

MSBO HR Town Hall Benefits Compliance – Back to Basics

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Overview

Section subtitle goes here

Overview

Myriad of laws apply to health and welfare plans, including:

ERISA	Sets reporting and disclosure and other requirements for certain health and welfare benefit plans
Internal Revenue Code	Governs taxation of benefits Includes specific requirements to allow employer to deduct the cost of benefits and employees to receive the benefits tax free
Affordable Care Act	Plan design Employer mandate - requires certain employers to offer health coverage to full time employees and their dependents that is affordable and provides minimum value Reporting and taxes
COBRA	Requires certain employers to offer the opportunity to continue health coverage to employees and dependents who lose coverage due to certain events
HIPAA	Special enrollment Prohibits discrimination based on health status in the provision of health benefits Requires that certain health information be protected
State Laws	Benefit mandates, reporting requirements, PA 106, PA 152

Overview

Employers subject to laws

ERISA

- Private sector employers of any size
- Exempt employers: churches governments (federal, state, county, city, school districts, public utility district employers), Indian tribal government plans

Internal Revenue Code

- Generally, applies to all employers

Affordable Care Act

- Benefit design requirements generally apply to all employers (some only to fully insured small employers)
- Employer mandate – employers with 50 or more full time employees in prior calendar year

COBRA

- Employers with 20 or more employees in previous year

HIPAA

- Special enrollment and non-discrimination – all employers
- Privacy - all group health plans with “protected health information”

State Laws

- Generally, fully insured plans issued in the state in which the law is enacted
- Private sector employers with self-insured plans generally exempt (due to ERISA preemption)
- Government employers with self-funded plans that are not subject to ERISA may or may not have to comply
- PA 106 and PA 152 apply to all public schools

Internal Revenue Code

Section subtitle goes here

Internal Revenue Code

Overview

Governs taxation of benefits

- If requirements are met, employer can deduct benefit expenses and benefit is not included in employee's taxable income

Benefits with favorable tax treatment:

- Cafeteria plans (Section 125)
- Health coverage (Section 104, 105 and 106)
- Health reimbursement arrangements (Section 105)
- Health flexible spending accounts (Section 105 and 125)
- Dependent care flexible spending accounts (Section 129 and 125)
- Health savings accounts (Section 223 and 125)
- Group term life insurance (Section 79)
- Others: disability, fringe benefits, adoption assistance, educational assistance

Cafeteria Plans

Overview

Authorized by Section 125 of the Internal Revenue Code

Sometimes referred to as flex plans, premium only plans, or 125 plans

Offers a choice between taxable compensation (wages) and qualified benefits (i.e. group health benefits)

Premium only plan (POP)

Choice between medical , dental or vision coverage in exchange for a salary reduction OR no coverage and no salary reduction

Flexible spending accounts

Choice between contributions to a health care or dependent care flexible spending account with reduced compensation OR no coverage and no salary reduction

Opt-out benefit

Choice between medical coverage OR no coverage and additional taxable compensation

Pre-tax contributions To an HSA

Choice between contributions to an HSA reduced OR no salary reduction

Cafeteria Plans

General requirements

Plan document required



Twelve-month period of coverage (generally tied to the plan year)

Employees make election prior to the beginning of the plan year

May not change election during the plan year unless they have a “change in election” event



Nondiscrimination requirements must be met

Cafeteria Plans

12-month period of coverage and election changes

Generally, cafeteria plan participants are not allowed to change or revoke a pre-tax benefit election during the plan year, however the plan may recognize certain permitted events to change election

Number of permissive events that allow a participant to change a pre-tax election mid-year. The IRS recognizes three broad categories:

- Change in status events (e.g. major life events, such as marriage, birth, adoption and certain employment changes)
 - Consistency rule – event must impact eligibility under plan and election change is consistent with that impact
- Changes in cost or coverage for the plan's qualified benefits; and
- Other laws or court orders (e.g. COBRA, HIPAA and the Affordable Care Act).

