $147/day
CHIPS Notice	ERISA §502(c)(9)(A) and ERISA §701(f)(3)(B)(ii)	$110 per day
Summary of Benefits Coverage	IRC Section 4980D	$100 per day and $1,000 additional assessment for each failure
Genetics Information	ERISA §702	$110 per day for each failure, goes up substantially if not corrected
All Compliance	ERISA – Various	Injunction, Civil Action

III. DOL Enforcement Process

F. DOL Document Requests

1. Signed (and authorized) Plan Documents, Adoption Agreements, Trust Agreements, Wrap documents and Amendments to Date.

2. Summary Plan Description.

3. Signed Forms 5500, audited Plan Financial Statements (if applicable) and all supplemental schedules for the last four years filed.

4. Summary Annual Reports for the last four years filed

5. Minutes of any Plan or Committee meetings.

III. DOL Enforcement Process

F. DOL Document Requests

6. Financial Records, including: trust reports, premium payments, claims payments, bank account statements, ledgers/journals, invoices/records of fees and expenses, checkbook registry, canceled checks and deposit slips.

7. Service Provider Contracts or Letters of Engagement

8. Latest Fidelity Bond Policy, including all Riders and Endorsements, covering fraud and dishonesty.

9. Latest Fiduciary Liability Insurance Policy (if applicable).

10. All health insurance contracts and policies including all amendments and riders covering the Plan……

III. DOL Enforcement Process

F. DOL Document Requests

11. If self-insured, all contracts for claims processing, administrative services and reinsurance.

12. Documents which describe the responsibilities of both the employer and employees with respect to the payment of the costs associated with the purchase and maintenance of health and welfare benefits.

13. A copy of an employee enrollment application in use.

14. Plan and issuer compensation agreements with attending providers for hospital stays in connection with childbirth and reconstructive surgery in connection with a mastectomy.

III. DOL Enforcement Process

F. DOL Document Requests

15. A copy of the following required notices, including lists and logs of issued notices and a description of procedures for distribution: a) Notice of special enrollment rights; b) Enrollment and annual notices required under the Women's Health & Cancer Rights Act; c) Newborn's Act notice relating to hospital stays in connection with childbirth; d) Notice regarding premium assistance under Medicaid or CHIP; and e) Michelle's Law notice (*only now if cover students over age 26)

16. To ensure compliance with the HIPPA nondiscrimination rules: health insurance billing invoices, premium schedules, employee and employer contribution schedules, and/or payroll records of withholdings for benefits.

17. A sample of the Certificate of Creditable Coverage provided to those employees who have lost health care coverage since January 1, 2012 or to be provided to those who may lose health care coverage under this Plan in the future, which certifies creditable coverage earned under this Plan.

III. DOL Enforcement Process

F. DOL Document Requests

18. A copy of the record or log of all Certificates of Creditable Coverage for individuals who lost coverage under the Plan or requested certificates.

19. A copy of the written procedure for individuals to request and receive certificates.

20. A sample general notice of preexisting condition informing individuals of the exclusion period, the terms of the exclusion period, and the right of individuals to demonstrate creditable coverage (and any applicable waiting or affiliation periods) to reduce the preexisting condition exclusion period, or proof that the Plan does not impose a preexisting condition exclusion.

21. A copy of the necessary criteria for an individual without a certificate of creditable coverage to demonstrate creditable coverage by alternative means.

III. DOL Enforcement Process

F. DOL Document Requests

22. Records of claims denied due to the imposition of the preexisting condition exclusion (as well as the Plan's determination and reconsideration of creditable coverage, if applicable), or proof that the Plan does not impose a preexisting condition exclusion.

23. Materials describing the Plan's procedures regarding notification to participants of the length of preexisting condition exclusion period that remains after offsetting for prior creditable coverage (if not completely offset).

24. Materials describing any wellness programs or disease management programs offered by the Plan. If the program offers a reward based on an individual's ability to meet a standard related to a health factor, the Plan should also include its wellness program disclosure statement regarding the availability of a reasonable alternative.

