Acadia BENEFITS

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Benefits & Employment Briefing

A quarterly newsletter about benefits and employment trends

Summer 2021

Group Health Plans and Cybersecurity: DOL and OCR Guidance

Cybersecurity has dominated national headlines recently as nefarious hackers and cybercriminals continue to breach critical corporate networks and systems, improperly access sensitive private data and launch crippling ransomware attacks.

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Patient-Centered Outcomes Research Institute Fees Due August 2

The Affordable Care Act (ACA) sought to create more well-informed health care consumers through funding the Patient-Centered Outcomes Research Institute (PCORI) to research and report on the effectiveness of America's health care delivery system. The ACA calls for PCORI to be funded largely by fees assessed against insurers and self-funded group health plan sponsors who must report and submit the fees annually by July 31 using IRS Form 720, Quarterly Federal Excise Tax Return.

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How Employers Can Claim Tax Credits for COBRA Premiums Paid on Behalf of Assistance Eligible Individuals under ARPA

The American Rescue Plan Act of 2021 (ARPA), signed into law on March 11, 2021, contains provisions that ensure that certain COBRA qualified beneficiaries can continue group health coverage without paying normally required premiums.

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Supreme Court Ruling Leaves ACA, Employer Reporting Obligations Intact

On June 17, 2021, the U.S. Supreme Court issued its much-anticipated ruling in the latest of a series of cases challenging the constitutionality of the Affordable Care Act (ACA). In a 7-2 majority opinion, the Court dismissed a lawsuit brought by two individuals and several states who had asserted that the Court should declare the ACA unconstitutional because its so-called individual mandate no longer operates as a tax since the 2017 Tax Cuts and Jobs Act reduced the penalty against individuals who fail to have health insurance to $0.

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IRS Announces 2022 Health Savings Account and High-Deductible Health Plan Amounts

The IRS recently issued Revenue Procedure 2021-25 in which it announced the 2022 inflation-adjusted amounts that apply to health savings accounts (HSAs) and high-deductible health plans (HDHPs). The newly announced figures include the maximum contribution limit for an HSA, the minimum permissible deductible for an HDHP, and the maximum limit on out-of-pocket expenses (e.g., deductibles, copayments and other amounts aside from premiums) for qualifying HDHPs.

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Group Health Plans and Cybersecurity: DOL and OCR Guidance

In response to this heightened activity, the U.S. Department of Labor (DOL) recently issued its first-ever formal cybersecurity guidance that includes best practices for ERISA fiduciaries to consider in guarding against cyber threats. For many group health plan sponsors, much of the guidance addresses issues and items that have long been required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

HIPAA imposes stringent security rules to safeguard group health plan participants' protected health information (PHI) and electronic protected health information (ePHI). Many of HIPAA's requirements mirror recent DOL guidance, and group health plan sponsors should understand how a plan's HIPAA responsibilities differ and whether they will need to adopt any new policies or procedures to address the DOL guidance.

DOL Cybersecurity Guidance

The DOL guidance generally targets retirement plans, but it is based on ERISA fiduciary principles that also apply to employer plan sponsors of ERISA group health plans. ERISA requires those responsible for administering plans (i.e., fiduciaries) to do so prudently and for the exclusive benefit of plan participants and beneficiaries, and the DOL notes that it considers this to include appropriately addressing and safeguarding against threats (including cyberthreats) to their plans.

DOL guidance addresses three areas:

- Tips for hiring a plan service provider
- General cybersecurity best practices for plan service providers
- Additional online security pointers for plan participants

The DOL guidance is not formal rulemaking, but it could signal items the DOL will look for as it addresses future participant claims that a plan sponsor breached its fiduciary duty by failing to properly assess the cybersecurity of plan service providers. Thus, group health plan sponsors might wish to incorporate the stated standards and best practices in selecting plan service providers. HIPAA already requires covered plans to enter Business Associate Agreements (BAA) with plan service providers who access or use PHI and ePHI, and much of what the DOL suggests is already required to be in the BAA (and is also addressed in a plan's general compliance with the Security Rule).

