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End-of-2021 Health Plan Reminders: Out With (Some of) the New, In With (A Lot of) the Old, and Some of the Same Auld Lang Syne

The following general summary is intended to educate employers and plan sponsors on the potential effects of recent government guidance on employee benefit plans. This summary is not and should not be construed as legal or tax advice. The government's guidance is complex and very fact specific. As always, we strongly encourage employers and plan sponsors to consult competent legal or benefits counsel for all guidance on how the actions apply in their circumstances.

Introduction

For many of us, this time of year means getting ready for the holidays, warmer clothing, and – if you're like us – quietly gritting your teeth when your loved ones correct you for calling it "Daylight *Saving* Time" (it is, by the way, Mom[1]).

But for many employers and plan sponsors of group health plans, it's also a perfect time to review some end-of-year action items and reminders before 2022 comes a-knocking. As we enter (what feels like) the eight-hundred-and-twenty-fourth month of the COVID-19 pandemic (*Nineteen!* It's been two *years*!), it is necessary to revisit the various COVID-related legislation, guidance, and relief and how they impact various health and welfare plan provisions.

And – even in these unprecedented times of relief and regulations – some general refreshers may be welcome concerning general compliance requirements of Internal Code § 125 cafeteria plans (at least *these* haven't changed!): nondiscrimination testing, Form 5500 filing obligations, and updated San Francisco Health Care Expenditure Rates.

Health and Dependent Care Flexible Spending Account Changes

Unless Congress acts, many of the provisions allowed by the Consolidated Appropriations Act, 2021 (CAA)[2] and the American Rescue Plan Act (ARPA)[3] soon end.

Enacted on December 27, 2020, the CAA introduced several temporary provisions with respect to Health Flexible Spending Accounts (Health FSAs) and Dependent Care Flexible Spending Accounts (DCFSAs).[4] On February 18, 2021, the Internal Revenue Service (IRS) released Notice 2021-15[5] to provide additional guidance and clarification concerning the CAA relief provisions.

The CAA and Notice 2021-15 collectively provided a number of discretionary relief provisions for Health FSAs and DCFSAs, including:

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[1] https://www.almanac.com/content/when-daylight-saving-time#:~:text=The%20correct%20term%20is%20%22Daylight,adjective%20rather%20than%20a%20verb.
[2] https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf
[3] https://www.congress.gov/117/plaws/publ2/PLAW-117publ2.pdf
[4] https://drq94yec07kda.cloudfront.net/cares/Consolidated%20Appropriation%20Act%202021.pdf
[5] https://www.irs.gov/pub/irs-drop/n-21-15.pdf

- unlimited carryovers of unused benefits or contributions for plan years ending in 2020 and 2021 into plan years ending in 2021 or 2022, respectively;
- extensions of grace periods for plan years ending in 2020 and 2021 for twelve months after the end of the plan year for both a Health FSA and a DCFSA;
- spend down unused contributions for Health FSAs (similar to DCFSAs) for employees who cease participation in the plan during calendar year 2020 or 2021;
- a special claims period and "carry-forward" rule for DCFSA dependents who "aged out" during calendar year 2020 or 2021, expanding the definition of an eligible dependent child to under age 14; and
- permitting special mid-year prospective election changes to an employee's contribution amounts to a Health FSA or DCFSA (but not in excess of any applicable dollar limitation) for plan years ending in 2021 irrespective of any change in status.

Enacted on March 11, 2021, ARPA, among other things, introduced a temporary (but noteworthy) change to DCFSAs. For taxable years beginning in 2021, the maximum amount of DCFSA benefits permitted for income exclusion is temporarily increased to $10,500 (or $5,250 for married taxpayers filing separately).

On May 10, 2021, the IRS provided welcome guidance[6] clarifying the federal tax implications of DCFSA benefits that continue to be available during tax years ending in 2021 or 2022 by virtue of extended claims periods or carryover as described above and the interplay with ARPA's optional DCFSA increased maximum permissible contribution amount. In Notice 2021-26, the IRS confirmed that amounts available pursuant to a carryover or under an extended claims period that would have been excluded from an employee's income if they had been used during the original year (2020 or 2021) will remain nontaxable if they are used for eligible dependent care expenses during the subsequent taxable year. Furthermore, because the increased DCFSA limit for 2021 applies to the individual's taxable year (and not the DCFSA plan year), DCFSA benefits from one taxable year that are used to reimburse expenses incurred during the next taxable year portion of a non-calendar plan year (e.g., July 1, 2021 – June 30, 2022)) are not carryover benefits or benefits available under an extended claims period and may be taxable if used to reimburse DCFSA expenses incurred in the 2022 taxable year portion of the non-calendar plan year beginning in 2021.

