IGP

IGP Country Profile

United States

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Customary employee benefits

Death benefits

Employee group life insurance plans commonly include an earnings-based schedule. A typical benefit paid for by an employer would be one- or two-times annual salary. Often there is also an optional employee-pay-all extra amount.

Basic life

The traditional plan for providing employee group term life insurance coverage calls for the payment of a fixed sum on the death of an employee. Earnings based schedules are more common than flat amount schedules, with a relatively common or "basic" schedule providing a benefit equal to two times' annual salary. The flat amount schedule can fluctuate based on union bargaining agreements, employee classification, hourly wage, years of service, etc. These benefits are usually offered on a non-contributory basis by the employers.

In addition to the basic group term life benefits, optional amounts can be offered in further increments of salary and are frequently 100% paid for by the employee and, therefore, purchased on a voluntary basis.

Accidental death and dismemberment (AD&D)

Accidental Death and Dismemberment benefits may be equal to the basic life benefits. Voluntary AD&D benefits are also available, typically providing additional amounts of coverage on an employee-pay-all basis.

Settlement option programs

These programs, similar to Bank Money Market and Certificate of Deposit products, typically offer employee group life beneficiaries a timely and valuable financial service in order to manage their insurance proceeds.

Accelerated benefits

Accelerated Benefits are offered with the group life plan, providing payment of a portion of the life insurance benefits prior to an insured's death. A terminal illness or a determined need for long-term care is usually the condition for eligibility.

Group Universal Life (GUL)

GUL offers a face amount of coverage with the ability for participants to put money in a fund that earns a fixed rate of interest.

Group Variable Universal Life (GVUL):

GVUL offers a face amount of coverage with the ability for participants to put money in a fund that contains a fixed interest rate and variable investment options.

Spouse benefits

Most states permit Dependent Life benefits to be offered with the employee as beneficiary. The most prevalent benefit amount for a spouse is USD 5,000 and USD 2,000 for a dependent child.

Waiting period

Generally, there is not a waiting period to file a death claim on group life insurance benefits.

Survivors' benefits

Spouse's pension

Survivor Income Benefits (SIB), (also known as Widows' and Orphans' Benefits) are available, but much less frequently purchased. Instead of defining the insurance benefit in terms of a lump-sum, SIB defines the benefit as a specified amount of monthly income payable for a specified period to survivors of deceased employees.

Maximum family benefit

Maximum Family Benefit can vary between 150-180% of the deceased worker's benefit amount. The rules are complex and affect beneficiaries in different ways, depending on their earnings levels and benefit types.

Medical benefits

Indemnity programs

In a comprehensive plan, the deductible and co-insurance features are usually applied without differentiation between "basic" and "supplementary" expenses, as discussed below.

A base plan may provide a benefit for hospital room and board, surgical benefits, in-hospital medical services, and laboratory fees and x-rays.

A supplementary plan may provide additional coverage. Under health care reform these plans must offer some additional benefits (such as preventive care) unless grandfathered .

Managed care

Managed care is widely used to control over-utilization of benefits and health plan costs. Although managed care takes on many forms, typically, a partnership is formed with the employer, utilizing various flexible plan design features, network alternatives such as Health Maintenance Organizations and Preferred Provider Organizations, and cost containment and utilization review programs in order to provide the best quality health plan while achieving management over costs.

- Health Maintenance Organizations (HMOs) provide comprehensive health care services for their members for a fixed periodic payment. Benefits are typically only paid for services rendered within the HMO provider network. A primary care physician gatekeeper refers members to specialist care or hospitalization when appropriate.
- Preferred Provider Organizations (PPOs) provide health care "at a discount" through a network of participating physicians and hospitals. Members may use providers outside the network at a higher cost, and referrals to specialist care generally are not required. PPOs are the most common type of plan offered by employers.
- Point-of-Service (POS) programs blend aspects of both HMOs and PPOs. Like an HMO, participants select a primary care physician, but like a PPO, participants may use an out-of-network provider for health services (at a higher cost).

Consumer-directed health plans

Consumer-directed health plans provide health care services for their members generally by combining high-deductible health plans and enhanced information about quality of care with employer- and/or employee-funded pre-tax health savings accounts (HSAs) or other funding mechanisms. HSAs are individual accounts that allow employees participating in qualifying high-deductible health plans to make or receive tax-free contributions and receive tax-free distributions, if used to pay for qualified medical expenses.

Other health benefits

Includes the following:

- **Dental**
  Dental services include preventive care, restorative care, diagnostic and therapeutic services, and supplementary services that include prosthodontic services and/or orthodontic services. In a comprehensive plan, benefits are based on reasonable and customary charges within a particular geographical area. Cost sharing may include a deductible (USD 50 for individual coverage or USD 150 for family coverage) and co-insurance. Preventive care is typically excluded from cost sharing by design (and in some cases federal mandate).
- **Prescription Drug Plans**
  Benefits for prescribed drugs and medicines can be provided on a service basis at the time the prescription is obtained. A co-payment or co-insurance by the covered individual for each prescription is usually required. Co-payments in a typical 3-tier retail design average about USD 11 for generic medications, USD 35 for preferred brand-name drugs, and USD 62 for non-preferred brand-name drugs. Employees using mail order pharmacies have lower co-pays.
- **Vision Care**
  Pays for eye exams, corrective lenses, and frames in an amount up to the actual fee, but not in excess of the schedule of benefits. Vision care may also consist of discounted fees for using selected providers.
- **Mental Health and Substance Use Disorders (Behavioral Health Benefits)**
  While the majority of employers continue to provide mental health and substance use disorder (MH/SUD) benefits through their

medical plans, some employers have carved out behavioral health benefits from their medical plan and provide them through a separate plan. Federal law requires that, if offered, mental health benefits have parity with surgical/medical benefits in cost sharing and other aspects.

- **Employee Assistance Programs (EAPs)**
  Employee assistance programs provide support for employees' work-related or personal problems. Most employers who offer EAPs contract with a separate vendor to provide services, which typically include short-term counseling and referrals.
- **Health promotion programs**
  There has been a strong trend toward promoting consumer health and well-being. In typical health promotion programs, insurance carriers work with clients (employers) to improve employee health and change behavior, e.g., through blood pressure screening, diabetes screening, tobacco cessation campaigns, exercise programs, weight control, and nutrition programs. When designing health promotion programs, employers should consider legal parameters, including applicable federal and state insurance laws.
- **Flexible benefits**
  Flexible benefits (also referred to as cafeteria plans) are commonly offered by employers. Design of such plans varies, of course, but most companies provide a core of basic benefits. The employee, in addition to the core benefits, may have a flexible benefits allowance which he or she may use to purchase other optional forms of benefits, including a richer health plan, additional amounts of life insurance, additional vacation days, child day-care, etc.
- Long-Term Care: Long-term care insurance is designed to offer protection against the potentially catastrophic costs of long-term care, beyond the limited coverage offered by Medicare and private health insurance. It is designed to cover care in a nursing home or home- or community-based setting, helping with the activities of daily living (i.e., eating, bathing, dressing, etc.). Coverage is available as individual policies, association group policies, and employer-sponsored group policies.

A typical group plan might provide for 100% reimbursement up to a selected maximum daily benefit (e.g., USD 150 for nursing home and USD 100 for home services). As premiums are age-based, individuals who sign up at an earlier age (in their forties, for instance) would pay lower premiums.

Eligibility

The private sector has typically assumed the role of offering health coverage to employees and their families. A very broad spectrum of health insurance products with various benefit levels and corresponding costs has evolved to suit geographical areas and differing industrial needs. Many larger employers self-fund their health plans or portions of them, often with stop-loss coverage. A comprehensive health care reform law enacted in 2010 continues to influence this landscape.

Additional information

Health and welfare benefit plans

The private sector has typically assumed the role of offering health coverage to employees and their families, particularly for people who are not eligible for Medicaid, a public program for low-income individuals. A very broad spectrum of health insurance products with various benefit levels and corresponding costs has evolved to suit geographical areas and differing industrial needs. Continued interest by the current administration, policymakers, and advocates in replacing or reshaping a 2010 health care reform law is expected to influence this landscape.

In addition to ERISA requirements, other federal laws also apply to employee benefits (particularly health plans), including portions of the Internal Revenue Code. While historically health and welfare benefits have been less regulated by federal law than retirement benefits, the landscape has changed for health benefits – most significantly by the 2010 passage of federal health care reform, known as the Affordable Care Act (ACA).

Disability

Short-term disability is commonly offered to all employees and is mandatory in a few states (California, Hawaii, New Jersey, New York, Rhode Island, and the US territory of Puerto Rico). The benefit can be a percentage of earnings or a flat amount. A typical short-term disability period is 13-26 weeks. Short-term disability may be self-funded or insured.