The DOL further provides some rather commonsense pointers to help limit cyber threats. These pointers target individual participants, but plan sponsors also might wish to consider providing the information to participants so that they better understand their role in limiting cybersecurity risks.

At a minimum, group health plan sponsors should view the new DOL guidance as a roadmap for creating a potential defense to any participant claim of an ERISA fiduciary breach based on failure to adequately address threats to participants' electronic data. The good news is that group health plan sponsors that comply with HIPAA's Security Rule and BAA requirements should be able to demonstrate to the DOL, if needed, that they have properly addressed cyber threats against their plans.

HIPAA Privacy and Security Rules

HIPAA's Privacy Rule contains administrative safeguard requirements that effectively amount to mini-security obligations for certain group health plan sponsors. HIPAA also includes a complex and detailed Security Rule with which self-funded group health plans and insured group health plans who handle ePHI have had to comply for years.

The Office for Civil Rights (OCR) has previously provided tools and guidance that outline steps to comply with HIPAA's rules based on a cybersecurity framework set forth by the National Institute for Standards and Technology (NIST). The NIST guidance directly addresses many of the items denoted in the new DOL guidance. Thus, a group health plan that builds its HIPAA compliance on NIST standards likely will satisfy most of the DOL's newly stated best practices.

For example, HIPAA requires group health plans that are covered entities to execute BAAs with service providers who are business associates.

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HIPAA specifically mandates that the BAA include requirements that a business associate must:

- ensure the confidentiality, integrity, and availability of all ePHI the business associate creates, receives, maintains, or transmits;
- comply with the Security Rule's administrative, physical and technical safeguards; and
- satisfy the Security Rule's policies and procedures and documentation requirements.

Further, if a business associate delegates any of its functions to a subcontractor that creates, receives, maintains, or transmits ePHI on behalf of the business associate, the business associate must enter into a written contract with the subcontractor to ensure that the subcontractor will agree to comply with the Security Rule. Again, following these HIPAA requirements should provide evidence that a group health plan sponsor has fulfilled its fiduciary duty relevant to the items set forth in recent DOL cybersecurity guidance.

The Security Rule further requires group health plans and business associates to conduct an accurate and thorough risk analysis of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of all ePHI that they create, receive, maintain, or transmit and to implement security measures sufficient to reduce those identified risks. So, many of the items the DOL cites in its recent guidance should already be part of a plan service provider's (i.e., business associate) best practices and should help insulate a group health plan from DOL scrutiny under its new guidance.

Certain fully insured plans that neither create nor receive PHI (except for summary health information and enrollment information) are exempt from many of the Privacy Rule and Security Rule requirements for protecting electronic information. Even these plan sponsors still must:

- Appoint a security officer
- Conduct a risk analysis to show that all electronic PHI is in the hands of business associates or the plan sponsor
- Develop risk management procedures to include responding to breaches of unsecured ePHI
- Periodically evaluate whether anything has changed that would require a change in the risk analysis or risk management procedures
- Ensure they have the appropriate business associate agreements and any necessary plan amendment that comply with the Security Rule

OCR also notes that group health plans that are subject to the HIPAA Security Rule must adopt security measures that include:

- Implementing a security management process, which includes conducting a risk analysis to identify threats and vulnerabilities to ePHI and implementing security measures to mitigate or remediate those identified risks.
- Employing procedures to guard against and detect malicious software.
- Training users on malicious software protection so they can assist in detecting malicious software and know how to report such detections.
- Instituting access controls to limit access to ePHI to only those persons or software programs requiring access.

Taking the foregoing measures will help avoid potentially hefty HIPAA noncompliance penalties. Moreover, doing so should go a long way to meeting the suggestions DOL includes in its cybersecurity guidance.