If an employer wants to adopt, include in cafeteria plan document

Although a plan may not be more generous than the IRS permits, it may choose to limit election change events that it will recognize

Health Coverage

Overview



Governed by IRC Sections 104, 105 and 106



Generally, allows for employer's payment of premiums and reimbursement for qualified medical expenses of employees and their tax dependents (spouse, dependent children to age 26)



Self-insured employer health plans are subject to nondiscrimination rules that prohibit discrimination in favor of highly compensated employees

Health Reimbursement Arrangements (HRAs)

Overview

Generally, a bookkeeping account set up by employer (employer may fund account; funded account becomes subject to additional rules)



Funded entirely by employer contributions



Used to reimburse employees for qualified medical expenses and/or insurance premiums



Several types of HRAs are permitted:

HRAs integrated with group health coverage (traditional HRAs);

Retiree-only HRAs (may include rollovers of vacation or sick time);

HRAs integrated with individual health insurance (ICHRA);

Excepted benefit HRAs (EBHRAs); and

Qualified small employer HRAs (QSEHRAs)



Need a plan document



Generally subject to HIPAA, COBRA, and 105(h) nondiscrimination rules

HRAs

Key differences

Traditional HRA

- Must be integrated with group health plan coverage
- May not reimburse individual insurance premiums (may reimburse group health plan premiums of plan that is integrated)
- No limit on contributions (employers typically limit)

ICHRA

- Reimburses individual insurance premiums including Medicare and other qualified medical expenses
- Employer must not offer traditional group health plan to same class of employees
- Individual must be enrolled in individual health insurance
- Same coverage must be offered to all employees within a class (PT, FT, seasonal, hourly)

EBHRA

- Employer must offer traditional group health plan to employees eligible for EBHRA (but integration not required)
- Maximum contribution \$2,200 (2026)
- May not reimburse individual or group insurance premiums

QSEHRA

- Available to employers with less than 50 FTEs
- Employer must not offer a group health plan
- Employees must be enrolled in MEC
- Contributions limited to \$6,450 single; \$13,100 family (2026)
- May reimburse premiums

Health FSAs

General rules

Description

- Bookkeeping account established through employer's Section 125 cafeteria plan, used to reimburse participants for unreimbursed qualified medical expenses

Special rules

- Part of cafeteria plan (12-month coverage period and change in election rules apply)
- Restrict eligibility to employees eligible for employer's group health plan
- Unused amounts at end of plan year are forfeited ("use it or lose it")
 - May have grace period or carryover (\$680 for 2026)
- Employees full annual election must be available at all times during the plan year
- Generally subject to HIPAA, COBRA, nondiscrimination and cafeteria plan rules

Contributions

- Employer and employee can contribute; limit employer contributions to \$500
- Maximum employee contribution \$3,400 (2026)

Distributions

- May be made for any IRC Section 213 medical expenses, excluding health insurance premiums

Dependent Care FSAs

General rules

Description

- Bookkeeping account established through employer's Section 125 cafeteria plan, used to reimburse participants for unreimbursed dependent care expenses

Special rules

- Part of cafeteria plan (12-month coverage period and change in election rules apply)
- Unused amounts at end of plan year are forfeited ("use it or lose it")
 - May have grace period
- Subject to nondiscrimination and cafeteria plan rules (but not HIPAA or COBRA)

Contributions

- Employer and employee can contribute
- Maximum contribution \$7,500 (\$3,750 married/filing separately)

Distributions

- Must be expenses incurred to allow employee, and the employee's spouse, to be gainfully employed
- Care must be for children under age 13, spouse that is incapable of self-care, or qualifying individual (e.g., elderly parent) that resides with employee for more than half of the year

Health Savings Accounts (HSAs)

General rules

Description

- An individual tax-exempt account created to pay for qualified medical expenses; employee owned and portable (like an IRA)

Eligibility

- Enrolled in a qualified high-deductible health plan (“HDHP”)
 - Minimum Deductibles - for 2026, \$1,700 (single) and \$3,400 (family)
 - Out-Of-Pocket Maximum - for 2026, \$8,500 (single) and \$17,000
- Not covered by non-HDHP that provides coverage for any benefit covered by HDHP
 - Exception for preventive care, telehealth, other permissible coverage
- May not be claimed as a tax dependent
- Not enrolled in Medicare

Special rules

- Pre-tax contributions part of cafeteria plan (but not subject to change in election rules)
- Employer contributions subject to comparability rules if not made through cafeteria plan
- Generally not subject to HIPAA, COBRA