Long-term disability coverage is not as common as short-term disability coverage, but is a popular benefit, particularly for salaried employees. The benefit period usually extends to age 65 with benefits based upon a percentage of the employee's monthly earnings and is often written in conjunction with short-term disability coverage (if insured).

Waiting period

Generally, an employee will be required to satisfy a waiting period before disability benefits will begin being paid. During the waiting period, employees are likely to use sick leave, vacation, or personal leave. If an employee is collecting disability benefits and the duration of the disability exceeded the limits of the short-term policy, the employee would probably begin collecting under a long-term disability plan (if offered) or benefits would terminate.

Retirement

Benefits

Presently, nearly 710,000 qualified defined benefit and defined contribution plans are in force in the United States . Over the past several years, almost all new plan formations have been defined contribution, so now defined contribution assets exceed defined benefit assets.

A defined benefit (DB) pension plan is an arrangement in which the employee accrues a benefit payable in the form of an annuity at the employee's normal retirement date. The benefit may be a percentage of career/final average salary or a flat dollar amount and may also be related to years of service.

Under defined benefit pension plans, certain vested accrued benefits are guaranteed by a governmental agency, the Pension Benefit Guaranty Corporation (PBGC). The PBGC's maximum guaranteed benefit for a single life annuity for 2023 is USD 81,000 annually at age 65. This federal insurance program is funded by plan sponsors (employers) through premiums paid on a per-participant basis plus additional premiums based on the adequacy of plan funding. In addition, minimum yearly employer contribution requirements apply to defined benefit plans, which are prescribed and monitored by the government with the intent of minimizing the under-funding of these plans.

A **cash balance plan** is a type of defined benefit plan in which the employee accrues a benefit in the form of a hypothetical account balance. An employee's account balance is credited with employer allocations and investment earnings determined under a formula selected by the employer and stated in the plan. These plans are considered defined benefit arrangements because (a) the allocation and the guaranteed credits are fixed by the plan's formula, and (b) investment gains or losses accrue to the plan, not the participant.

A **defined contribution (DC) plan** provides for the deposit of contributions made by the employee, employer, or both in individual accounts for employees. An employee's benefit is equal to the value of the individual account, which will vary based on investment income, gains and losses, expenses, employer contributions and any employer forfeitures on account of other participants (non-vested portions) that may be reallocated to active participants.

401(k) plans, named for the corresponding section of the Internal Revenue Code, have become the most popular form of defined contribution plan in the US. Participants in a 401(k) plan elect to contribute a percentage of their own salary to a plan generally on a pre tax basis (401(k) plans also are known as "cash or deferred arrangements" for this reason). Alternatively, some plans automatically enroll employees at a set percentage that they may opt out of or change. The employer typically matches some portion of the employee's contribution; for example, a 50% match on the first 6% of the compensation an employee contributes is a common formula.

Eligibility

DB and Cash Plans: Generally, a plan requires a person to reach at least age 21 to be eligible to participate in the plan and to have a year of service.

The IRS requires employers to allow employees to be able to join a DC plan if they are 21 years old and have a year of service completed.

Additional information

The federal government has played a key role in the development of private pension and profit sharing plans since the 1920s, but it was not until 1974 that comprehensive regulation of private plans came into existence with the passage of the "Employee Retirement Income Security Act of 1974" ("ERISA").

ERISA imposes numerous and significant requirements on employer-sponsored benefit plans, including those that provide retirement, health and other types of welfare benefits. As a rule, private employers don't have to offer employees any of the benefits subject to ERISA, but to the extent they do, they must comply with ERISA's terms. ERISA generally preempts state law relating to employee benefit plans, although ERISA preemption does not apply to insurance policies (as opposed to self-funded benefit plans).

Retirement benefit plans

In addition to ERISA requirements, Section 401 of the Internal Revenue Code, as amended, sets forth numerous requirements that plans must meet to be tax-qualified plans to which special tax advantages are available. A plan must be established by the employer for the exclusive benefit of employees and their

beneficiaries, assets of the plan must be maintained under a trust agreement or an insurance company group annuity contract, and the plan must be a definite, funded and written program that is communicated to employees.

Plans must satisfy requirements related to employee eligibility, vesting of contributions, in-service withdrawal restrictions, distributions, spousal protections, participant notifications, funding levels (defined benefit plans), and must not discriminate in favor of highly compensated employees.

Financial accounting standards applying to post-retirement and other post - employment benefits

Private sector employers preparing financial statements under US Generally Accepted Accounting Principles must account for pensions, retiree medical, retiree life insurance and any other post-retirement benefits on an accrual basis that recognizes the cost over the service period of the participants, rather than on a cash basis or other basis. In addition, employers must account for most post-employment benefits (such as long-term disability benefits) on an accrual basis.

These employers must recognize on their balance sheets the net funded status of the post-retirement and other post-employment benefit plans that they sponsor, even if the plan is unfunded. For multi-employer plans (plans providing collectively bargained benefits to employees of more than one employer), employers do not recognize the net funded status on the balance sheet or determine an expense on an accrual basis, but just disclose the cash paid to the organization sponsoring the plan.

Retiree health and other non-pension post-employment benefits offered by state and local government employers are subject to rules of the Governmental Accounting Standards Board (GASB). GASB has recently changed its financial accounting and reporting standards to require governmental employers to report net liabilities and costs under a different approach than that required for private-sector employers.

Legislative news

Retirement legislative developments

(as of April 2023)

Department of labor fiduciary rule

The Department of Labor (DOL)'s 2016 investment advice fiduciary rule was invalidated as regulatory overreach by the US 5th Circuit Court of Appeals in 2018. The court's decision effectively reinstated the DOL's original 1975 investment advice fiduciary rule.

The 1975 rule defines an investment advice fiduciary more narrowly than the nullified 2016 rule to include a person who (i) renders advice or makes recommendations as to the advisability of investing in, purchasing, or selling securities or other property; (ii) on a regular basis; (iii) pursuant to a mutual agreement between the individual and the plan — and the advice (iv) serves as a primary basis for investment decisions with respect to plan assets, and (v) is individualized to the particular needs of the plan.

On June 30, 2020, the Securities and Exchange Commission's (SEC) four 'Regulation Best Interest rules' which are designed to create a unified conflict of interest mitigation standard for all brokers and advisers, not just those working under ERISA took effect. This was preceded by a proposal on June 29, 2020, from the Trump Administration's DOL to replace the defunct 2016 fiduciary rule and allow for exceptions under ERISA to investment advice fiduciaries, provided they act in the best interests of retirement savers.

The proposal is intended to align with the SEC's rules. In a move that took many by surprise, President Biden's DOL allowed the previous administration's directive to become effective in February 2021. However, it is expected that the DOL will continue to build on the rule by adding additional guidance and redefining what is meant by 'fiduciary advice'.

SECURE Act 2.0

The SECURE Act represents retirement security legislation that became law on December 20, 2019. Highlights include allowing long-term part-time workers to participate in 401(k) plans and requiring employers maintaining a 401(k) to have a dual eligibility requirement under which an employee must complete either one year of service (with the 1,000-hour rule) or three consecutive years

of service where the employee completes at least 500 hours of service.

The new "Secure 2.0" - securing a Strong Retirement Act (H.R.2954) was passed by the House on March 29, 2022, with bipartisan support. The measure is intended to build upon the original Secure Act of 2019, which ushered in changes aimed at increasing retirement security. The bill was signed into law by President Biden on December 29, 2022. The key differences in some provisions that could directly affect retirement savers or retirees includes:

- **Auto-enrollment in 401(k) plans**
  The bill that cleared the House would require employers to automatically enroll employees in their 401(k) plan at a rate of at least 3% and then increase it each year until the worker is contributing 10% of their pay. Businesses with 10 or fewer employees, government plans, church plans, and new companies in business for less than three years are among those that would be excluded from the mandate.
- **Catch-up contribution**
  Under current law, retirement savers age 50 or older can make so-called catch-up contributions to their retirement savings. On top of the standard annual contribution limits — $22,500 for 401(k) plans and $6,500 for individual retirement accounts in 2023 — For individuals who are 50 or over, standard catch-up contributions allow an extra $7,500 per year in their 401(k) or $1,000 in their IRA. Both the House and Senate bills aim to expand those amounts, although the specifics differ.

  The House bill would expand the 401(k) catch-up to $10,000 for individuals who are aged 62, 63, or 64 beginning in 2024. The House bill would expand the 401(k) catch-up to $10,000 for individuals who are age 62, 63, or 64 beginning in 2024. Workers enrolled in so-called SIMPLE plans would be allowed $3,500 in 2023 in catch-up contributions, up from the current $3,000. Salary reduction contributions in a SIMPLE IRA plan are not treated as catch-up contributions until they exceed $15,500 in 2023.
- **Required minimum distributions**
  The 2019 Secure Act changed when required minimum distributions, or RMDs, from retirement accounts must begin to age 72 (73 if you reach age 72 after Dec. 31, 2022) rather than from 70½. Under the House-passed bill, those mandated annual withdrawals wouldn't have to start until age 73 in 2023, and then age 74 in 2030 and age 75 in 2033.

