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FOREFRONT

INNOVATIVE BENEFIT SOLUTIONS, INC.

April 2021

The Setting For Every Community Up For Retirement Enhancement Act (SECURE)

The SECURE Act has made big changes to retirement plans in the way distributions are handled. Two of the biggest changes are: Required Minimum Distributions (RMDs) and elimination of Stretch IRAs for most beneficiaries.

Under the old law, participants were required to begin taking RMDs at 70.5. Now, the age at which RMDs are required is 72. In addition, due to the COVID-19 pandemic, those participants who had RMDs due in 2020 may skip this distribution if they choose.

Please check with your tax advisor regarding how the SECURE Act may affect you and your family members.

Stretch IRAs

- For many who inherit IRAs or 401(k)s starting in 2020, the SECURE Act eliminated the ability to "stretch" your taxable distributions and related tax payments over your life expectancy.
- If you've inherited an IRA on or after January 1, 2020, you must withdraw all assets from the inherited account within 10 years.
- There are three possible strategies to consider based on your situation:

1. Withdraw the assets as evenly as possible over the 10 years
2. Wait until the end of the 10 year period and then withdraw everything
3. Make irregular withdrawals over the 10 year period

Randall B. Marking
President

How to Handle Unused 2020 FSA Balances

Employers should consider very soon the SECURE Act's temporary special relief for health and dependent care flexible spending arrangements (FSAs). Many employees haven't been able to use up their FSA accounts during the pandemic, and with many FSA plan years ending this month, some employees have been pressuring their employers to refund unused amounts. Employers needed Congress or the IRS to provide a compliant way they could mitigate the loss to employees. The new legislation provides that relief. While an employer still can't refund unused amounts, it now has several options to let employees access their unused balances and change their elections in 2021 as needed:

- **For health and dependent care FSAs**, employees can carry over apparently uncapped unused 2020 amounts to 2021, or employers can extend an existing FSA's grace period from 2-1/2 months to 12 months. Employers can apply this additional flexibility to 2022 plan years for 2021 unused amounts. The law appears to let an employer adopt either the carryover or grace period approach for any plan year, but not both.

- **For dependent care FSAs**, the law also temporarily increases the age of children whose expenses qualify for reimbursement from 12 years old to 13.

- **For health FSAs**, additional flexibility allows reimbursing medical expenses incurred after participation ends (e.g., post-termination of employment), similar to how the dependent care spend-down provision currently works.

While the law offers this increased flexibility for 2020 and 2021 FSAs, employers don't have to adopt any or all of these new options. Employers that want to implement the changes will need to amend their plans generally by the end of the 2021 plan year.

Source: "Big News for Employers – Long Sought Answers on How to Handle Unused 2020 FSA Balances and Much More!" - Mercer.

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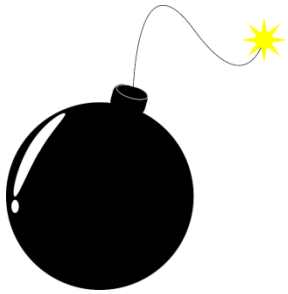

You have all heard about the 1.9 trillion coronavirus stimulus bill. Within this bill is a ticking time bomb for Republicans. Let's take a look.

Obamacare's big failure has been what it did not do to help—and actually hurt—middle class buyers of individual health insurance. Since the health law's inception, consumers, who are eligible for little or no Obamacare subsidy, have faced daunting premiums and out-of-pocket costs.

In 2021, for example, a family of four with mom and dad age 40 in Wisconsin would find that the cheapest unsubsidized Silver Plan would cost about $20,000 in annual premiums, with a per person deductible of $6,500 a year.

President Biden's plan would fix that by capping what people at any income level would pay for marketplace plans at 8.5% of their income—the 400% of the federal poverty level cap on subsidy eligibility would no longer apply.

A family of four making the current 400% of poverty level annual income of $106,000 would pay no more than $9,010 in annual premiums (8.5% of their income) under the new rules.

The House passed stimulus package includes this and goes even further by letting people who earn up to 150% of the federal poverty level to get full subsidies and also extending full subsidies to those receiving unemployment benefits.

At 150% of the federal poverty level, four person families earning up to $39,750, and individuals earning up to $19,320, would pay nothing in premiums for their Obamacare individual health insurance under the House passed plan.

The House stimulus bill would also cover 95% of Medicaid expansion costs for states that have not yet expanded—up from the baseline 90% match.

The Congressional Budget Office has estimated that these changes would cover 1.3 million more people and cost $34 billion.

If these changes survive in a Senate passed coronavirus stimulus bill, they would dramatically improve the costs middle class individuals and families face on the Affordable Care Act's insurance exchanges and encourage states to expand their Medicaid programs.