Contributions

- Employer and employee can contribute
- Single coverage - \$4,400; Family coverage - \$8,750
- Catch-up (age 55+) - \$1,000

Distributions

- Unreimbursed qualified medical expenses, but generally no health insurance premiums

Group Term Life Insurance

Overview

Value of GTLI is tax exempt up to \$50,000 for employees (not spouses or dependents unless \$2,000 or less or if plan is discriminatory)

- Amounts in excess of these amounts included in employee's income

May also have voluntary life insurance

Affordable Care Act

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Affordable Care Act

Overview

Impacts employers, group health plans, insurers and individuals

- Plan design requirements
- Requires large employers to offer health coverage to full-time employees and their dependents, or pay a penalty (“employer mandate”)
- Reporting requirements
- Taxes

Plan Design Mandates

Group health plans may have to comply with a number of requirements, including:

Providing coverage to dependent children until they turn age 26

Eliminating annual and lifetime aggregate dollar limits for essential health benefits

Eliminating preexisting condition exclusions

Comply with out-of-pocket maximums

Preventive services, including pediatric vaccines and contraceptive services, unless exception applies

Clinical trials

Embedded out-of-pocket maximum

Federal external review

Nondiscrimination against gay, lesbian, and transgender employees

Emergency services

Benefit Mandates

Essential Health Benefits (EHBs)

Small fully insured employers are required to cover EHBs:

Ambulatory patient services

Emergency services

Hospitalization

Maternity and newborn care

Mental health and substance use disorder services (including behavioral health treatment)

Prescription drugs

Rehabilitative and habilitative services and devices

Laboratory services

Preventive and wellness services and chronic disease management

Pediatric services, including oral and vision care

Large employer, self-insured, and small grandfathered plans not required to offer EHBs

BUT, EHBs that are offered are subject to prohibition on annual/lifetime limits

Flexibility in defining EHBs

Must select EHB package from state EHB plans

Grandfathered Status

Plans that have maintained grandfathered status do not have to comply with some of the plan design mandates

Grandfathered plan

Same plan design that was in place prior to March 23, 2010

Exempt from certain ACA provisions:

- Preventive care
- Clinical trials
- Patient Protections
- Out of pocket maximums

Must include notice of grandfathered status in all “material” documents

Loss of grandfathered status

5 plan design changes that can result in loss of status

- Elimination of benefits
- Increase in % of cost sharing
- Increase in fixed-amount cost sharing
- Decrease in employer contributions
- Adding annual limit

Employer Mandate

Two general requirements

Applicable “large employer” (ALE) must offer “minimum essential coverage” (“MEC”) to at least 95% of “full-time employees” (“FTEs”) and their dependents (or pay a penalty)

Offer must be “affordable” and provide “minimum value” (or pay a penalty)

Large employer = an average of at least 50 full-time and full-time equivalent employees in prior calendar year

MEC is broadly defined

FTE = average of at least 30 hours of service per week or 130 hours per month (next slide)

Employer Mandate

Full-time employee



FTE = average of at least 30 hours of service per week or 130 hours per month



Employer has two options to determine:

Monthly – if work 30 hours per week/130 hours in a month, considered full-time for that month

Look back – if work 30 hours per week/130 hours per month during applicable look back period, considered full-time for following stability period



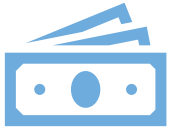
Hours of Service = any hour for which an employee is paid or entitled to payment even when duties are not performed such as vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence



There are additional special rules for counting hours for educational employees and special rules for breaks in service

Employer Mandate

Affordability



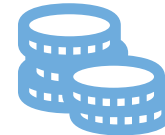
Requirements

Employee's required contribution for lowest cost option for employee-only coverage that provides minimum value must be affordable



Defined

9.5% (adjusted – 9.96% in 2026) of employee's household income



Safe harbors

Federal poverty level
Rate of pay
W-2

Employer Mandate

2026 penalties

At least one full-time employee must get subsidy for coverage purchased through marketplace to trigger either penalty

2026	
Failure to offer MEC to at least 95% of FTEs and their dependents	\$3,340 per each FTE (minus the first 30 FTEs)
Failure to offer affordable/minimum value coverage	\$5,010 per FTE that receives a marketplace subsidy