III. DOL Enforcement Process

F. DOL Document Requests

25. If the Plan is claiming or has claimed grandfathered health plan status within the meaning of Section 1251 of the Affordable Care Act, please provide the following records:

a) A copy of the grandfathered health plan status disclosure statement that was required to be included in plan materials provided to participants and beneficiaries describing the benefits provided under the Plan; and

b) Records documenting the terms of the Plan in effect on March 23, 2010 and any other documents necessary to verify, explain or clarify status as a grandfathered health plan. This may include documentation relating to the terms of cost sharing (fixed and percentage), the contribution rate of the employer or employee organization towards the cost of any tier of coverage, annual and lifetime limits on benefits, and if applicable, any contract with a health insurance issuer, which were in effect on March 23, 2010.

III. DOL Enforcement Process

F. DOL Document Requests

26. Regardless of whether the Plan is claiming grandfathered status, please provide the following records in accordance with Section 715 of ERISA as added by the Affordable Care Act:

a. In the case of a plan that provides dependent coverage, a sample of the written notice describing enrollment opportunities relating to dependent coverage of children to age 26;

b. If the Plan rescinded any participant's or beneficiary's coverage, a list of participants or beneficiaries whose coverage has been rescinded, the reason for the rescission, and a copy of the written notice of rescission that was provided 30 days in advance of any rescission of coverage;

c. If the Plan imposes a lifetime limit or has imposed a lifetime limit at any point since September 23, 2010, please provide documents showing the limits applicable for each plan year on or after September 23, 2010. (Please provide a sample of any notice sent to participants or beneficiaries stating that the lifetime limit on the dollar value of all benefits no longer applies and that the individual, if covered, is once again eligible for benefits under the Plan); and

d. If the Plan imposes an annual limit or has imposed an annual limit at any point since September 23, 2010, please provide documents showing the limits applicable or each plan year on or after September 23, 2010.

III. DOL Enforcement Process

F. DOL Document Requests

27. If the Plan is NOT claiming grandfathered health plan status under Section 1251 of the Affordable Care Act, please also provide the following records:

    a. A copy of the choice provider notice informing participants of the right to designate any participating primary care provider, physician specializing in pediatrics in the case of a child, or health care professional specializing in obstetric or gynecology in the case of women, and a list of participants who received the disclosure notice;
    b. If the Plan provides any benefits with respect to emergency services in an emergency department of a hospital, please provide copies of documents relating to such emergency services for each plan year on or after September 23, 2010;
    c. Copies of documents relating to the provisions of preventive services for each plan year on or after September 23, 2010;
    d. Copy of the Plan's Internal Claim and Appeals and External Review Processes;
    e. Copies of a notice of adverse benefit determination, notice of final internal adverse determination notice, and notice of final external review decision; and
    f. If applicable, any contract or agreement with any independent review organization or third party administrator providing external review.

III. DOL Enforcement Process

F. DOL Document Requests

28. Notices provided to participants and beneficiaries explaining their rights to continuation of coverage as required by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), including a list or logs of notices issued.

29. All documents relating to the use or collection of generic information, for any reason, with respect to the Plan.

30. Any other documents which may explain or clarify the above items.

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III. DOL Enforcement Process

G. DOL Enforcement Initiatives

- Focus on employee contributions
- Plan expenses/settlor fees
- Wellness Plan compliance
- Women's Health and Cancer Rights Act (ERISA Section 713)
- Mothers' and Newborns Health Protection Act (ERISA Section 711)
- Mental Health Parity Act and Mental Health Parity and Addiction Equity Act (ERISA Section 712)
- Genetic Information and Nondiscrimination Act (ERISA Section 714)
- Abusive Multiple Employer Welfare Arrangements (MEWA)
- Special Focus – Wellness
  - Initiatives with Surcharge a Focus –ERISA 702
  - Annual Opportunity to Qualify
  - Surcharge cap of 20%, or 50% for tobacco Program
  - Reasonable Alternative MUST be offered and documented

III. DOL Enforcement Process

H. Be Prepared

Are You Ready?
Are Your Clients and Customers Ready?

Participant Claims and Requests?
U.S. Department of Labor Requests?
Plaintiffs' Lawyers Requests – Subrogation and Other?
Providers?