OCR Ransomware Guidance

OCR has also released guidance for HIPAA covered entities to follow if besieged by a ransomware attack, and instructs that a compliant security incident response should determine:

- The scope of the incident to identify what networks, systems, or applications are affected
- The origination of the incident (who, what, where, when)
- Whether the incident is finished, is ongoing or has propagated additional incidents throughout the environment
- How the incident occurred (e.g., tools and attack methods used, vulnerabilities exploited)

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These initial steps should allow the relevant entity to prioritize subsequent incident response actions and guide it in further analyzing the incident and its impact. Subsequent security incident response activities should include:

- Containing the impact and propagation of the ransomware
- Eradicating the instances of ransomware and mitigate or remediate vulnerabilities that permitted the ransomware attack and propagation
- Recovering from the ransomware attack by restoring data lost during the attack and returning to "business as usual" operations
- Conducting post-incident activities, which could include a deeper analysis of the evidence to determine if the entity has any regulatory, contractual or other obligations due to the incident (such as providing notification of a breach of PHI), and incorporating any lessons learned into the overall security management process to improve incident response effectiveness for future security incidents

Part of a deeper analysis should involve assessing whether a breach of PHI resulted from the security incident.

Finally, OCR notes that the presence of ransomware (or any malware) is a security incident under HIPAA that may also result in an impermissible disclosure of PHI in violation of the Privacy Rule and a breach, depending on the facts and circumstances of the attack.

Conclusion

Group health plans have become increasingly more reliant on technology, particularly as workforces and workplaces have shifted to allow for more remote access through a greater number of channels during the COVID-19 pandemic. Amid escalating cyberattacks in this environment, the agencies tasked with enforcing ERISA fiduciary rules and HIPAA privacy and security rules have stepped up their efforts to ensure that plan sponsors know about, and are equipped to address, potential threats to sensitive and private participant information. The fines and costs of a breach involving ePHI can be high, so group health plan sponsors would be wise to revisit their responsibilities under HIPAA and to ensure that their required compliance measures address recent DOL guidance.

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Patient-Centered Outcomes Research Institute Fees Due August 2

Timing

The ACA originally called for final PCORI fees to be due for plan years ending before October 1, 2019. However, the Setting Every Community Up for Retirement Enhancement Act of 2019 (SECURE Act) extended the PCORI fee requirement for another 10 years. Thus, insurers, HMOs and self-funded plan sponsors will continue paying PCORI fees for plan years ending through September 30, 2029. **The next PCORI fees and filings are due by August 2, 2021, because the normal July 31 deadline falls on a Saturday.**

Amount

The PCORI fee for plan years ending between January 1, 2020, and September 30, 2020, is $2.54 per covered life, and for plan years ending between October 1, 2020, and December 31, 2020, is $2.66 per covered life. Filers will use these specified amounts to calculate total payments due on August 2, 2021.

The overall amount due depends on the number of covered lives under a plan. IRS has approved the following three methods for calculating this number.

- *Actual Count Method.* Count the number of covered lives each day of the plan year and divide by the number of days in the plan year.
- *Snapshot Method.* Count the number of covered lives on one specified day each calendar quarter and divide by four. An employer also may count the number of covered lives for several days in each calendar quarter (provided that each quarter counts the same number of days) and divide by the number of days counted. IRS also allows a snapshot factor method where an employer chooses a day (or days) and counts the employees covered under self-only coverage

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and adds 2.35 times the number of employees with other than self-only coverage.

- *Form 5500 Method.* For a plan offering just self-only coverage, add the number of participants reported on Form 5500 at the beginning and end of the plan year and divide by two. For a plan offering self-only and other tiers of coverage (e.g., family), add the number of participants at the beginning and end of the plan year. Keep in mind that only employers who have already filed Form 5500 for the applicable plan year prior to the PCORI fee due date may use the Form 5500 Method. Thus, a calendar-year plan that has received a 2½-month filing extension cannot use the Form 5500 Method.