ACA Reporting and Disclosure Requirements



Marketplace notice

Info about the marketplace and general info about employer's plans (if applicable)

New hires must receive within 14 days of date of hire

If info about the employer's plans and coverage changes, update the Notice



Summary of Benefits Coverage (SBC)

Applies to all health plans subject to ACA



W-2 Reporting

Currently only applies to employers that file more than 250 W-2s during the calendar year (controlled group rules do not apply for this purpose)

Box 12, Code DD = employer + employee cost for coverage

COBRA

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COBRA

Overview

General - COBRA requires certain employers to allow certain individuals (qualified beneficiaries) to continue group health plan coverage for a limited period of time; qualified beneficiary pays for coverage

COBRA applies if:

- Employer is covered under the law
 - 20 or more employees in prior year (state law may apply COBRA rights to smaller employers), and
- Employer maintains a group health plan
 - Medical, dental, vision, health FSA (special rules for health FSAs), EAPs, wellness programs, etc., and
- There is a qualified beneficiary
 - Employee, spouse or dependent covered under the plan who will lose coverage due to a qualifying event
- Who experiences a qualifying event (triggering event + loss of coverage) – next slide

Qualifying Events

Termination of employment

- Gross misconduct exception

Reduction of hours

- Can include leaves of absence

Divorce or legal separation

- Legal separation only applicable if recognized by the state

Death of covered employee

Loss of dependent child status

Entitlement to Medicare for a covered employee

- Entitlement = enrolled
- Note, employee may enroll in Medicare while still employed – this is not a qualifying event for spouse and dependents unless it causes a loss of coverage under the terms of the Plan
- Rare, due to Medicare Secondary Payer rules

Employer bankruptcy (retiree coverage only)

TIP: These events are qualifying events ONLY if there is a loss of coverage associated with the event

Qualifying Events

Event must cause loss of coverage



Loss of coverage = no longer covered under same terms and conditions as in effect before qualifying event

Includes changes in premium cost to employee



Not all losses are due to a qualifying event, and not all qualifying events cause a loss of coverage

Failure to pay premiums
Status change from eligible to ineligible without any reduction in hours or termination of employment
Status change from full time to part time (or other) without a loss of coverage
Commencement of FMLA leave

Requirements:

Duration of coverage

Qualifying Event		Maximum COBRA Coverage Period
- Termination of Employment - Reduction in hours	→	18 months
Permanent SSA Disability	→	29 months
- Death of employee - Divorce or legal separation - Child loses dependent status - Employee entitlement to Medicare	→	36 months
Employer bankruptcy	→	Lifetime for certain retirees

TIPS

- ✓ 18-month period may be extended to 29 or 36 months in certain situations
- ✓ State law may extend
- ✓ May terminate early in certain situations (e.g., non-payment of premium, enrolls in other coverage after electing COBRA)

Requirements

Benefits



Qualified beneficiaries may only continue coverage they had at time of qualifying event

Even if coverage no longer of value (region specific HMO)



May change coverage:

Open enrollment
Special enrollment
Region-specific HMOs if plan permits active employees to change

COBRA

Special rules

Variety of notice requirements, including:

- Initial notice
- Notice of qualifying event

Premiums

- May charge 102% of cost for similarly situated employees; disability extension 150%
- Fully insured plans = premium cost from insurer; self-insured plans must calculate under specific rules
- Fixed in advance of each 12-month period

Strict deadlines for notices, elections and payment of premiums

HIPAA

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HIPAA Privacy and Security

Overview

HIPAA = The Health Insurance Portability and Accountability Act of 1996

- Portability (special enrollment) and nondiscrimination
- Privacy and Security
 - Three Key rules:
 - Privacy Rule
 - Security Rule
 - Breach Notification Rule
 - Why should you care?
 - Civil and criminal actions may be brought by HHS
 - Monetary penalties may be assessed

HIPAA Special Enrollment

Special Enrollment

Requires group health plans to provide special enrollment rights upon the occurrence of certain events *(not required for HIPAA-excepted benefits)*