IV HIPAA – Employer Risk and Another Fundamental Requirement

A. HIPAA Requirements

1. The Basics: Health Insurance Portability and Accountability Act of 1996

- ✓ Regulates the **security of certain information** related to health care
- ✓ Covers the portability and continuity of health insurance, **health information privacy**, administration of health insurance, medical savings accounts and long-term care insurance
- ✓ Employer Plans are **subject to HIPAA**. Plans with more than 50 are **Covered Entities** under HIPAA
- ✓ A group health plan may not disclose Protected Health Information ("PHI") to the "plan sponsor" or permit a health insurance issuer or HMO to do so, unless the group health plan **restricts uses and disclosures** of PHI by the plan sponsor as required by HIPAA
- ✓ The **use and disclosure of PHI includes responsibilities**.
- ✓ **Liability** arises for improper use or disclosure

IV HIPAA – Employer Risk and Another Fundamental Requirement

A. HIPAA Requirements

2. What should be done regarding HIPAA?

- ❑ Are HIPAA Rules Likely to Be Changed?
  - No. Nothing on the table to change the HIPAA rules.
- ❑ Be Prepared – there are no changes being discussed or published
  - Government audits, employee inquiries, plaintiff's lawyers
- ❑ Are Policies and Procedures in Place?
  - Employers who have policies and procedures should include HIPAA policies and procedures to avoid increased exposure

V. Change Will Happen But the Fundamentals are NOT Changing

A. Repeal and Replace of the Affordable Care Act – Means What?

1. No Fundamental Changes to ERISA. Take Note! Long-standing and foundational legal requirements under ERISA and related U.S. Tax law, and HIPAA, are not going to be substantially changed by any repeal of ACA.

- ***Repeal and Replace will NOT change the Plan Document/Summary Plan Description Requirement***
- ***Repeal and Replace will NOT change HIPAA requirements.***
- ***Repeal and Replace will NOT change other standard requirements.***
- ***Repeal and Replace will NOT stop government non-political employees, or plaintiffs.***

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V. Change Will Happen But the Fundamentals are NOT Changing

A. Repeal and Replace of the Affordable Care Act – Means What?

2. Enforcement – YES!

"I was particularly surprised…that the IRS headcount has gone down quite dramatically, almost 30% in over last number of years… and especially for an agency that collects revenues this is something that I am concerned about…."

Testimony of Steve Mnuchen, Candidate for Secretary of Treasury, January 19, 2017.

A Law and Order Team.

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V. Change Will Happen But the Fundamentals are NOT Changing

A. Repeal and Replace of the Affordable Care Act – Means What?

3. Repeal and Replace? Likely Actions (*Note: this is the slide as submitted*):

- Repeal the individual mandate
- Potentially repeal the employer mandate
- Permit the sale of health care insurance nationally and across state lines
- Allow individuals to fully deduct health care insurance premiums
- Potential expansion of HSAs – Health Savings Accounts
- Remove barriers to entry into free markets for drug providers that offer safe, reliable and cheaper products
- Allow consumers access to imported, safe and dependable drugs from overseas to bring more options to consumers
- Reduce the number of individuals needing access to programs like Medicaid and Children's Health Insurance Program (methodology unspecified)

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V. Change Will Happen But the Fundamentals are NOT Changing

A. Repeal and Replace of the Affordable Care Act – Means What?

4. Repeal and Replace – Items Intended to Preserve (*Note: This slide too*)

- Preserve the prohibition on preexisting condition exclusions.
- Preserve and potentially expand the use of HSAs - Health Savings Accounts.
- Preserve some type of availability of insurance for those who need it ("We must also make sure that no one slips through the cracks simply because they cannot afford insurance. We must review basic options for Medicaid and work with states to ensure that those who want healthcare coverage can have it").
- Preservation of some form of dependent child to age 26 (or some other age) coverage rights (recent development from recent interviews).
- Improve health care information and billing transparency.

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V. Change Will Happen But the Fundamentals are NOT Changing

A. Repeal and Replace of the Affordable Care Act – Means What?

5. Repeal and Replace – Open Issues and Things to Think About (*Note: This slide too*)

- How to preserve the prohibition on preexisting condition exclusions and maintain insurance market stability.
- What is impact of potentially expanded HSAs
- How to preserve availability of insurance both for ACA Exchange Plans, and for Medicaid Expansion, some 30MM+ people while maintaining stability in insurance markets and while reducing healthy person insurance purchases that expanded lower risk premium payments through the employer and individual mandates.
- How to also preserve some form of dependent child to age 26 (or some other age) coverage rights (recent development from recent interviews).
- How to Improve health care information and billing transparency while reducing costs.