To-Do

Employers who chose to offer any of these changes under CAA and Notice 2021-15 may amend their plan and the amendment may be retroactive, if (1) the amendment is adopted no later than the last day of the first calendar year beginning after the end of the plan year in which the amendment is effective (e.g., plan amendments for the 2020 plan year must be adopted on or before December 31, 2021); and (2) the plan or arrangement must have been operated in accordance with the terms of the amendment during the period beginning on the effective date of the amendment and ending on the date the amendment is adopted.

For example, if an employer with a calendar-year Health FSA that opted to permit participants to carryover unlimited unused funds from 2020 to 2021 must amend its cafeteria plan by **December 31, 2021**.

What's Changing?

As stated above, the CAA Health FSA relief provisions permit employers to offer carryovers of the full unused balance from plan years ending in 2020 and 2021 into subsequent plan years (i.e., into plan years ending in 2021 and 2022, respectively)

Unless Congress takes further action to extend any of these relief provisions into 2023:

[6] https://www.irs.gov/pub/irs-drop/n-21-26.pdf

- For Health FSAs that elected unlimited carryover as part of the CAA, the carryover limit into plan years beginning in 2023 will be $570.00.[7]
- For DCFSAs that elected unlimited carryover, such carryover will not be permitted for DCFSAs with plan years ending after December 31, 2021.
- For Health FSAs and DCFSAs that elected extended 12-month grace periods, grace periods shall not exceed two (2) months and 15 days for plan years ending after December 31, 2021.
- For DCFSAs, beginning January 1, 2022, the reimbursement of dependent care expenses related to the care of an eligible dependent child will be restricted to children that are age 12 or younger.
- For plans that elected to offer flexibility with prospective mid-year election changes without a qualifying life event, such mid-year election changes will only be allowed with the occurrence of a change in status for plan years ending before December 31, 2021.
- For the 2022 tax year, the DCFSA annual statutory max will revert to no greater than $5,000.

Outbreak Period Deadline Relief Continues

On April 29, 2020, the Department of Labor Employee Benefits Security Administration (EBSA) issued Disaster Relief Notice 2020-01[8], which provides relief during the COVID-19 "Outbreak Period" (defined as the period beginning March 1, 2020 and ending sixty days after the date on which the President declares the COVID-19 national emergency has ended) for all disclosures and notifications required under Title I of the Employee Retirement Income Security Act of 1974 (ERISA) (except those referenced in the "Joint Notification of Extensions of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak" [the "Final Rule"][9]) and states that a plan will not be in violation of ERISA as long as these disclosures and notifications are provided "as soon as administratively practicable under the circumstances."

The Final Rule and subsequent agency guidance provides that, for all group health plans, disability and other employee welfare plans, and all pension plans that are subject to the Employee Retirement Income Security Act of 1974 (ERISA) or the Internal Revenue Code (the Code), applicable deadlines for individuals and plans that fall within the Outbreak Period will be extended on a case-by-case basis until the earlier of (1) the end of the Outbreak Period; or (2) one year from the date the plan or individual's deadline period would have commenced (which will vary by individual occurrence). This means the following deadlines – on an individual-by-individual basis - will be extended for the duration of the Outbreak Period relief:

- the 30-day period (or 60-day period, in some cases) to exercise HIPAA special enrollment rights in a group health plan following birth, adoption, or placement for adoption of a child; marriage, loss of other health coverage; or eligibility for a state premium assistance subsidy;
- the 60-day deadline by which a participant or qualified beneficiary must provide notice of divorce or legal separation, a dependent child that ceases to be an eligible dependent under the terms of the plan), or a Social Security disability determination used to extend COBRA coverage;
- the 60-day deadline in which to elect COBRA coverage;
- Individuals electing COBRA outside of the initial 60-day election period (as referenced above) generally have one year and 105 days after the election notice is provided to make the initial premium payment; and individuals electing COBRA within the generally applicable 60-day election