  The Senate proposal would raise the RMD age to 75 by 2032. It also would waive RMDs for individuals with less than $100,000 in aggregate retirement savings, as well as reduce the penalty for failing to take RMDs to 25% from the current 50%.
- **Annuities**
  To receive an income stream later in life is a qualified longevity annuity contract, or QLAC. Once an annuity is purchased, an individual must specify when they would want the income to start. However, the maximum that can go into a QLAC is $200,000 or 25% of the value of your retirement accounts, whichever is less.

Contrasting fortunes of the PBGC's single-employer and multi-employer programs

The Pension Benefit Guaranty Corporation (PBGC)'s single-employer and multi-employer programs continue to reflect contrasting financial positions. The single-employer insurance program reported a favorable net position of $36.6 billion at the end of the 2022 fiscal year, an improvement of $5.7 billion, primarily credited to increased premium collections and recoveries from companies formerly responsible for the plans.

By comparison, the multi-employer program recorded a positive net position of $1.1 billion at the end of FY 2022, compared to $481 million at the end of FY 2021, an improvement of $577 million. The Multi-employer Program is financed by premiums paid by insured plans and investment income.

According to the DOL, the multi-employer program remains severely underfunded and is on track to become insolvent by the end of 2026 if action is not taken to repair the program. According to the agency's 2022 annual projections report, the program currently covers approximately 11.2 million participants in an estimated 1,360 multi-employer plans. The report stresses that without legislative changes, the large deficits reported by the multi-employer program are expected to increase over time.

PBGC has made significant progress in implementing the Special Financial Assistance (SFA) Program, established under the American Rescue Plan Act of 2021. The SFA Program provides funding assistance to severely underfunded multi-employer pension plans

and will ensure that millions of America's workers, retirees, and their families receive the pension benefits they earned through many years of hard work. During FY 2022, PBGC paid $7.5 billion in SFA, all of which was paid pursuant to applications approved under the provisions of the interim final rule.

There has already been some movement towards shoring up the multi-employer program, including the enactment of the Butch Lewis Emergency Pension Plan Relief Act of 2021 (S.547), which was signed into law by President Biden on March 11, 2021, as part of the American Rescue Plan Act of 2021 (H.R.1319).

While this law provides financial assistance to eligible multi-employer plans at risk of becoming insolvent, it does not address any structural reforms needed in the PBGC multi-employer program. Instead, the bill provides financial aid by allocating money from the Treasury Department via the PBGC to struggling multi-employer plans.

Rollback of COVID relief packages

Retirement relief measures introduced as part of the CARES Act were largely discontinued at the end of 2020. This Act was introduced to address the economic impacts of the COVID-19 outbreak. It included changes to both defined benefit and defined contribution plans, including allowing employers with defined benefit plans to delay contributions due in 2020 until January 1, 2021, and suspending the RMD rule for 2020.

The American Rescue Plan Act of 2021 ("ARPA") (H.R.1319), which was signed into law in March 2021, contains the Butch Lewis Emergency Pension Relief Act aimed at providing financial relief to struggling multi-employer and single-employer plans. In addition, Congress passed the COVID-Related Tax Relief Act of 2020 (COVIDTRA), which was enacted as part of the Consolidated Appropriations Act of 2021 by President Trump in December 2020. COVIDTRA includes legislation to repackage the Coronavirus Related Distribution (CRD) exception allowed during 2020 as a Qualified Disaster Distribution.

Similar to a CRD, distributions not exceeding $100,000 can be withdrawn from retirement accounts without the 10% penalty. COVIDTRA also extends the measure, which allows retirement savers to borrow up to $100,000 from their 401(k) accounts and to defer payments on the loan in the case of non-COVID disasters, such as hurricanes or wildfires. However, to avail of these measures, individuals must meet the guidance of residing in a qualified disaster area and prove suffering an economic loss due to the disaster.

On April 6, 2022, the U.S. Department of Education (ED) extended the student loan payment pause through Aug. 31, 2022. The student loan payment pause is extended until the U.S. Department of Education is permitted to implement the debt relief program or the litigation is resolved. Payments will restart 60 days later. If the debt relief program has not been implemented and the litigation has not been resolved by June 30, 2023 — payments will resume 60 days after that.

The pause includes the following relief measures for eligible loans:

- A suspension of loan payments
- A 0% interest rate
- Stopped collections on defaulted loans

Once the payment pause ends, students will receive their billing statement or other notice at least 21 days before payment is due. This notice will include their payment amount and due date. In the meantime, students can get an estimate of their payment amount and due date through their loan servicer.

The Retirement Improvement and Savings Enhancement (RISE) Act

The Retirement Improvement and Savings Enhancement (RISE) Act of 2021 (H.R. 5891) 'was introduced in early November of 2021. The RISE Act includes provisions that have been introduced in separate pieces of legislation, including the Securing a Strong Retirement Act, often referred to as "SECURE 2.0," in a reference to 2019's Setting Every Community Up for Retirement Enhancement (SECURE) Act. According to a fact sheet about the RISE Act, the bill would:

- Establish an online, searchable "Retirement Lost and Found" database at the Department of Labor (DOL) to help workers locate their retirement savings as they move from job to job
- Allow 403(b) retirement plans to participate in multiple employer plans (MEPs) and pooled employer plans (PEPs)
- Ensure more part-time workers are offered opportunities to join retirement savings plans

- Clarify rules regarding the recovery of inadvertent over payments to retirees, minimizing hardships
- Enable employers to provide small financial incentives, such as low-dollar gift cards, to incentivize workers' participation in retirement plans; and
- Simplify and clarify reporting and disclosure requirements related to retirement plans.

Health legislation developments

(As of March 2023)

The Affordable Care Act (ACA)

The ACA applies broadly to private and public employers. It imposes various conditions on employer-sponsored plans and assessments on large employers who do not offer coverage to their full-time employees (defined as those averaging 30 or more hours of work per week) if at least one full-time employee gets federal subsidies toward public exchange coverage.

Virtually all individuals living in the US can obtain individual coverage on a guaranteed issue basis, with some qualifying for federal subsidies, in the public exchange established by the ACA.

Key substantive requirements applicable to employer-provided plans include:

- Bans on annual or lifetime limits on "essential health benefits."
- Maximum 90-day waiting periods
- Ban on preexisting condition limitations
- Coverage of children to age 26
- Ban on discrimination based on race, color, national origin, sex, age, or disability in health programs and activities that receive federal funds
- For non-grandfathered plans — annual cost-sharing limitations, required first-dollar coverage for preventive services, enhanced claims and appeal rights, specific emergency service provisions, right to participate in clinical trials

After their efforts to repeal the ACA were unsuccessful, Republican lawmakers successfully abolished the ACA's individual mandate penalty as part of the tax bill they passed in late 2017. As a result, since January 2019, there is no longer a federal penalty for being uninsured. However,

in an attempt to stabilize their health insurance exchanges, states including California, Rhode Island, Massachusetts, New Jersey, Vermont and the District of Columbia impose their own state mandates.

In June 2021, the Supreme Court rejected an appeals court ruling challenging the legality of the individual mandate. A panel of the US Court of Appeals for the 5th Circuit Court ruled in mid-December 2019 that the ACA individual mandate was unconstitutional. It did not, however, determine if the entire ACA was valid. It instead remanded the case back to the District Court to decide whether other parts of the Act could survive without the individual mandate. T

The case was appealed to the US Supreme Court in early January 2020 and was rejected by the court with a 7-2 majority in June 2021. The court ruled that the plaintiffs could not demonstrate any injury resulting from the individual mandate rule and therefore did not have sufficient legal standing to sue. The Supreme Court decision closes out the significant legal challenges to ACA, and in a statement following the ruling, President Biden indicated that it is time to move forward and expand the Act further.

The Biden Administration has made it a priority to continue to strengthen the ACA. President Biden is committed to building on the progress made by the ACA by reducing premiums for the millions of Americans enrolled in Marketplace coverage and closing the Medicaid coverage gap, which would lead to four million uninsured people gaining coverage.

Over 35 million adults are now covered across 40 states (including the District of Columbia) due to Medicaid expansion, though 10 states have not expanded.

Furthermore, they allowed states to expand Medicaid eligibility up to 133% of the Federal Poverty Level ($17,130 for an individual; $35,245 for a family of four) and remove categorical requirements that previously prevented many low-income people from being able to enroll in the program. Medicaid expansion – adopted by 41 states and Washington DC, as of March 2022, has connected people to coverage and improved health outcomes for women of color and families.

Lastly, the Biden Administration recently announced a new Special Enrollment Period (SEP) opportunity for low-income consumers with household incomes under 150% of the Federal Poverty Level who are eligible for premium tax credits under the ACA and American Rescue Plan (ARP), which is approximately $19,000 for an individual and $40,000 for a family of four in 2022.