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V. Change Will Happen But the Fundamentals are NOT Changing

B. PROPOSED: The American Health Care Act

1. Background

March 6, 2017, the **House Ways and Means Committee** and the **Energy and Commerce Committee** each released formal proposals to partially repeal and replace the Affordable Care Act.

In recognition of the slim majority in the Senate, the Republicans in both houses are focusing on a special legislative process called **"reconciliation"** to advance these measures.

Reconciliation was created in 1974 and allows for expedited consideration of certain tax, spending and debt limit legislation. In the Senate, such bills are not subject to filibuster (60 votes by Senate rules). This process only applies when legislation changes spending, revenues and the federal debt limit.

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V. Change Will Happen But the Fundamentals are NOT Changing

B. PROPOSED: The American Health Care Act

2. Group Health Plans - Changes

- ✓ Repeal of the Employer Mandate, Retroactively Effective to 1/1/16
- ✓ Delay of the Cadillac Tax Until 2025
- ✓ Repeal of Flexible Spending Account Employee Contribution Limits Effective 1/1/18
- ✓ Expansion of Health Savings Accounts, Effective 1/1/18
- ✓ Repeal of Prohibition on Reimbursements of Over the Counter Medications under Flexible Spending, Health Reimbursement, Archer Savings and Health Savings Accounts, Effective 1/1/18
- ✓ Repeal of Tax Deduction Limits for Expenses Related to Medicare Part D Subsidy, Effective 1/1/18
- ✓ Advance Refundable Tax Credit Toward Cost of Individual Insurance and Unsubsidized COBRA Coverage (that does not cover abortions), Effective for non-exchange coverage in 2018, AHCA replaces the ACA credits in 2020.

V. Change Will Happen But the Fundamentals are NOT Changing

B. PROPOSED: The American Health Care Act

3. <u>ACA Provisions that are Preserved by AHCA (not repealed)</u>

- Prohibition on annual and lifetime limits on essential health benefits
- Prohibition on pre-existing condition exclusions - group health plans
- Prohibition on excessive eligibility waiting periods
- Preventive Care health services covered 100%
- Coverage for dependent children to age 26
- Limits on out-of-pocket expense for in-network benefits
- Enhanced claims and external review procedures
- Prohibition on retroactive coverage terminations (rescissions)

V. Change Will Happen But the Fundamentals are NOT Changing

B. PROPOSED: The American Health Care Act

4. Other Provisions of the AHCA

- Repeal of the Individual Mandate by reducing it to "$0.00"
- Continuous coverage requirement (after 63 day break in coverage, premiums can increase by 30% for 12 months)
- Carriers can charge older individuals at rates that are 5 times higher than rates charged to younger individuals (change from 3:1)
- Premium Recapture to entire excess amount if tax credits are paid and income increases during the year
- Repeal of the medical device 2.3% excise tax
- Repeal of increased miscellaneous expense deduction threshold for deducting qualifying medical expenses from 10% back to 7% of gross
- Repeal of the Medicare Tax increase (required an additional .9% 2018)
- Permit catch up contributions in an HSA for both spouses (effective 1/1/18)
- Special HSA transition rules to permit Account as having been created on date of coverage, if established within 60 days of coverage.

V. Change Will Happen But the Fundamentals are NOT Changing

B. PROPOSED: The American Health Care Act

4. Other Provisions of the AHCA, continued

For 2018-2019, modify premium tax credits as follows:

- Increase credit amounts for young adults with income above 150% FPL and decrease amounts for adults 50 and older above that income level
- For end of year reconciliation of advance credits, the cap on repayment of excess advance payments does not apply
- Tax credits cannot be used for plans that cover abortion
- Premium tax credits can be used to purchase catastrophic plans
- Premium tax credits can be used to purchase qualified health plans (i.e., covering essential health benefits) sold outside of the exchange, but are not advance-payable for such plans. Premium tax credits cannot be used to purchase grandfathered or grandmothered individual health insurance policies sold outside of the exchange