Who Pays for Which Plans?

As noted above, carriers will calculate and pay PCORI fees for insured plans, but they will pass those fees through to employer policyholders. An employer with a self-insured health plan must pay the PCORI fee for any non-excepted plan provided to employees or retirees (including COBRA participants). No PCORI fees apply to certain excepted benefits (e.g., stand-alone dental and vision plans, onsite medical clinics, health savings accounts (HSAs), stop-loss policies and most health flexible spending accounts (FSAs)). Also, most employee assistance plans (EAPs), disease management programs and wellness programs are exempt if they do not provide significant benefits for medical care or treatment.

PCORI fees apply to health reimbursement arrangements (HRAs), but an employer will pay only one fee if the HRA (which is considered a self-insured plan) is integrated with a self-insured group health plan with the same plan year. If an HRA is integrated with a fully insured group health plan, the employer will pay PCORI fees for the HRA, while the carrier will pay for the fully insured plan.

Conclusion

Employer plan sponsors should be aware by now that the SECURE Act breathed a new 10-year life into PCORI fees. Employers who sponsor insured group health plans should see the insurance carrier's PCORI payments reflected on their premium statements. Employers who sponsor self-funded group health plans or HRAs should be working to be sure to properly calculate 2020 PCORI fees and file Form 720 by August 2, 2021. Though there are no specific ACA penalties for late PCORI filings, IRS will treat these amounts as delinquent excise taxes and can levy interest and penalties against delinquent filers. So, employers who fail to meet their PCORI fee filing obligations should correct the oversight as soon as possible by filing a new or corrected Form 720 and remitting the total PCORI fee amount.

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How Employers Can Claim Tax Credits for COBRA Premiums Paid on Behalf of Assistance Eligible Individuals under ARPA

Specifically, for periods of coverage beginning on or after April 1, 2021, and ending September 30, 2021, ARPA allows so-called assistance eligible individuals (AEIs) to be deemed to have paid COBRA premiums in full. Employers will be able to claim employment tax credits to offset the amounts (including applicable administrative fees) of these unpaid COBRA premiums. The IRS recently released guidance and forms to assist employer plan sponsors that will begin seeking applicable tax credits on quarterly returns due August 2, 2021 (extended since July 31 falls on a Saturday this year).

Premium Payees

IRS Notice 2021-31 provides that certain "Premium Payees" will be eligible to claim available fully refundable tax credits pursuant to ARPA. Premium Payees specifically include employers that sponsor self-funded group health plans or fully insured group health plans subject to COBRA. Such employers will be able to claim a dollar-for-dollar Medicare hospital insurance tax credit for any applicable COBRA premium assistance provided under ARPA.

Tax Credits

In general, the amount of the available tax credit will equal the COBRA premiums covered by an employer and not paid by an employer's qualifying AEIs. If the credit amount is more than an employer's Medicare tax amount due, including situations in which an employer might not owe any Medicare hospital insurance tax, the employer can

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receive a payment for the difference from the IRS. In this case, IRS guidance directs employers to file Form 7200, Advance Payment of Employer Credits Due to COVID-19, to request an advance of the tax credit. The IRS still will require these employers to file Form 941, Employer's Quarterly Federal Tax Return, to claim the available tax credit.

Recent Q&A guidance from the IRS clarifies that an employer becomes entitled to the tax credit when it receives a COBRA election from an AEI. For example, if an AEI submits a COBRA election on July 25 for coverage retroactive to May 1, the employer can claim a tax credit for May through July as of July 25. If coverage continues for August, the employer is eligible to claim a tax credit for August as of August 1.