In states that use the HealthCare.gov platform, 45% of consumers who signed up for health coverage during the 2021 SEP had household incomes under 150% of the Federal Poverty Level. This new SEP will make it easier for low-income people to enroll in Marketplace coverage throughout the year and benefit from the ARP savings.

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA requires organizations working in health care to implement controls to safeguard the protected health information (PHI) of plan participants.

HIPAA decrees that these organizations, known as “covered entities” (i.e., any health care provider, health plan, or health data clearinghouse), comply with newly introduced requirements, including implementing technical, physical and administrative safeguards and conducting six annual self-audits.

These rules also apply to any vendors (known as “Business Associates”) engaged by the covered entity to provide services that involve access to PHI. While a group health plan is considered a covered entity, it is a separate legal entity from the employer offering the plan or other sponsors of the group health plan.

Employers providing health coverage via an insurance policy are therefore not responsible for HIPAA compliance unless their business falls under the definition of a covered entity or business associate. However, most self-funded health plans are subject to HIPAA compliance.

2021 has seen some legislative development regarding HIPAA with an amendment to the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH) enacted in January (H.R.7898 – 116th Congress).

The amendment requires the Department of Health and Human Services (HHS) to assess the use of recognized security practices by a covered entity or business associate in the case of resolving potential violations, evaluating fines, and conducting audits. It is also

expected that following a relaxation of President Biden's Regulatory Freeze Pending Review, several proposed regulations, which include amendments to HIPAA requirements, will advance.

The U.S. Department of Health and Human Services' (HHS) Office for Civil Rights (OCR) published a Notice of Proposed Rule Making (Proposed Rule) on April 12, 2023, proposing amendments to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to strengthen privacy protections for reproductive health information and privacy.

Employee Retirement Income Security Act (ERISA) Covered Plans

ERISA applies to employer-sponsored health coverage, life and disability insurance, some severance plans, and other types of welfare benefit plans. But some plans are not covered by ERISA, including, for example, plans maintained by federal, state, and local governments and most church plans.

ERISA imposes numerous requirements related to plan documents, administration, and duties of plan fiduciaries. Required reporting includes annually filing Form 5500 with the US Department of Labor (DOL), although some plans are exempted. Numerous disclosure requirements to plan participants and beneficiaries also apply to ERISA plans.

Enhanced procedures for ERISA disability claims and appeals took effect in April 2018. The DOL rule extends to ERISA disability claims procedural protections similar to ACA standards for health plans. In March 2019, a judge in the District of Columbia found major provisions in a proposed DOL rule modifying the definition of "employer" under ERISA to expand the availability of association health plans (AHPs) to be unlawful.

The rule's interpretation to make it easier for small businesses and "working owners" to form employer groups or associations that offer large group health plans exempt from some requirements (such as covering certain "essential health benefits" and community rating rules) that the ACA imposes on the small group and individual markets were deemed to have unreasonable interpretations of ERISA.

The modified employer definition would apply only to health benefits and would not change prior guidance on other ERISA benefits. On April 26, 2019, the DOL filed a notice of appeal to the court's ruling, with the first oral arguments heard in November 2020.

Internal revenue code requirements

The Internal Revenue Code has provisions applying to certain types of health and welfare plans, including some not subject to ERISA. For example, under IRS nondiscrimination rules, some health and welfare plans (e.g., self-insured health plans, group term life insurance, cafeteria plans, and dependent care assistance plans) receive tax-favored treatment only if provided to a broad segment of employees that includes adequate representation of the non-highly paid. Nondiscrimination rules also will apply to insured group health plans if the Internal Revenue Service releases guidance.

Other federal mandates applying to employer group health plans

Numerous other federal mandates apply to most employer-sponsored health coverage:

- Special enrollment rights if other coverage is lost or new dependents are gained
- Required parity between mental health and substance abuse benefits and medical/surgical benefits
- Detailed rules to ensure wellness programs do not discriminate against those with adverse health factors
- Other health status nondiscrimination, including genetic nondiscrimination
- Privacy and security standards

A number of these and other federal mandates have disclosure requirements.

As the opioid crisis continues to garner the attention of lawmakers, there is a renewed focus on mental health and substance abuse benefit parity and a promise of increased enforcement in employer-sponsored plans.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) levied equality for mental health and substance use services to prohibit group plans from imposing less favorable limits than those set for physical health conditions. However, implementation across group plans has been mixed, and there

has been evidence of "discriminatory practices" regarding non-quantitative treatments.

The DOL can require employers to reimburse their employees for parity violations on self-funded insurance plans but currently cannot act against the insurance company itself. The Consolidated Appropriations Act, 2021 (CAA) (H.R.133 – 116th) included a provision to expand the compliance requirements under MHPAEA to guarantee equal coverage limits for mental health and substance use disorder benefits and medical and surgical benefits. Employer-sponsored group health plans must monitor their compliance with MHPAEA, with the DOL releasing an online self-compliance tool to help plan sponsors and administrator's complete compliance audits.

Group health plans are also subject to broader federal laws prohibiting discrimination, such as Title VII (which prohibits workplace discrimination on the basis of race, sex, religion and certain other protected categories); the Americans with Disabilities Act (ADA), the Genetic Information Nondiscrimination Act (GINA); and the Age Discrimination in Employment Act (ADEA). Compliance with ERISA, the ACA and other mandates specific to health plans does not necessarily ensure compliance with these broader laws.

Separately, the Equal Employment Opportunity Commission (EEOC) (the agency that enforces the ADA, GINA, and Title VII, among other federal laws) and plaintiffs asserted that Title VII's ban on sex discrimination extends to discrimination based on sexual orientation, race, color, religion or gender identity. In June 2020, the Supreme Court ruled in favor of the plaintiffs of three cases involving individuals who alleged unfair dismissal from their employment due to their LGBT status.

The judges cited that federal law prohibits discrimination based on sex, including an individual's sexual orientation and gender identity. The Equality Act (HR 5) would update civil rights legislation to protect individuals' sexual orientation and gender identity in the same manner as race, sex, religion, and national origin.

Newborns and Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act of 1996 introduced Federal legislation which prohibits health insurance plans offering maternity coverage from restricting benefits for hospital stays following childbirth to less than 48 hours after a normal birth delivery (96 hours in the case of a cesarean section).

Every group plan which provides maternity or newborn coverage must provide a disclosure notification of these rights to the plan beneficiaries. It should be noted that many states have enacted their own version of the law regulating coverage for mothers and newborns, which may differ slightly from federal law and, in some instances, may supersede federal requirements.

A newborn is covered under the mother's policy and deductible for just the first 30 days following birth. However, under the ACA, a birth is deemed a qualifying life event. It triggers a 60-day special enrollment period allowing for an application or change request for health insurance coverage to enroll the infant.

COBRA

The "Consolidated Omnibus Budget Reconciliation Act of 1985" (COBRA) requires that most employers sponsoring group health plans offer employees and their dependents continued health care coverage in certain circumstances, such as termination of employment or divorce, when coverage under the plan would otherwise end. This federal law applies to employers with 20 or more employees, including self-insured employers.

The continuation period ranges from 18 to 36 months, depending on the event. A plan, however, may provide longer periods of coverage beyond the maximum period required by law. In the event of unemployment, the cost of COBRA coverage is borne by the individual, with no contribution from the employer.

Although COBRA and its associated compliance obligations remain in effect, the availability of individual coverage through the public exchange may reduce the number of individuals electing COBRA.

As part of the American Rescue Plan Act of 2021 (ARPA) (H.R.1319), a 100% premium COBRA subsidy and additional COBRA enrollment rights were introduced for 'assistance eligible individuals' (AEIs), which includes individuals who were affected by an involuntary termination or a reduction in work hours.

Between April 1, 2021, and September 30, 2021, group health plans offering COBRA coverage are required to offer AEIs and their beneficiaries a 100% subsidy of COBRA premiums.

The premium is covered by either the plan or the employer and will be reimbursed through a refundable credit against payroll taxes. In addition, individuals who have previously opted out of COBRA or who had previously dropped out of coverage must be notified by employers of the opportunity to opt back in. The maximum eligibility period of COBRA can extend to 36 months under certain qualifying events, meaning that employers will need to notify individuals who became eligible for coverage from April 1, 2018, to guarantee compliance with ARPA.

Legal clarity pending for employer wellness plans

In 2016, the American Association of Retired Persons (AARP) sued the EEOC over their assertion that employers with wellness plans could offer the higher incentives permitted by the ACA and request family members provide certain medical information without violating the ADA or GINA.

In December 2018, the EEOC reversed its prior stance by vacating the incentive provisions of its final wellness program regulations, effective from January 1, 2019. The current law does not expressly prohibit or permit offering incentives to participate in a wellness program. However, employers need to structure their wellness programs to ensure compliance with the EEOC rules, with awareness around incentives subject to ADA or GINA.

