COMMONWEALTH BENEFITS GROUP

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Compliance Recap | November 2022

In November, the IRS released revised guidance to address the so-called "family glitch," permitting employers to allow mid-year election changes when someone related to a plan participant is eligible to elect a qualified health plan on the Marketplace. This is also a good opportunity to review all of the change in status events that allow employees to make changes in a cafeteria plan.

Cafeteria Plan Change in Status Events and Permissible Employee Election Changes

Cafeteria plans are governed by IRS Code Section 125 and allow employers to help employees pay for expenses such as health insurance with pre-tax dollars. Employees can choose between a taxable benefit (such as cash) and two or more specified pre-tax qualified benefits (health insurance, for example). Employees can select the benefits they want, much like an individual standing in a cafeteria line.

Only an eligible employee can make cafeteria plan elections, but they can choose benefits that also cover other individuals such as spouses or dependents. Elections, with an exception for new hires and for HIPAA special enrollment periods, must be prospective and can only be made if certain events occur. Also, cafeteria plan elections are irrevocable and cannot be changed during the plan year, unless a permitted change in status occurs.

Plans may allow participants to change elections due to:

- Change in legal marital status
- Change in the number of dependents
- Change in employment status
- A dependent satisfying or ceasing to satisfy dependent eligibility requirements
- Change in residence
- Commencement or termination of adoption proceedings (only for adoption assistance benefits)

Plans may also allow participants to change elections based on the following changes that are not a change in status:

- Significant cost changes
- Significant curtailment (or reduction) of coverage
- Addition or improvement of benefit package option
- Change in coverage of a spouse or dependent under another employer plan
- Loss of certain other health coverage (for example, government provided coverage, such as Medicaid)
- HIPAA special enrollment rights (contains requirements for plans subject to HIPAA)
- Medicare Part D Disclosure
- COBRA qualifying event
- Judgment, decrees, or orders (like qualified medical child support order (QMCSO)
- Entitlement to Medicare or Medicaid
- Family Medical Leave Act (FMLA) leave
- Pre-tax health savings account (HSA) contributions (employees are free to change their HSA contributions whenever they wish, in accordance with their payroll/accounting department process)
- Reduction of hours
- Marketplace enrollment

Together, the change in status events and other recognized changes are considered "permitted election change events."

Common changes that do not constitute a permitted election change event are:

- A provider leaving a network (unless, based on very narrow circumstances, it resulted in a significant reduction of coverage)
- A legal separation (unless the separation leads to a loss of eligibility under the plan), or commencement of a domestic partner relationship
- A change in financial condition

Read the full guide to understand qualifying events and making election changes off-cycle.

2023 Annual Benefit Card

The Annual Benefit Card has been updated and revised to reflect 2023 benefit contribution limits and maximums. Download the handy, wallet-sized card.

IRS Revises Guidance to Allow Expanded Mid-Year Cafeteria Plan Election Changes

The IRS released revised guidance to address the so-called "family glitch," permitting employers to allow mid-year election changes when an individual related to a plan participant is eligible to elect a qualified health plan

on the Marketplace. The cafeteria plan change may be due to either a special enrollment period or occur during the Marketplace's annual open enrollment period.

Plan sponsors do not have to allow election changes under the new guidance. However, plans that choose to permit such changes may do so for elections effective on or after January 1, 2023.

PCORI Fee Adjustment Announced

The IRS announced the annual increase to the Patient-Centered Outcomes Research Institute (PCORI) fees that are paid by self-insured groups and health insurers.

The adjusted applicable dollar amount for PCORI fees for plan and policy years ending on or after October 1, 2022, and before October 1, 2023, is $3.00. PCORI fees are calculated by multiplying the applicable dollar amount for the year by the plan's or policy's average number of covered lives.

PCORI fees are reported annually on the second quarter IRS Form 720 no later than July 31 of the calendar year immediately following the last day of the policy year or plan year to which the fee applies.

Question of the Month

Q. Who pays for health coverage during FMLA leave?

A. An employer does not have to pay its employees' share of health coverage premiums while they are on Family and Medical Leave Act (FMLA) leave. However, employers covered by the FMLA (generally, private-sector employers with 50 or more employees and public agencies and local educational agencies with any number of employees) must maintain coverage under any group health plan for the duration of an FMLA leave at the level and under the conditions that coverage would have been provided if the employee had been continuously employed for the duration of the leave. This means that, if the company is covered by the FMLA, it must pay the same share of the health coverage premiums for an employee on FMLA leave as it would have paid if the employee had not been on leave.

The requirement to maintain group health plan benefits during FMLA leave extends to any medical, surgical, hospital, dental, or vision care; mental health counseling; and substance abuse treatment provided under the company's group health plans. This requirement is not limited to "major medical" plans and applies to all group health plans that an FMLA-covered employer provides to its FMLA-eligible employees, including, for example, health flexible spending arrangements (FSAs).

The employer cannot require employees on FMLA leave to pay more for coverage than they would have paid if they had remained actively employed instead of taking the leave. Furthermore, the same group health plan benefits that were provided before the employee's FMLA leave began generally must be maintained during the leave. So, for example, if an employee was receiving family coverage before an FMLA leave, family coverage must be maintained during the leave. In addition, employees on FMLA leave must be allowed to change health plans or benefits to the same extent as if they were not on leave. Likewise, if the employer provides a new health

plan or changes health benefits or plans, employees who are on FMLA leave at the time are entitled to the new or changed plans or benefits to the same extent as if they were not on leave. Note that the employer's obligation to maintain coverage (and pay its share of the premiums) would end if employees chose to drop coverage during their leaves, failed to pay their share of the premium by the applicable deadline, failed to return to work at the end of the leave, or informed the employer of an intent to not return.

Keep in mind that FMLA leave is subject to other rules besides these. Also, it should not be confused with non-FMLA leave, during which employees who lose group health plan coverage may be able to elect COBRA and continue group health coverage during the leave at their own expense.