Claiming Credits

The IRS has stated that employers who are Premium Payees can reduce their quarterly federal employment tax deposits by an amount equal to the ARPA premium subsidy credit the employers claim. This also means that employers whose credit exceeds their Medicare tax responsibility can reduce any employment tax obligations up to the amount of the ARPA tax credit. The IRS instructs employers to report the claimed tax credit amount, as well the number of individuals receiving the premium assistance for the relevant quarter, on the affected quarterly return Form 941. Thus, any employer who wishes to claim a tax credit for any coverage provided during the period from April through June would do so on its Form 941 due this year on August 2.

Revised Forms 941

The IRS has released draft Form 941 to accommodate employers who wish to claim ARPA COBRA premium subsidy tax credits. The new Form 941 includes the following new lines:

- 11e: amount nonrefundable COBRA premium assistance credit
- 11f: number of individuals receiving COBRA premium assistance
- 13f: refundable amount of COBRA premium assistance credit

Note that the Instructions for Form 941 explain how employers should count the number of AEIs for reporting purposes. Employers should count each AEI that received assistance as one individual, even if the COBRA coverage is for more than one AEI (e.g., family coverage). For example, if the coverage was for a former employee, spouse, and two children, an employer would include one individual on line 11f.

Additionally, the IRS has included a new Worksheet 5 to assist employers and their tax preparers in calculating the correct amount of any ARPA COBRA premium assistance tax credits. Employers should use the worksheet to determine the proper information to include on the new lines on Form 941. The worksheet and further instructions are available on the IRS website.

Maintaining Records

Worksheet 5 also alerts employers to maintain a copy for their records. This directive aligns with prior guidance that instructs employers to maintain sufficient records to support their claims for ARPA COBRA premium assistance tax credits to be prepared in case the IRS later challenges the amounts an employer claims.

Conclusion

The first round of Employer's Quarterly Federal Tax Returns on which employers who are Premium Payees will claim ARPA COBRA premium assistance tax credits are due by August 2, 2021. Employers and their tax preparers should familiarize themselves with the changes to Form 941 as well as the Instructions for Form 941 and Worksheet 5 to ensure that they properly prepare, file and document their claims for these valuable tax credits.

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Supreme Court Ruling Leaves ACA, Employer Reporting Obligations Intact

The Court declined to rule on the constitutionality of the individual mandate, but rather determined that the plaintiffs did not have the proper legal right to sue. Though the dismissal leaves open the possibility of future litigation, it does nothing to alter the ACA obligations for applicable large employers (ALEs). Thus, ALEs must continue to provide annual group health coverage statements (Forms 1095-C)

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to full-time employees and file annual health coverage information returns (Forms 1094-C and 1095-C) with the IRS.

Background

The ACA created reporting requirements under Internal Revenue Code (Code) Sections 6055 and 6056. Under these Code sections, certain employers must provide information to the IRS about the health plan coverage they offered or provided to employees during the prior calendar year. Each reporting entity specifically must file a separate statement (Form 1095-B or Form 1095-C) for each individual who was provided with minimum essential coverage (for providers reporting under Section 6055), or for each full-time employee (for ALEs reporting under Section 6056), respectively, and a transmittal form (Form 1094-B or Form 1094-C) applicable to all of the statements filed with the IRS.

Individual statements (Form 1095-B, 1095-C, or a substitute form) are due to full-time employees and individuals covered under self-insured health plans no later than January 31 of the year immediately following the calendar year to which the statements relate. Reporting entities must file forms with the IRS by February 28 if filed by paper or by March 31 if filed electronically.

ALE reporting enters its seventh season in 2022, so many employers are quite familiar with their reporting obligations and have compliant systems in place to ensure their filings and statements are complete, correct and timely. However, ALEs should carefully review their reporting practices and procedures to account for new Forms 1095-C and to avoid IRS scrutiny as it ushers in a less lenient enforcement era.