On January 7, 2021, the EEOC released new Notices of Proposed Rulemaking for wellness incentives under ADA and GINA. The rules state that employers may not offer more than a minimum incentive (such as a gift card of modest value) to encourage employee participation in voluntary wellness programs if those programs collect personal medical data of the employee through disability-related inquires or medical exams.

An exception to this is a health-contingent wellness program that either qualifies as or is part of a group health plan. Under the ADA safe-harbor rule, group health plans can provide incentives of up to 30% cost of coverage (50% for tobacco cessation programs) if the plan complies with HIPAA requirements. In addition, wellness programs that do not require disability-related inquires or medical exams are exempted from the proposed rule.

However, the EEOC's Notices of Proposed Rulemaking were suspended on January 20 by the Biden Administration as part of the regulatory freeze until the newly appointed EEOC chair reviews and approves the proposals. As a result, the EEOC formally withdrew the recommendations from the Federal Register. Yet, there is no

indication if the proposals will be finalized in their original state or if they will be subject to revision.

Health Savings Accounts (HSAs) see growth

According to Devenir Research, with more than 35.5 million health savings accounts holding nearly $104 billion in assets, a year-over-year increase of 6% for assets and 9% for health savings accounts for the period ending December 31, 2022, HSAs and their place in the market have continued to evolve at a rapid clip.

Additionally, as of the end of January 2022, participants saved more than $100 billion in over 33 million HSAs. Employee/Account holder contributions increased to $47 billion in 2022 (up 11% from the year prior Employee contributions increased, with the average balance in an HSA account rising by 13%.

While there is currently insufficient data to determine how much the pandemic played a role in the growth of contribution levels, many employees deferred non-essential medical care during this period which likely influenced the accrual of account assets.

Devenir currently projects that the HSA market will approach 43 million accounts by the end of 2025, holding almost $150 billion in assets.

The Health Savings Act of 2021 (S.380), introduced in February 2021, aims to expand consumer opportunities to participate and contribute to HSAs. The act proposes to:

- Eliminate the annual limit on tax-deductible contributions to HSAs by individuals and their employers
- Eliminate the requirement to be enrolled in a high-deductible health plan to make tax-free contributions to HSAs
- Expand qualified medical expenses
- Permit administrative, clerical or payroll contribution error corrections on or before the last day to file taxes
- Allow the tax-free transfer of an HSA to the family after the account holder's death.
- Ensure HSAs receive equivalent bankruptcy protections as retirement funds.

This bill modifies the requirements for health savings accounts (HSAs) to:

- Rename high deductible health plans as HSA-qualified health plans
- Allow spouses who have both attained age 55 to make catch-up contributions to the same HSA
- Make Medicare Part A (hospital insurance benefits) beneficiaries eligible to participate in an HSA
- Allow individuals eligible for hospital care or medical services under a program of the Indian Health Service or a tribal organization to participate in an HSA
- Allow members of a health care sharing ministry to participate in an HSA
- Allow individuals who receive primary care services in exchange for a fixed periodic fee or payment, or who receive health care benefits from an on-site medical clinic of an employer, to participate in an HSA
- Include amounts paid for prescription and over-the-counter medicines or drugs as qualified medical expenses for which distributions from an HSA or other tax-preferred savings accounts may be used
- Increase the limits on HSA contributions to match the sum of the annual deductible and out-of-pocket expenses permitted under a high deductible health plan; and
- Allow HSA distributions to be used to purchase health insurance coverage.

The bill also (1) exempts HSAs from creditor claims in bankruptcy, and (2) reauthorizes Medicaid health opportunity accounts.

The bill allows a medical care tax deduction for (1) exercise equipment, physical fitness programs, and membership at a fitness facility; (2) nutritional and dietary supplements; and (3) periodic fees paid to a primary care physician and amounts paid for pre-paid primary care services.

Paid family leave

The Family and Medical Leave Act (FMLA), which has been in place since 1993, allows eligible employees of covered companies to take up to 12 weeks of unpaid leave each year for illness or injury, care of a family member, and for the birth, adoption or foster care of a child, or military deployment of a family member. FMLA covers employers with at least 50 employees within 75 miles.

Employees may become eligible if they worked at least 1,250 hours for a covered employer during the 12 months prior to the leave period commencing. However, a report from the DOL showed that up to two-thirds of eligible employees could not afford to take unpaid leave. In addition, the definition of family under FMLA is narrow, encompassing spouses, parents, and children under 18 only.

Thirteen states and the District of Columbia have enacted paid family leave (PFL) laws: California, Connecticut, the District of Columbia, Massachusetts, New Jersey, New York, Rhode Island, Virginia, and Washington have laws in effect; Colorado, Delaware, Maryland, New Hampshire, and Oregon enacted laws not yet in effect.

Of these, Colorado and Oregon are yet to bring into effect the paid family leave program. A PFML policy is scheduled to begin September 3, 2023, in Oregon and January 1, 2024, in Colorado.

Recently in 2023, two more states namely New Hampshire and Vermont passed its approval to a Paid Family Leave bill, however both of these states have a voluntary paid family leave system.

Other states, such as Missouri and South Carolina, are currently considering legislation that would provide paid family leave only for government employees. On April 5, 2023, The South Carolina House unanimously approved a bill allowing teachers or other school district staff up to six weeks of paid leave when they give birth or adopt a child.

In 2021, North Dakota passed legislation banning cities and counties from enacting local paid family leave legislation.

In April 2021, President Biden put forward the American Families Plan to Congress for consideration. The plan includes a measure to create a national comprehensive paid family and medical leave program, phased in over ten years. The program would guarantee 12 weeks of paid parental, family, and personal illness/safe leave by the tenth year, paying workers up to $4,000 a month, with a minimum of two-thirds of average weekly wages replaced, rising to 80% for the lowest wage workers. It would also ensure that employees would receive three days of bereavement leave per year starting in the program's first year. This plan would be funded by tax increases for the top 1% of income earners and increased capital gains and dividend tax rates for those who earn over $1 million per year.

The Building an Economy for Families Act was also proposed in April. This plan would provide up to 12 weeks of paid family and medical leave for all workers, replacing up to two-thirds of the employee's wages. In addition, eligibility would be extended to individuals not covered under FMLA, including part-time employees and gig workers. The act also broadens the definition of family to include domestic partners, adult children, siblings, grandparents, grandchildren and any other association by blood or affinity that is equivalent to a family relationship.

An additional piece of legislation, the Healthy Families Act (S.1195), would allow employees in a company with 15 or more workers to accrue up to seven paid sick leave days per year or 56 hours of paid sick time to address their own health needs and those of their families.

According to the Center for American Progress, of the 7 million workers without paid family and medical leave, 35.8% needed family care-giving leave but couldn't afford to take unpaid time off. 44% of individuals are not covered by the FMLA. Of those not covered, 2.6 million individuals—at some point in the year—need to take leave but don't for fear of losing their jobs. Of women without paid leave, 30% end up leaving their jobs after giving birth.

The U.S. House of Representatives recently passed a program that would provide four weeks of paid family and sick leave to many workers beginning in 2024. The Biden administration has made this legislation a priority, originally proposing 12 weeks of paid family leave in the Build Back Better Act. After briefly jettisoning paid family leave altogether, the House passed a slimmed-down version on November 19, 2021, which was approved by the U.S. Senate in August 2022.

The No Surprise Act

Beginning January 1, 2022, new federal protections backed by the Biden Administration will protect millions of consumers from surprise medical bills—unexpected bills from an out-of-network

provider, out-of-network facility, or out-of-network air ambulance provider. The protections, implemented under the No Surprises Act, ban surprise billing in private insurance for most emergency care and many instances of non-emergency care. They also require that uninsured and self-pay patients receive key information, including overviews of anticipated costs and details about their rights.

In addition to shielding millions of consumers from surprise medical bills, these protections will further President Biden's work to promote competition in health care and other sectors of the American economy.

For insured individuals, protections from surprise medical bills

For people who have health coverage through an employer, a Health Insurance Marketplace, or an individual health plan purchased directly from an insurer, the rules that took effect January 1, 2022:

- Bans surprise bills any time you receive emergency care, and require that cost sharing for these services, like co-pays, always be based on in-network rates, even when care is received without prior authorization.
- Bans surprise bills from certain out-of-network providers if you go to an in-network hospital for a procedure. This means cost sharing for certain additional services during your visit will generally be based on in-network rates.
- Requires providers and facilities to share with patients easy-to-understand notices that explain the applicable billing protections and who to contact if they have concerns that a provider or facility has violated the new surprise billing protections.

For uninsured individuals, better advanced knowledge of costs

For people who do not have health insurance or pay for care on their own (also known as "self-paying"), the rules that took effect January 1, 2022, require most providers to give a "good faith estimate" of costs before providing non-emergency care.