But here's the catch. These improvements are part of a temporary stimulus bill and would only apply to health insurance subsidies and federal Medicaid costs in 2021 and 2022.

On January 1, 2023, the Obamacare insurance subsidies would revert to the old levels that have caused middle class families to face these huge premiums.

What else is happening at the end of 2022? The Congressional elections.

This would make Obamacare another huge election-year issue.

Would Republican House and Senate candidates support making these *middle class* improvements to the Affordable Care Act permanent, or would they call for letting them drop?

Now, that is one heck of an ugly election-year choice for Republicans who have consistently called for Obamacare to be repealed and replaced.

If Democrats can succeed in keeping these substantial improvements to Obamacare in a stimulus bill and they can get passed through the Senate, they will have set one whopper of a political time bomb for Republicans come November 2022.

Source: "The Democrats Are About to Set a Whopper of an Obamacare Political Time Bomb for Republicans" – Forbes.

New Transparency Rules

The new rules require most employer-sponsored group health plans and health insurance issuers to disclose price and cost-sharing information up front, giving enrollees estimates of any out-of-pocket expense they will have to pay to meet their plan's cost-sharing requirements. Health plan sponsors and insurance issuers will also have to give patients and other stakeholders access to previously unavailable pricing information, using a standardized format that allows easy cost comparisons.

Excluded plans and benefits. Excepted benefits and expatriate plans typically aren't subject to certain PHSA healthcare reform mandates, such as PHSA Section 2715A, so the new rules won't apply, for example, to limited-scope vision or dental plans, retiree-only plans, employee assistance programs that don't provide significant medical care, and certain fixed indemnity policies. The rules specifically provide that the transparency requirements also won't apply to grandfathered plans, health reimbursement arrangements (HRAs) and other account-based plans (apparently regardless of excepted-benefit status), or short-term limited-duration insurance (STLDI).

No quality metrics for now. The proposed regulations requested comments about using provider quality measurements and reporting in the private healthcare market to complement cost-sharing transparency. While regulators received a number of comments supporting this idea, the final rules do not require any quality metrics. The agencies intend to consider the comments for future action and encourage plans to innovate with quality metrics to improve consumers' healthcare decisions.

Key transparency disclosures. Most plans will have to make cost information available in two ways:

- Posting machine-readable files with pricing information on a publicly accessible internet site
- Providing a self-service tool for enrollees to obtain personalized out-of-pocket cost estimates

Machine-readable pricing files on the internet for public access

To facilitate price comparisons and consumerism in the healthcare market, health plans and insurance issuers will need to make three machine-readable files publicly available on the internet:

- In-network rate file
- Out-of-network allowed amount file
- Prescription drug file

These regularly updated, standardized files will contain, among other things, the plan's in-network provider negotiated rates, historical payments of allowed amounts paid to out-of-network providers and prescription drug rates. The files must provide information for all covered items and services, including prescription drugs.

Effective date. The files must be available for plan years beginning on or after January 1, 2022.

Self-service cost-estimator tool for enrollees

Plans and issuers will need to provide an internet tool that enables enrollees to obtain personalized out-of-pocket cost estimates for in- and out-of-network healthcare items and services, including durable medical equipment and prescription drugs. Plans and issuers can limit the tool's availability to enrollees and have no obligation to give access to employees or dependents who might become covered in the future. When making healthcare decisions, enrollees may choose to share their personal cost-sharing liability with a healthcare provider or authorize a provider to serve as their representative under ERISA's claim procedure rules.

This tool will help enrollees understand how their plan determines cost-sharing amounts and facilitate comparison-shopping before receiving medical care. The tool must include certain content elements — generally, the same information found in a healthcare claim's explanation of benefits (EOB). The rules don't require outreach or education, but regulators encourage plans to promote awareness of the self-service tool and ways enrollees can use it to shop for lower-priced services.

Source: "Healthcare cost transparency rules and MLR changes finalized" – Mercer.

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Subsidies For COBRA Premiums

The American Rescue Plan Act fully subsidizes premiums for COBRA health coverage from April 2021 through September 2021 and requires special COBRA election periods and extensive new COBRA notices.

The bill provides a 100% subsidy for COBRA continuation coverage for "assistance eligible individuals" — that is, COBRA qualified beneficiaries. This group includes any employees along with their spouses and dependent children who lose (or lost) group health plan coverage due to the employee's involuntary termination of employment or reduction of work hours and elect (or elected) COBRA coverage. Other COBRA qualifying events causing a loss of coverage, such as voluntary termination of employment, death of a covered employee or a dependent aging out, won't qualify for a subsidy. Subsidy-eligible COBRA coverage can include hospital and major medical coverage as well as dental and vision plans, but not health flexible spending arrangements (FSAs).