V. Change Will Happen But the Fundamentals are NOT Changing

B. PROPOSED: The American Health Care Act

4. Other Provisions of the AHCA, continued

- Starting in 2020, replace ACA income-based tax credits with flat tax credit adjusted for age. Credits are payable monthly; annual credit amounts are:
  - $2,000 per individual up to age 29
  - $2,500 per individual age 30-39
  - $3,000 per individual age 40-49
  - $3,500 per individual age 50-59
  - $4,000 per individual age 60 and older
- Families credits for up to 5 oldest members, up $14,000 per year (
- Amounts are indexed annually to CPI plus 1 percentage point.
- U.S. citizens and legal immigrants who are not incarcerated and who are not eligible for coverage through an employer plan, Medicare, Medicaid or CHIP, or TRICARE, are eligible for tax credit.
- Married couples must file jointly to claim the credit.
- Eligibility for the tax credit phases out income above $75,000 (joint $150,000)

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V. Change Will Happen But the Fundamentals are NOT Changing

C. 21st Century Cures Act, Qualified HRA

1. Qualified HRA - Entities that are not Applicable Large Employer (more than 50 full-time equivalents), are eligible to consider this new optional special form of Health Reimbursement Arrangement. There are a number of requirements, all of which must be followed

   - Your Entity must provide the Qualified HRA to everyone who is eligible on the same terms for single or family coverage
   - Your Entity must fully fund the amounts (no employee contributions)
   - Your Entity cannot offer a group health plan
   - The Qualified HRA pays or reimburses medical expenses under Code Section 213, which can include medical expenses and insurance premiums

V. Change Will Happen But the Fundamentals are NOT Changing

B. Change Has Taken Place – 21st Century Cures Act, Qualified HRA

1. Qualified HRA – requirements continued

- Reimbursements are limited to $4,950 for employee only and $10,000 for family coverages, pro-rated for partial years and indexed in amount in the future
- Your Employees must obtain minimum essential coverage or the HRA amounts will be subject to tax
- Your Employees who purchase a plan on the Marketplace Exchange will have the premium tax credit reduced by the benefit available under the Qualified HRA

V. Change Will Happen But the Fundamentals are NOT Changing

B. Change Has Taken Place – 21st Century Cures Act, Qualified HRA

2. Eligibility Requirements for Qualified HRA. Under the Qualified HRA, coverage must be offered to <u>all Employees</u> except:

- ✓ Employees with less than 90 days of service
- ✓ Employees who are younger than age 25
- ✓ Employees who are part-time or seasonal
- ✓ Employees who are union employees or non-resident aliens.

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V. Change Will Happen But the Fundamentals are NOT Changing

B. Change Has Taken Place – 21st Century Cures Act, Qualified HRA

3. Notice Requirements

- Notice is mandatory
- Notice must be issued ninety (90) days in advance of the Plan year.
- Notice has to include:

  ✓ the amount of the Qualified HRA
  ✓ a statement that if the employee applies for the tax credit for health insurance on the Marketplace Exchange that the employee must report the full amount of the Qualified HRA
  ✓ the employee must have minimum essential coverage, or the Qualified HRA amounts will be subject to tax

How will this be effectively used? Is it a meaningful options?

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VI . Practical Considerations – Employer and Provider Considerations

What Should Employers Do?

- ✓ Don’t Lose Sight of the Basics - Prepare Wrap Plan Document/Summary Plan Descriptions for all Health and Welfare Plan. Be prepared and ready. Once Prepared, Updates are Easy
- ✓ Prepare, Initiate and Update HIPAA Rules and Policies, Obtain Business Associate Contracts and Employee Consents
- ✓ Ensure your Cafeteria Plan Documentation and other Miscellaneous documentation is Up to Date
- ✓ Be Vigilant and Up-To-Date on the Basics, be Prepared for the Changes

Whose Job Will Be On the Line?
Who Will Win Your Client Over?
“Win!” (President Trump) Be Prepared.

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Notes and Questions.

Jeff is the Founder and Principal of **Zimon LLC**, a boutique employee benefits and compensation firm. He is AV© rated by Martindale Hubbard, in Chambers USA, and is an Ohio Super-Lawyer. Formerly the Chair of the Employee Benefit and Compensation and ERISA Litigation Group of a large 180 lawyer law firm, Jeff's more than two decades of experience in ERISA and benefits has afforded him the opportunity to handle a broad range of matters, for clients of all sizes, in virtually every area of ERISA and employee benefits and compensation, from 401(k) plans, collectively bargained plans, funding, claims, TPA agreements, plan mergers, Fiduciary compliance, ACA and group health plans, and all aspects of benefit dispute resolution and ERISA litigation.