The good faith estimate must include expected charges for the primary item or service, as well as any other items or services that would reasonably be expected. For an uninsured or self-pay consumer getting surgery, for example, the estimate would include the cost of the surgery, as well as any labs, other tests, and anaesthesia that might be used during the procedure. Uninsured or self-pay consumers who receive a final bill that exceeds the good faith estimate by $400 or more can dispute the final charges.

Mental health awareness

USA is facing an urgent need to prioritize mental health as a critical aspect of well-being. Over one in five adults in the United States suffer from mental illness, and one in four older adults reported having anxiety or depression. The Administration is focused on dramatically increasing mental health support amongst youth, from early childhood through adolescence – especially after recovery from the pandemic.

The Affordable Care Act (ACA)

The ACA was enacted in 2010, with the goal of making health care more affordable to Americans. ACA-compliant plans cover mental health care as one of 10 essential benefits. Most employer-sponsored plans must also include mental health services under the ACA.

In addition, the ACA requires insurance companies to cap customers' out-of-pocket spending and prohibits limits on annual or lifetime coverage for mental health care. These steps ensure mental health insurance is both available and affordable.

The Mental Health Parity and Addiction Equity Act

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was enacted in October 2008 and took effect on January 1, 2009.

The act requires health insurers and group health plans that offer mental health and substance use disorder benefits to provide the same level of benefits for mental and/or substance use treatment and services that they do for medical/surgical care. MHPAEA was expanded to ensure that qualified plans offered on the Health Insurance Marketplace® cover many behavioral health treatments and services.

This rule would propose amendments to the final rules implementing the Mental Health Parity and Addiction Equity Act (MHPAEA). The amendments would clarify plans' and issuers' obligations under the law, promote compliance with MHPAEA, and update requirements to take into account experience with MHPAEA in the years since the rules were finalized as well as amendments to the law recently enacted as part of the Consolidated Appropriations Act, 2021.

The Mental Health Matters Act

The Mental Health Matters Act of 2022 (H.R. 7780) was recently passed by U.S. House of Representatives. H.R. 7780 would significantly increase the U.S. Department of Labor's ("DOL") ability to enforce compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA") of 2008 that requires employer-sponsored healthcare benefit plans to treat mental health and substance use disorder services in parity with traditional, medical services.

- H.R. 7780 would help improve the well-being of young children in Head Start and K-12 schools, including by building on the President's efforts to increase the number of school-based mental health services providers and authorizing grants to partnerships between high-need local educational agencies and institutions of higher education
- It will create programs to provide youth, their families, and staff with greater access to trauma-informed support and mental health services
- H.R. 7780 will strengthen the provision of affordable mental and other health care by authorizing critical tools and resources for the Secretary of Labor to enforce provisions of the Employee Retirement Income Security Act, including those added by the Mental Health Parity and Addiction Equity Act of 2008
- Also, it will help prevent Americans from being improperly denied mental health and substance use benefits by ensuring a fair standard of review by the courts and banning so-called forced arbitration agreement

The ERISA Industry Committee (ERIC)—which represents large employer plan sponsors was not in favor of Mental Health Matters Act stating that the bill includes provisions that weaponize the Department of Labor (DOL) to sue employers rather than helping them come into compliance.

The legislation, introduced in May by Rep. Mark DeSaulnier, D-California, would enable the agency or a plan member to sue a group health plan or issuer to recover any losses for not covering mental health benefits. They can also sue for ensuring "re-adjudication of claims and payment of benefits.

Better Mental Health Care for Americans Act

On March 22, 2023: Michael Bennet introduced new legislation called Better Mental Health Care for Americans Act in Congress to ensure full parity and integration for mental and behavioral health – expanding access, improving outcomes, and lowering costs.

Specifically, the Better Mental Health Care for Americans Act would:

- Require parity for mental and behavioral health services in Medicare Advantage, Medicare (Part D), and Medicaid
- Ensure that Medicare Advantage plans maintain accurate and updated provider directories so beneficiaries understand who is in-network
- Encourage mental and behavioral health integration with physical care by increasing reimbursement rates for Medicare and Medicaid
- Establish a demonstration project to increase access to integrated mental and behavioral health care for children across different setting, like schools
- Increase accountability and oversight of integrated mental and behavioral health care under Medicare
- Medicaid, and private health insurance plans
- Require the Centers for Medicare and Medicaid Services to develop and implement plans to better align payments, measure access and quality, and improve prevention services for mental and behavioral health care

A few other initiative and developments in the proposal stage

- **Treatment of opioid use disorder**
  HHS Regulatory Plan includes a proposed rule that is intended to make permanent certain telehealth flexibilities for substance use disorder treatments that were granted during the COVID-19 public health emergency. This rule would allow certain providers to provide buprenorphine via telehealth, as well as provide extended take-home doses of methadone to patients, when it is safe and appropriate to do so. Both changes are intended to increase access to comprehensive opioid use disorder treatment.

Typical employee benefits plans

A. Overview of typical plans

Both group insurance and pension plans in the US have developed along increasingly diverse and complex lines to the extent that it is no longer possible to cite an average or normal plan. The following overview is intended to illustrate a basic outline of benefits often provided and should not be used as a basis for designing a plan for any particular group of employees.

Life

Group term life	
Basic Life	Earnings-based schedule, typically 1-2 times salary, with additional optional coverage available
Optional Contributory Life	Options of supplementary flat or times earnings amounts
Accidental Death and Dismemberment (AD&D)	An amount usually equal to the basic life benefit.
Dependent Life	Typically, modest amounts, such as spouse USD 5,000 and child USD 2,000
Common features of life insurance products	• **Initial enrollment period:** typically, 31 days after the employee's date of hire, with subsequent open enrollment periods. • **Guaranteed issue limits:** provide a level of coverage without medical evidence, while evidence of insurability provisions may require an insured to provide medical evidence for amounts above the guaranteed issue limit or after the initial or open enrollment period. • **Waiver of premium:** in the event of the insured's disability, continuing coverage for a stated period of time. Waiver of premium usually continues even if the policy is terminated by the employer. • **Accelerated benefits:** in the event of the insured's terminal illness or need for long-term care allow payment of a portion of the life insurance benefits prior to the insured's death. • **Age reduction provisions** lower the life insurance coverage amount as the insured's age increases. • **Portability provisions** allow terminating employees who are not retiring or disabled to continue group term life coverage, which may be at preferred premium rates. • **Conversion provisions** allow employees to convert group coverage to individual policy coverage upon employment termination.

A. Overview of typical plans (continued)

Disability

Group disability	
Short-term disability (STD)	• Common benefit for all employees • Waiting period: Typically, 7 days • Benefit: Typically, 60% of base pay (may reduce to lower percentage after limited time • Duration: 26 weeks is the most common • Mandated program in certain states and Puerto Rico
Long-term disability (LTD)	• Elimination period: Typically, 6 months (180 days) or STD benefit period, if integrated. • Benefit: Typically, 60% of base pay, offset by Social Security and worker's compensation, subject to a maximum, such as USD 10,000 per month. • Maximum duration: Usually until normal retirement age. Shorter periods common for mental health or nervous disabilities or alcohol or substance use disorders. • Definition of disability is commonly the employee's inability to perform the duties of the employee's own or regular occupation for the first 2 years of disability. After 2 years, disability is the inability to perform the duties of any occupation for which the individual is qualified by education, training or experience. • Increasing benefits may be provided through cost-of-living increases, or future or automatic increase riders. • Residual benefits may be paid for disabilities resulting in a partial loss of earnings, or for disabilities resulting in reduced time and duties. • Renewability features protect the policyholder from changes to benefits; with non-cancelable policies, an insurer cannot increase premiums or reduce benefits. • Disabilities related to pre-existing conditions may be excluded from coverage, and proof of continuing disability is normally required. • Return to work and rehabilitation programs may be included.

A. Overview of typical plans (continued)

Health

Group health	
Basic indemnity plan	**Hospital:** • Room and board: dollar amount per day or semi-private room rate, payable for a maximum number of days, such as 365. • Special hospital services: such as operating room, anesthesia, etc. **Surgical:** • Reasonable and customary charges • Scheduled maximum per procedure **In-Hospital Medical:** • Doctor's visits in the hospital **Lab Tests and X-rays:** • Reasonable and customary charges • Scheduled amount per procedure **Maternity Benefit:** • Provided on same basis as other medical expenses **Supplemental Major Medical:** • Covers expenses not covered by basic plan **Comprehensive Indemnity Plan (most typical):** • Same benefits as basic plus Supplemental • Deductible and co-insurance apply immediately **Other Benefits:** • Might include dental, prescription drugs, and vision care benefits.