2021 ALE Reporting Forms

The IRS recently released its draft version of 2021 Form 1095-C. Form 1095-C will remain essentially the same for 2021 reporting, but employers who offer individual coverage health reimbursement arrangements (ICHRAs) to satisfy ACA coverage offer requirements should note a couple of new coverage codes for Line 14. Specifically, these employers will use Code 1T to report situations in which they offer an ICHRA to an employee and spouse (no dependents) with ACA affordability determined using the employee's primary residence ZIP code. Also, ALEs will use Code 1U to report an ICHRA offered to employee and spouse (no dependents) using the employee's primary employment site ZIP code affordability safe harbor. Finally, 2021 Form 1095-C reserves Codes 1V through 1Z for future use.

The draft form includes instructions to recipients that provide that an ALE who sponsors a self-funded plan and who reports information in Part III of Form 1095-C to reflect dependents covered under the plan should attach additional copies of page 3 in situations where the ALE is reporting more than 13 dependents.

No 2021 Individual Statement Extension and Heightened IRS Enforcement Stance

Last year, the IRS issued Notice 2020-76 in which it carried on its annual tradition of granting ALEs an automatic extension (typically 30 days) of time to provide full-time employees with required individual Forms 1095-C. Employers who have come to rely on this annual extension should take note that Notice 2020-76 also stated that the 2019 reporting cycle likely would be the last for which it would grant such relief.

The IRS stated that it had received so few comments to its prior request regarding the extended deadline that it would not provide extensions for any future years unless it received enough comments from affected parties that explain why the relief continues to be needed. No information exists that the IRS has received sufficient comments, so employers should not expect an automatic extension for 2021 individual statements that are due by January 31, 2022. ALEs should coordinate with any service providers who assist with ACA reporting to be sure everything is in place to ensure that individual statements can be timely issued by the normal deadline.

ALEs also should take extra measures to ensure that their 2021 Forms 1094-C and 1095-C are complete and accurate. The IRS stated in Notice 2020-76 that it would not extend its annual relief from Code Sections 6721 and 6722 penalties for ALEs who made mistakes on their annual reports but could show that they had attempted in good faith to meet their ACA reporting obligations. ALEs should

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take particular note of this announcement because the penalties for filing incorrect reports can be substantial. Moreover, many of the arguments on which ALEs have been able to rely to reduce or avoid IRS penalties in the past are unlikely to carry the same weight as they have in past filing cycles.

Bottom Line

The ACA has survived yet another legal battle and isn't going anywhere soon. This also means ALE obligations, including annual reporting requirements, also are here to stay for the foreseeable future. Given recent IRS guidance, employers with ACA reporting obligations should reexamine their reporting processes and procedures and redouble their efforts to timely and accurately meet the ACA's requirements.

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IRS Announces 2022 HSA and HDHP Amounts

These limits will differ depending on whether an individual is covered by a self-only or family coverage tier under an HDHP.

The IRS's new higher HSA contribution limit and HDHP out-of-pocket maximum will take effect January 1, 2022. HDHP deductible limits will increase for plan years that begin on or after January 1, 2022.

The IRS determined to leave the minimum required deductibles for HDHPs at 2021 levels, but HDHP out-of-pocket maximums will increase $50 for self-only coverage and $100 for family coverage.

The chart below shows the old 2021 limits as well as the new 2022 limits. Also note that the maximum permitted catch-up HSA contribution for eligible individuals who are 55 or older remains unchanged for 2022.

Employers that sponsor HDHPs may need to make plan design changes as they finish 2022 planning. Additionally, affected employers will need to ensure that they update all plan communications, open enrollment materials and other documentation that addresses these limits to be sure participants and beneficiaries are adequately informed.

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	2021		2022	
Applicable Limit	**Self-Only**	**Family**	**Self-Only**	**Family**
HSA Maximum Contribution	$3,600	$7,200	$3,650	$7,300
HSA Maximum Catch-up Contribution	$1,000	$1,000	$1,000	$1,000
HDHP Minimum Deductible	$1,400	$2,800	$1,400	$2,800
HDHP Maximum Out-of-Pocket Expense	$7,000	$14,000	$7,050	$14,100

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