The premium assistance will be available from April 1, 2021, through September 30, 2021, regardless of whether COBRA coverage began earlier or ends later. The subsidy will end sooner than September for qualified beneficiaries whose maximum COBRA coverage period ends earlier (as measured from the date of the original COBRA qualifying event) or who become *eligible* for another group health plan (other than excepted benefits) or Medicare.

Subsidy-eligible individuals electing coverage pay no portion of the premium for health coverage. Employers and plans that comply with certain reporting requirements will receive refundable tax credits equal to the premiums that individuals otherwise would have owed. The credit will be provided by the Treasury Department through a reduction of Medicare payroll taxes.

Source: "Law and Policy Group: COBRA help, dependent care items in COVID-19 bill near enactment" – Mercer.

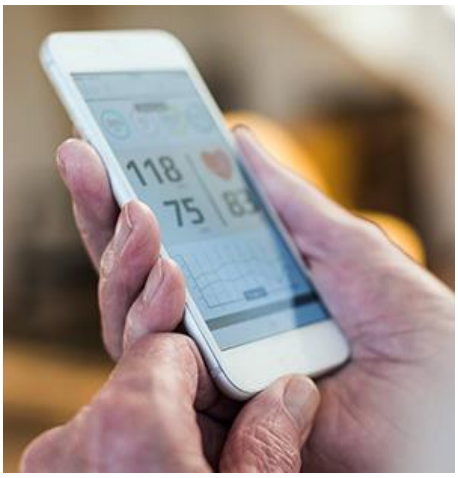
New COBRA Election and Notice Periods

A 60-day special election period is available to assistance-eligible individuals who haven't exhausted their original 18-month COBRA period and either did not elect COBRA when first eligible or elected COBRA but dropped it before April 1, 2021. COBRA elected during this special period, which runs for 60 days after the date the plan administrator provides assistance-eligible individuals the new required COBRA notice, will not extend beyond the individual's normal COBRA continuation period. An assistance-eligible individual who did not initially elect COBRA, or who elected but dropped COBRA coverage prior to April 1, may receive the subsidy on a prospective basis, without having to elect and pay for COBRA retroactively for months prior to the subsidy becoming available.

Within 60 days of April 1, 2021, employers' COBRA notices will have to include information about the availability of the subsidy and the special 60-day enrollment period for qualified beneficiaries. This information may be added to current COBRA notices or provided in a separate document accompanying the current notice. The legislation sets out content for these notices and directs the Labor secretary to publish model notices within 30 days of the bill's enactment. Employers will also have to provide a notice of expiration before the premium subsidy expires.

Source: "Law and Policy Group: COBRA help, dependent care items in COVID-19 bill near enactment" – Mercer.

Amazon Care



Amazon is going to try again in taking a stab at the healthcare industry through telehealth.

According to Amazon, their mobile app Amazon Care will offer online appointments with healthcare professionals, as well as home and worksite visits.

Currently, this app is only available to Amazon employees in Washington; however, it was reported by the Business Insider that Amazon Care is going to "undertake a national expansion, with the goal of serving workers at other major companies. Care Medical, the group that runs Amazon Care's doctor's visits, has been quickly laying the groundwork to operate throughout the U.S. The group has filed with regulators to operate in at least 28 states".

The ultimate goal for Amazon Care is to provide virtual care in all 50 US states and to expand the healthcare offering for the rest of Amazon's U.S. workers, while encouraging employers to use the service as well. Amazon Care would also like to provide more in-person visits, particularly where companies are headquartered.

* In March, Stat, a medical journal, reported that Care Medical filed to do business in 17 additional states besides Washington, including Georgia, Maine, and Alaska. The Seattle Times identified a few more. Care Medical has filed in more states since those reports, including Connecticut, Kentucky, Missouri, New Jersey, Pennsylvania, and Wisconsin. Care Medical filed in additional states as recently as March 9.

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We are a privately owned insurance benefits firm specializing in the development, delivery, and implementation of employee benefits. Our primary focus is tailoring health care solutions for active and retiree populations. These solutions include our proprietary programs wrapped within a complete package of employee benefits and administration. We are a one-stop shop.

IBSI is on the cutting edge of providing benefits to active employees as well as both pre- and post-65 retirees for major employers nationwide. We offer Medicare Supplement, Major Medical, Life, Dental, Vision, and Prescription Drug Benefits on both a fully insured and self-funded basis. We integrate HMO Risk contracts and PPO's with our core solutions for the retiree segment.

Apology regarding error in 4th Quarter Newsletter in the President's Letter