A. Overview of typical plans (continued)

Pension

Pension plan	
Salaried employees	• Based on career or final average earnings • Often integrated with Social Security • Fixed dollar benefits payable monthly (automatic cost-of-living adjustments are not common) • Full vesting after 5 years of service • Normal retirement age 65 • Generally attractive incentives for early retirement
Union employees	• Based on service only, e.g., USD 40 per month at retirement for each year of service • Benefit level renegotiated every 2 to 3 years

401K plan	
Defined contribution plans	• Pre-tax employee contributions, after-tax voluntary contributions and Roth contributions (subject to nondiscrimination regulations and annual dollar limits). • Matching employer contribution (e.g., 25% - 50% of the first 6% of pay the employee contributes) • Participant-directed investments • Generally, 11 to 15 investment options • Loans up to the lesser of USD 50,000 or 50% of vested account balance • Lump sum payments at death, disability, termination, or retirement (a few plans also allow for some forms of annuities and/or installments)

B. Group life, disability, and health plans

While the following descriptions are illustrative of both small and large employers, the major difference that usually arises is in the funding methods.

Small employers typically have their plans fully insured to protect themselves from large claims fluctuations. Large employers may have funding arrangements, such as minimum premium or administrative services only (ASO), to maximize their cash flow, as well as to take on part or all of the risk of claim fluctuations. All examples assume the policy or coverage period runs on a calendar-year basis.

Specifically, regarding health plans, the following description illustrates a PPO plan with managed care/utilization review features. In the following description, the terms "you" and "your" refer to the covered employee.

Summary of benefits	
Eligibility requirements	**Eligible class:** • All full time salaried and hourly employees (a full time employee works an average of at least 30 hours per week) (defined by the policyholder). **Eligible dependents:** • Qualifying child: Children up to the age of 26. **Waiting period:** • You may enroll yourself and your dependents on the first day after 30 days of active work.
Life insurance	• Salaried: Two times base pay
Accidental death and dismemberment insurance	• Salaried: Two times base pay
Dependent life insurance	• Spouse: USD 5,000 • Child(ren), up to the age of 26: USD 2,000 The amount of your dependent's life insurance benefit can be no greater than half the amount of your life insurance benefit.
Optional life insurance	Salaried: Ranges from 1 to 5 times base pay

B. Group life, disability and health plans (continued)

Summary of benefits (continued)	
Short-Term disability	**Weekly benefit:** • 60% of weekly base pay **Maximum duration:** • 26 weeks **Waiting period:** • For sickness: 7 days (benefits begin on 8th day of disability) • For accident: 7 days • For hospitalization: 7 days
Long-term disability	**Waiting period:** • 180 days or STD benefit period, if integrated **Benefit:** • 60% of monthly base pay, offset by Social Security, subject to a maximum, such as USD 10,000 per month **Duration:** • Typically, two years or until normal retirement age, unless no longer disabled; shorter periods common for mental health or substance use disorders
Medical coverage	**Deductible (in-network):** • Individual: USD 650 per calendar year • Family: USD 1,500 per calendar year **Co-insurance:** • Percentage varies with the type of expense (see the chart that follows). **Type of expense:** / **Plan pays** / **You pay** In-network patient hospital: 80% 20% after the deductible Emergency room visit: 80% 20% after the deductible Out-of-network physician office visit: 60% 40% after the deductible **Out-of-pocket limit (in-network):** Individual: USD 3,000 Family: USD 6,850

B. Group life, disability and health plans (continued)

<table>
<tr><th colspan="2">Summary of benefits (continued)</th></tr>
<tr><td>Medical plan cost management features</td><td>

The medical plan includes required and recommended cost management features. One must comply with required procedures to receive maximum benefits and/or avoid penalties. A toll-free patient advocate telephone number is available for assistance with the required procedures.
Pre-admission review
If a pre admission review is not obtained as required, the insured may be required to pay a larger portion of covered expenses or pay a penalty. This amount will not apply to the deductible or out of pocket limit. Note: pre-admission reviews must conform to mental health parity rules.
Second surgical opinion
If a required second surgical opinion is not obtained, the benefit for the surgery will be reduced by a certain percentage.
Outpatient surgery
If the insured chooses out-patient over in-patient surgery when there is a choice, the deductible will be waived, and the benefit will be increased to 100%.

</td></tr>
<tr><td>Dental coverage</td><td>
Deductible

Individual: USD 50 (per calendar year)
Family: USD 150 (per calendar year)

Co-insurance
Percentage varies with the type of expense (see the chart that follows):
<table>
<tr><th>Type of expense</th><th>Plan pays</th><th>you pay</th></tr>
<tr><td>• Preventive Treatment:</td><td>100%</td><td>0% & the deductible is waived</td></tr>
<tr><td>• Basic Treatment</td><td>80%</td><td>20% after the deductible</td></tr>
<tr><td>• Major Treatment:</td><td>50%</td><td>50% after the deductible</td></tr>
<tr><td>• Orthodontic Treatment:</td><td>100%</td><td>0% after the deductible</td></tr>
<tr><td></td><td colspan="2">*Subject to benefit maximums</td></tr>
</table>
Benefit maximums

Orthodontic Treatment: USD 1,000 for lifetime
Preventive and Basic/Major Treatment:USD 1,500 per year

</td></tr>
</table>

C. Defined benefit plan

Manufacturing company (1,500 lives)

This company has two defined benefit pension plans: one for union employees and one for salaried (non-union) employees.

Union plan	
Eligibility requirements	An employee is eligible to join the plan the first day of the month following the date of employment.
Cost of the plan	The plan will be funded exclusively by the employer.
Benefit formula	The accrued monthly benefit is based on the following schedule: **1. Credited service 1/1/80 12/31/74:** USD 8.50 per month at retirement for each year of credited service. A year of credited service is 1,800 hours of work in a calendar year. Proportionate years of credited service will be granted for less than 1,800 hours of work in a calendar year. **2. Credited service 1/1/85-1/1/88:** USD 10.00 per month at retirement for each year of credited service. **Note:** Typical of most union plans, the benefit level is renegotiated every 2 to 4 years. In this plan, the new benefit level applies prospectively. In some union plans, the new benefit level applies to all credited service for active employees. By 1/1/2000, the benefit level in this plan had risen to USD 35.00 per month at retirement for each year of credited service.
Normal retirement	Age 65
Early retirement	Age 55 with 10 years of service.
Vesting	100% vesting after 5 years of service.
Form of payment	The normal form is a 10 year certain and life annuity for single employees. A joint and survivor 50% annuity will be paid to married participants, at an adjusted amount, unless both the participant and the spouse elect another form of payment. There is no lump-sum payment available under the plan. 75% joint and survivor coverage also is available.

C. Defined benefit plan - manufacturing company (1,500 lives) (continued)

This company has two defined benefit pension plans: one for union employees and one for salaried (non-union) employees.

Non-union, salaried plan	
Eligibility	Age 21 and 6 months of service
Cost of the plan	Employer pays 100% of cost of plan
Normal retirement benefit	1.75% of final average earnings multiplied by years of credited service. ("Final average earnings" is defined as the highest 5 consecutive years of earnings during the last 10 years of employment.)
Normal retirement	Age 65
Early retirement	Age 55 with 5 years of service. The benefit is reduced actuarially for each month that early retirement precedes normal retirement.
Vesting	100% vesting after 5 years of service.
Forms of payment	Life annuity for single employees. Reduced joint and survivor coverage, 50% for married participants, unless both the participant and spouse decline the 50% joint and survivor coverage. 75% joint & survivor coverage is also available.

Note: Typical of most plans, there is no lump-sum option at retirement. There is also no automatic cost-of-living/inflation adjustment after retirement, although this plan has periodically increased retiree benefits when there were surplus assets in the fund.