[7] https://www.healthequity.com/doclib/compliance/Compliance_Alert_2022-Index_Figures_11.16.2021.pdf
[8] https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/disaster-relief/ebsa-disaster-relief-notice-2020-01
[9] https://www.federalregister.gov/documents/2020/05/04/2020-09399/extension-of-certain-timeframes-for-employee-benefit-plans-participants-and-beneficiaries-affected

period have one year and 45 days after the date of their election to make the initial payment;[10]

- the date by which monthly COBRA premium payments are due; and
- the deadline under the plan by which participants may file a benefit claim (under the terms of the plan) and the deadlines for appealing an adverse benefit determination or requesting an external review.

Until Congress or the President acts to declare the National Emergency has ended, this plan deadline relief will continue into 2022.

ARPA COBRA Subsidy

ARPA provided a 100 percent federal subsidy of COBRA continuation coverage premiums for certain qualified beneficiaries who became eligible for COBRA continuation due to an involuntary termination of employment or reduction in hours. This federal subsidy was available for continuation coverage periods from April 1, 2021 through September 30, 2021. ARPA further provided that the "person to whom premiums are payable" (the "Premium Payee") – generally the employer or the plan– is entitled to claim a tax credit to be reimbursed for the COBRA premiums not paid by these assistance eligible individuals due to the COBRA premium subsidy.

A Premium Payee is entitled to the tax credit as of the date it has received an assistance eligible individual's election of COBRA continuation coverage. Generally, this tax credit is claimed by reporting the COBRA premium assistance provided to these assistance eligible individuals by filing IRS Form 941. The deadline to file IRS Form 941 for 2021 is the end of the month following the close of the quarter (e.g., for the October – December 2021 reporting period, the filing due date will be January 31, 2022).

While the COBRA subsidy period introduced by ARPA ended on September 30, 2021, as referenced above, it is possible that an assistance eligible individual may – by virtue of the ongoing Outbreak Period plan deadline relief – elect COBRA coverage after September 30, 2021 retroactively (perhaps even to – or before April 1, 2021). Therefore, Premium Payees that provided the COBRA subsidy for such a retroactive election of COBRA coverage may need to claim the attendant tax credit on their January 31, 2022 Form 941 filing.

Nondiscrimination Testing

What Are Nondiscrimination Tests?

The overall "25% Concentration" test compares all the pre-tax benefits elected by key employees with all the pre-tax benefits elected by non-key employees. Not more than 25% of the total benefits elected by all employees may be attributed to key employees.

Example:

All elections to the cafeteria plan add up to $35,000. Of those total elections, key employee elections equal $5,000. Key employee elections are about 14 percent of the total elections to the plan (14.3% - $5.000 / $35,000). In this example, the cafeteria plan passes the 25% Concentration Test.

The "55% Average Benefits" test involves only the dependent care portion of the cafeteria plan. The average dollar amount of benefits elected by non-highly compensated employees must be at least 55% of the average dollar amount of benefits elected by highly compensated employees.

[10] https://www.irs.gov/pub/irs-drop/n-21-58.pdf

Example:

Assume that highly compensated employees' elections are $10,000 to the dependent care portion of the plan and there are five highly compensated employees in the company. Non-highly compensated employees elect $19,500 to the dependent care portion of the plan and there are 13 non-highly compensated employees. The highly compensated average dollar amount is $2,000 (= $10,000 / 5). The non-highly compensated average dollar amount is $1,500 (= $19,500 / 13). The average dollar amount of benefits elected by non-highly compensated employees is 75% of the average dollar amount of benefits elected by highly compensated employees ($1,500/$2,000). In this example, the dependent portion of the cafeteria plan passes the 55% Average Benefits test.

The **"5% Owner" test** compares the dependent care benefits elected by more-than-5% owners of a company with dependent care benefits elected by non-owners. Not more than 25% of the total dependent care benefits elected by everyone in the dependent care benefit may be attributed to more-than-5% owners.

Example:

Assume a $5,000 election to the dependent care portion of the plan by a more- than-5% owner and elections in the amount of $19,500 made by all non-owners. The more-than-5% owner's election is 20% of the total benefits elected to the dependent care portion of the plan (20% = $5,000 / ($24,500 [=$5,000 + 19,500]). In this case, the dependent care portion of the plan passes the 25% Owner test because only 20% of the dependent care benefits were elected by the more-than-5% owner.