Loss of other
coverage

Employer group health coverage or other
health insurance

Eligibility for
state premium
subsidy/loss of
CHIP or
Medicaid

Become eligible for assistance under
Medicaid or CHIP/Loss of Medicaid, CHIP

Acquisition of a
new spouse or
dependent

Marriage, birth, adoption, or placement for
adoption

Overview

HIPAA Privacy and Security

Privacy Rules

- Privacy rules limit how a “covered entity” may “use and disclose” “protected health information” (PHI)

Security Rules

- Security rules extend protections to “electronic protected health information” (ePHI)

HIPAA Privacy and Security

HIPAA Applies to Covered Entity

Covered Entity =

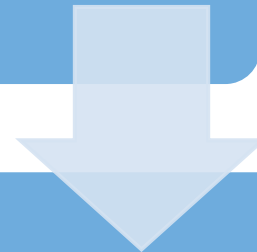
- Health plan, including group health plan sponsored by employer
- Health care provider who electronically transmits health information in connection with a HIPAA standard transaction (claims, benefit eligibility, etc.)
- Health care clearinghouse
- NOT a business associate, but many HIPAA requirements apply directly to business associate
- NOT employer/plan sponsor, BUT if receives PHI (other than summary health information for purposes of obtaining premium bids or modifying, amending or terminating plan, or enrollment/disenrollment information) must agree to protect PHI

HIPAA Privacy and Security

Business associates and employers

Gallagher is a business Associate

- We enter into business associate agreement (BAA) requiring us to comply with HIPAA



Employers are not covered entities and are not directly subject to HIPAA

- BUT if the employer wants to use or receive PHI, it must agree to protect the information and put a number of safeguards in place

HIPAA Privacy and Security

PHI and ePHI



What is Protected Health Information (“PHI”)?

Any individually identifiable health information

Created, received, or maintained by or on behalf of a Covered Entity, such as an employer-sponsored health plan, that relates to:

- the past, present, or future mental/physical health of an individual (including provision for healthcare and payment for healthcare)

“Individually Identifiable” - identifies the individual OR there is a reasonable basis to believe the information can be used to identify the individual

Electronic Protected Health Information (“ePHI”):

Any protected health information (PHI) that is transmitted or maintained in electronic material

- **Including:** storage material (hard drives), removable digital memory, magnetic tape, memory card, transmission media (internet, private networks, intranet)

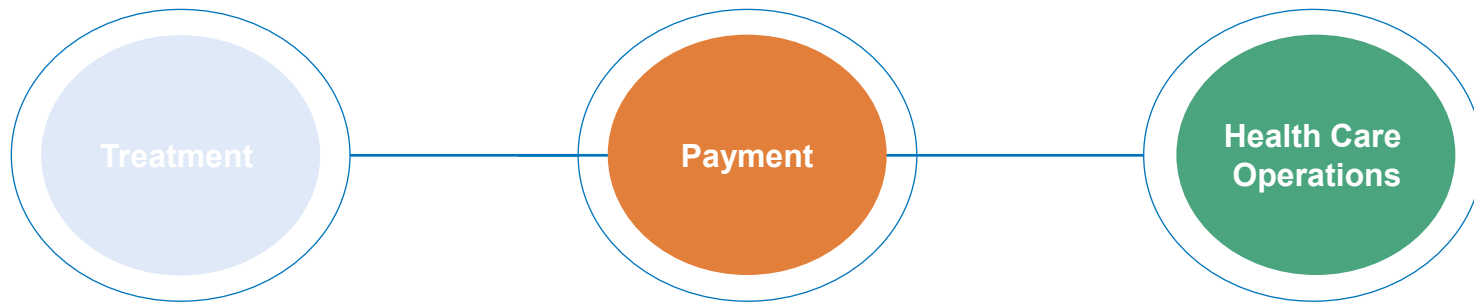
Tip!

PHI can exist in multiple formats: oral, written, and electronic (ePHI).