The **"Eligibility, Benefits Available, and Contribution and Benefits"** tests ensure that employers offer all benefits to an adequate number of employees and benefits do not discriminate in favor of highly compensated or key employees.

In the event the cafeteria plan does not meet all the nondiscrimination requirements, employers may need to change benefit elections and payroll amounts to bring the plan into compliance. It is important to test prior to the end of the cafeteria plan year. Generally, if testing is completed after the end of the plan year, it's too late to take corrective action. Instead of reducing key or highly compensated elections to pass the nondiscrimination test(s), the affected employees would be taxed on their total election amount.

Form 5500 Obligation

A frequently overlooked responsibility for cafeteria plan sponsors is Form 5500 filings under certain circumstances. In 2002, IRS Notice 2002-24[11] suspended the filing requirement imposed on cafeteria and fringe benefit plans. However, don't be misled! The filing requirement for welfare benefit plans remains unchanged.

What is a welfare benefit plan?

Welfare benefit plans provide benefits such as medical, dental, life insurance, apprenticeship and training, scholarship funds, severance pay and disability. Health FSAs contained inside cafeteria plans and Health Reimbursement Arrangements (HRAs) qualify as welfare benefit plans.

Who must file a Form 5500?

Employers that sponsor welfare benefit plans covered by Title I of ERISA, with 100 or more participants at the beginning of the plan year, are required to file a Form 5500 for those plans. However, there are a couple of exceptions that apply, depending on the type of employer sponsoring the plan. A general

[11] https://www.irs.gov/pub/irs-drop/n-02-24.pdf

exception applies to:

- a governmental plan; or
- a church plan under ERISA § 3(33).

The plan *may* not be exempt from filing if:

- it is deemed to have plan assets;
- plan funds are separated from the employer's general assets;
- plan funds are held in trust; or
- plan funds are forwarded to a third-party administrator.

Most non-exempt employer plans will complete all questions on Form 5500. Depending on the funding arrangement or payments from the plan, attaching Schedules may be applicable.

Since 2009, however, the "Instructions for Form 5500" were modified to make clear that plans that are paid from the general assets of the employer need not file Schedule C.

When does a welfare benefit plan need to file a Form 5500?

Forms must be filed by the last day of the seventh calendar month after the end of the plan year. A plan may obtain a one-time extension of time to file. Form 5558 must be sent by the original due date to gain a 2½ month extension of time in which to complete and file the Form 5500.

2022 San Francisco Healthcare Expenditure Rates

The San Francisco Office of Labor Standards Enforcement recently released updated Health Care Security Ordinance (HCSO)[12] required health expenditure rates for 2022.

Updated Rates

The 2022 Healthcare Expenditure Rates – and previous years' rate history[13] – is as follows:

Employer Size	Rate Per Hour						
	2022	**2021**	**2020**	**2019**	**2018**	**2017**	**2016**
Large employers (≥ 100 employees)	$3.30	$3.18	$3.08	$2.93	$2.83	$2.64	$2.53
Medium employers (20-99 employees); Non-profit (50-99 employees)	$2.20	$2.12	$2.05	$1.95	$1.89	$1.76	$1.68
Small employers (≤ 19 employees); Non-profit (≤ 49 employees)	Exempt						

[12] https://sfgov.org/olse/health-care-security-ordinance-hcso

[13] More information concerning the San Francisco Office of Labor Standards Enforcement's Health Care Security Ordinance required health expenditure rates, including developments related to the ongoing COVID-19 pandemic is available at https://www.wageworks.com/employers/employer-resources/compliance-briefing-center/regulatory-updates/2020/2021-san-francisco-health-care-expenditure-rates-released/ and https://sfgov.org/olse/health-care-security-ordinance-hcso.

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Conclusion

The past couple of years have been an eventful ride, and group health plans have much to consider and review as we near December 31, 2021. These are but a few of the specific year-end deadlines and requirements that are quickly approaching.

Compliance becomes clearer for employers through knowledge. It's as easy as contacting HealthEquity for more information about its services, and your own accounting or legal sources for additional guidance.

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