HIPAA Privacy and Security

How Plan May Use and Disclose PHI

The use and disclosure of PHI is generally prohibited unless otherwise permitted in the rules. Uses and disclosures of PHI are permitted for:



Providing care by health care providers

Billing, resolving payment disputes, determine or fulfill responsibility for coverage, provide reimbursement

Care coordination, case management, quality assessment, underwriting, premium rating, and other activities relating to renewal

Generally, must limit use or disclosure to “minimum necessary”

HIPAA Privacy and Security

Administrative responsibilities

Determine extent to which HIPAA applies

- Fully insured plans where employer has no access to PHI have limited responsibilities (rare)

Create written HIPAA Policies and Procedures

Designate HIPAA Privacy and Security Officer

Conduct workforce training

Create and distribute HIPAA Notice of Privacy Practices

Perform risk assessment

Evaluate breaches of PHI and report if required

Document compliance activity

Establish procedures whereby individuals may provide HIPAA complaints

Establish system for sanctions for employees who violate HIPAA

Mitigate any harmful effect on HIPAA violations

Keep logs of improper disclosures

Communicate and allow employees to exercise HIPAA rights

PA 152 and PA 106

7

Public Act 152

What it is and why employee contributions are affected

PA 152 limits the amount a Michigan public employer may contribute toward employee medical benefit plan costs.

1

Annual medical plan cost

Premiums and other eligible medical benefit plan costs are identified.

2

PA 152 method

The district applies either the Hard Cap or the elected 80/20 option.

3

Employee contribution

Employees fund the portion not paid by the district, subject to bargaining and allocation decisions.

80/20 OPTION

- District contribution is limited to 80% of total annual medical benefit plan costs.
- Employees collectively fund at least 20% of total annual costs.
- Because compliance is measured in total, an individual employee contribution may not equal exactly 20%.

HARD CAP

- District contribution is limited to a state-set annual dollar amount.
- The calculation uses the number enrolled in single, two-person and family coverage.
- Employees fund plan costs above the amount paid by the district.
- District has the freedom to negotiate limits below the state-set annual dollar amounts.

Key takeaway: 80/20 is percentage-based. Hard Cap is dollar-based.

The decision to use either the 80/20 option or Hard Cap is made by the District and is not a negotiated benefit. Neither method automatically guarantees a lower employee contribution.

Public Act 152: Hard Cap vs. 80/20

2026 and 2027 State of Michigan annual Hard Cap limits

Coverage Tier	2026	2027	Increase
Single	\$7,942.09	\$8,180.35	3.0%
Individual + Spouse / 1 Dependent	\$16,609.38	\$17,107.66	3.0%
Family	\$21,660.30	\$22,310.11	3.0%

How the Hard Cap is calculated: Each annual tier amount is multiplied by the district's enrollment in that tier. The amounts are added together to determine the district-wide maximum employer contribution.

Illustrative employee impact

Example: Annual family medical plan cost = \$24,000

80/20 Option

\$19,200 District

\$4,800 Employee

2026 Hard Cap

\$21,660.30 District Maximum

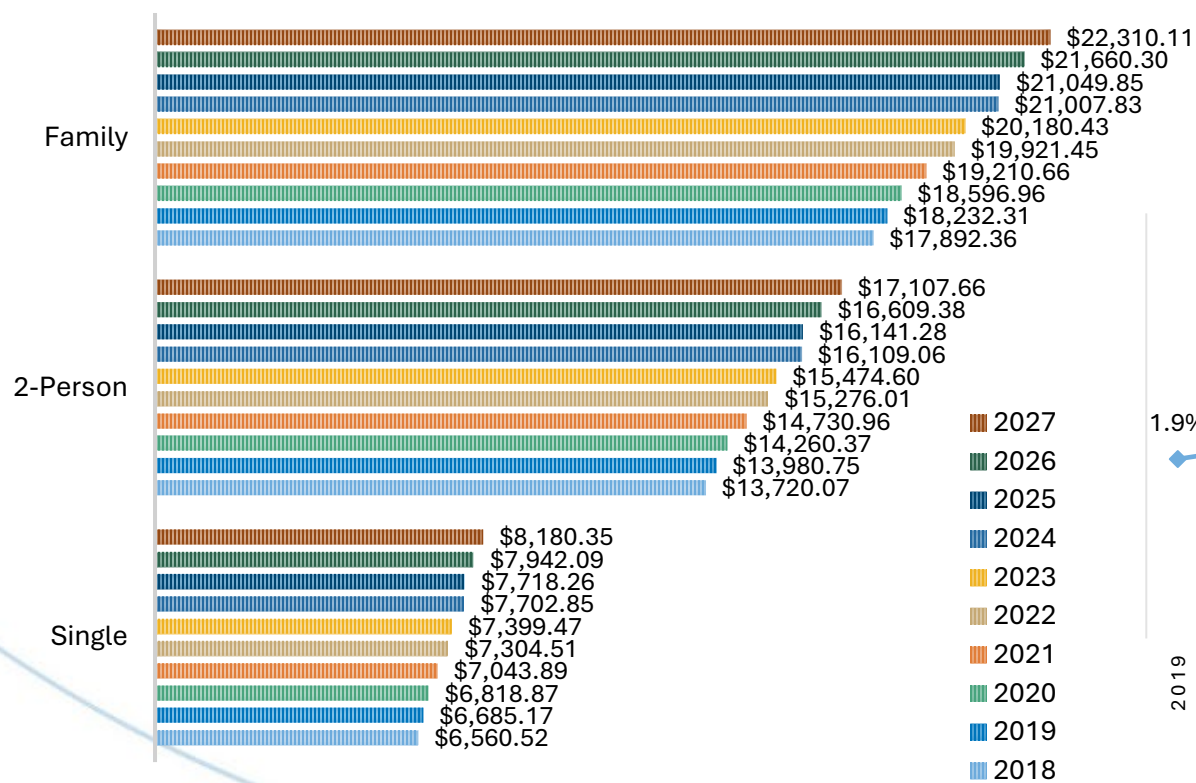
\$2,339.70 Remaining

What changes the result? Actual plan cost, enrollment by coverage tier, district contribution allocation, and collective bargaining provisions.

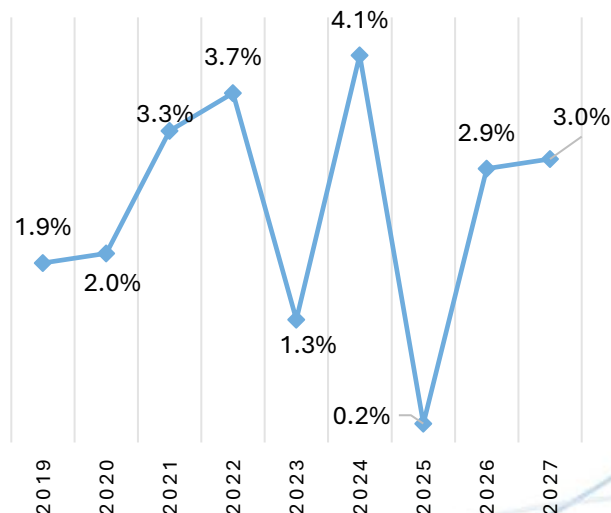
Important: The example is simplified for education. Hard Cap compliance is calculated across the covered population, and the district may allocate contributions differently.

Michigan Public Act 152

- Public Funded Health Insurance Contribution Act – pending new legislation
- Employer hard caps established by PA152 are noted below



CAP INCREASE AT RENEWAL



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Public Act 106 (Medical, Dental and Vision Bidding)

Overview

What is PA 106?

The state of Michigan's Public Act 106, otherwise known as the Public Employers Health Benefit Act, was enacted in 2007 to require public employers that provide health coverage or benefits for their employees to solicit at least four bids when the benefit plan is established. At least one of those bids must be from a Voluntary Employees' Beneficiary Association (VEBA).

What are the requirements?

The Act requires that public employers engage in a similar bidding process every three years when renewing or continuing a benefit plan.

Note: Full details regarding Public Act 106 can be found here: [mcl-act-106-of-2007.pdf \(mi.gov\)](https://www.michigan.gov/mcl-act-106-of-2007.pdf)

Transparency Posting



Departments

Business/Finance

Budget Transparency

Board Approved Budget

Personnel Expenditures

Current Operating
Expenditures

Current Bargaining
Agreements

Employer Sponsored Health
Care Plans

Audited Financial
Statements

Medical Benefit Plan Bids

Procurement Policy

Expense Reimbursement
Policy

Accounts Payable Check
Register – or – Statement of
Reimbursed Expenses

Employee Compensation

District Paid
Association Fees

District Paid Lobbying Costs

Approved Deficit
Elimination Plan

District Credit Card
Information

Questions?

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