D. 401(k) plan

Financial institution (700 lives)

401(k) plan	
Eligibility	First day of the month after completion of 6 months of service.
Employee contributions	Eligible employees may contribute from 1% to 20% of eligible compensation to the plan on a pre tax basis. Compensation by law is limited to USD 305,000 annually (in 2022). Additionally, 401(k) plans must limit pre-tax deferrals to USD 20,500 in 2022. Employees of age 50 or older may contribute up to an additional USD 6,500 in 2022.
Employer contributions	The employer will match 50% of the first 6% of an employee's compensation contributed as a pre tax deferral. No match on any pre tax contributions that exceed 6%.
Profit-sharing contribution	At the end of the fiscal year, the employer also may make a discretionary contribution to the plan based on profits. Each participant will share in this profit-sharing contribution in the ratio that his/her compensation bears to total compensation (as defined in the plan document).
Vesting	Participants are always 100% vested in their own contributions (required by law). A participant will vest 100% in the employer-provided profit-sharing contributions and matching contributions after 3 years of service.
Investment direction	Participants will direct the investment of all employee and employer contributions. The same investment elections must apply to all contributions in a participant's account. The investment options include a stable value fund (supported by guaranteed interest contracts), a domestic stock fund, an international stock fund, a growth stock fund, a growth and income fund, and a balanced stock and bond fund. The plan also offers lifestyle fund options, as well as managed accounts. Participants can direct investment in 1% increments into any of these investment options.
Investment changes	Participants may change how future contributions will be invested, and/or reallocate past contributions.
Withdrawals	The plan permits participants to withdraw up to 50% of their entire vested account balance if hardship requirements are met. The withdrawal is subject to ordinary income tax and a special 10% penalty tax for early withdrawals (generally applies prior to age 59 1/2).
Loans	The plan permits participants to borrow the lesser of 50% of their vested account balance or USD 50,000. Loans are not subject to current taxation as long as they are repaid to the plan, generally within 5 years (a longer repayment period is permitted for primary residence loans).** The plan requires repayment through payroll deduction, at an interest rate that is 1% above the rate

D. 401(k) plan - financial institution (700 lives) (continued)

401(k) plan	
Termination of employment	At termination, participants may leave their account balance in the plan, elect to roll the funds over into an individual retirement account (IRA), elect to roll them over into a new employer's plan (if applicable), or take a lump sum distribution. A lump sum distribution is subject to 20% tax withholding (if rollover eligible). A special 10% penalty tax also may apply to participants under age 59 1/2 who don't roll over their lump-sums.
Death & disability benefits	100% of the account balance automatically vests at death or total disability.

Benchmarking Information

	%
Group life coverage* **	82%
Death benefit	83%
AD&D	
Disability coverage* **	71%
Long term disability	61%
Short term disability	
Retirement plans*	93%
Defined contribution	7%
Defined benefit	
Other**	42%
Wellness	10%
Childcare	14%
Flexible workplace	8%
Subsidized commuting	51%
Employee assistance programs	

Source: Cerulli - US Retirement Markets Report, 2018*
US Bureau of Labor Statistics, 2020**
Society for Human Resource Management (SHRM), 2020***

Employee benchmarking basis buyer preference

The footnotes refer to the number of cases considered for the benchmarking and are available on page 37.

Group short-term disability for IT Sector

	Preference 1	Preference 2	Preference 3
Maximum benefit amount[1]	33% preferred between $2,500 or greater	19% preferred between $2,000 to $2,499	17% preferred between $1,500 to $1,999
Benefit percentage[2]	76% preferred 60%	9% preferred 66.7%	5% preferred 50%
Elimination period[3]	51% preferred 8/8	14% preferred 15/15	14% preferred 1/8
Maximum benefit duration[4]	33% preferred 12 weeks	26% preferred 13 weeks	16% preferred 26 weeks
Contributory basis[5]	84% preferred non-contributory	16% preferred contributory	
Eligibility wait period[6]	44% preferred no wait period	34% preferred 16-30 days	12% preferred 1st of month
Definition of disability[7]	75% preferred residual	15% preferred total disability only	10% preferred partial

Group long-term disability for IT Sector

	Preference 1	Preference 2	Preference 3
Own OCC period[1]	84% preferred 2 years of benefits	13% preferred full duration	2% preferred 3 years of benefits
Maximum benefit amount[2]	51% preferred $10,000 to $12,499	22% preferred $12,500 or greater	15% preferred $5,000 to $7,499
Elimination period[3]	75% preferred 90 days	24% preferred 180 days	1% preferred other
Contributory basis[4]	79% preferred non-contributory	21% preferred contributory	
Benefit percentage[5]	89% preferred 60%	6% preferred 66.7%	3% preferred 50%
Maximum benefit duration[6]	56% preferred normal retirement age	22% preferred To Age 65	21% preferred To Age 67
SS integration[7]	100% preferred full family	Less than 1% preferred other	
Eligibility wait period[8]	36% preferred 361+ days	24% preferred 16-30 days	20% preferred no wait

Employee benchmarking basis buyer preference (continued)

The footnotes refer to the number of cases considered for the benchmarking and are available on page 37.

Group life base for IT sector

	Preference 1	Preference 2	Preference 3
Maximum issue limit[1]	38% preferred $0 to $99,999	23% preferred $250,000 to $499,999	16% preferred $100,000 to $249,999
Employee benefit schedule[2]	35% preferred 1.00 x annual salary	30% preferred flat amount $50K+	20% preferred 2.00 x annual salary
Accelerated benefit option[3]	60% preferred 71%-80%	19% preferred 41%-50%	7% preferred 81%-90%
Contributory basis[4]	93% preferred non-contributory	7% preferred contributory	
Eligibility wait period[5]	54% preferred 1-15 days	22% preferred no wait	10% preferred 1st of month
Waiver definition[6]	49% preferred to age 65/60/9m	9% preferred To Age 70/65/9m	7% preferred SSNRA/60/6m

Group short-term disability for automotive sector

	Preference 1	Preference 2	Preference 3
Maximum benefit amount[1]	26% preferred between $1,000 to $1,499	23% preferred between $1,500 to $1,999	17% preferred between $0 to $499 and $500 to $999
Benefit percentage[2]	74% preferred 60%	9% preferred 50%	6% preferred 66.7%
Elimination period[3]	44% preferred 8/8	22% preferred 15/15	16% preferred 1/8
Maximum benefit duration[4]	22% preferred 13 weeks	19% preferred 12 weeks	18% preferred 26 weeks
Contributory basis[5]	55% preferred non-contributory	45% preferred contributory	
Eligibility wait period[6]	48% preferred 16-30 days	40% preferred 31-60 days	4% preferred 181-360 days, 1st of month, no wait
Definition of disability[7]	72% preferred residual	15% preferred total disability only	13% preferred partial

Employee benchmarking basis buyer preference (continued)

The footnotes refer to the number of cases considered for the benchmarking and are available on page 37.

Group long-term disability for automotive sector

	Preference 1	Preference 2	Preference 3
Own OCC period[1]	80% preferred 2 years of benefits	14% preferred full duration	4% preferred 3 years of benefits
Maximum benefit amount[2]	44% preferred $10,000 to $12,499	25% preferred $10,000 to $12,499	13% preferred $10,000 to $12,499
Elimination period[3]	64% preferred 90 days	32% preferred 180 days	4% preferred 360 days
Contributory basis[4]	59% preferred non-contributory	41% preferred contributory	
Benefit percentage[5]	95% preferred 60%	3% preferred 66.7%	2% preferred 50%
Maximum benefit duration[6]	62% preferred normal retirement age	19% preferred to age 65	10% preferred to age 67
SS integration[7]	100% preferred full family		
Eligibility wait period[8]	53% preferred 31-60+ days	35% preferred 16-30 days	6% preferred 361+ days and no wait

Group life base for automotive sector

	Preference 1	Preference 2	Preference 3
Maximum issue limit[1]	71% preferred $0 to $99,999	13% preferred $ $250,000 to $499,999	9% preferred $100,000 to $249,999
Employee benefit schedule[2]	54% preferred flat amount <$50K	30% preferred flat amount $50K++	20% preferred 2.00 x annual salary
Accelerated benefit option[3]	60% preferred 71%-80%	25% preferred 41%-50%	10% preferred 1.00x annual salary
Contributory basis[4]	93% preferred non-contributory	7% preferred contributory	
Eligibility wait period[5]	47% preferred 31-60 days	30% preferred 1-15 days	15% preferred 16-30 days
Waiver definition[6]	48% preferred to age 65/60/9m	20% preferred SSNRA/60/6m	9% preferred 1Yr/65/9m

The data below represents the number of cases considered for each feature in the sector while benchmarking buyer preferences.

Group short-term disability for IT sector

[1] No. of cases: 1,594

[2] No. of cases: 1,610

[3] No. of cases: 1,586

[4] No. of cases: 1,476

[5] No. of cases: 1,727

[6] No. of cases: 443

[7] No. of cases: 1,009

Long-term disability for IT sector

[1] No. of cases: 1,585

[2] No. of cases: 1,700

[3] No. of cases: 1,575

[4] No. of cases: 1,760

[5] No. of cases: 1,704

[6] No. of cases: 1,598

[7] No. of cases: 1,490

[8] No. of cases: 186

Group life base For IT sector

[1] No. of cases: 1,466

[2] No. of cases: 1,294

[3] No. of cases: 1,045

[4] No. of cases: 1,531

[5] No. of cases: 657

[6] No. of cases: 1,354

Group short-term disability for automotive sector

[1] No. of cases: 60

[2] No. of cases: 65

[3] No. of cases: 70

[4] No. of cases: 54

[5] No. of cases: 73

[6] No. of cases: 25

[7] No. of cases: 39

Group long-term disability for automotive sector

[1] No. of cases: 55

[2] No. of cases: 63

[3] No. of cases: 56

[4] No. of cases: 66

[5] No. of cases: 63

[6] No. of cases: 58

[7] No. of cases: 53

[8] No. of cases: 17

Group long-term disability for automotive sector

[1] No. of cases: 55

[2] No. of cases: 63

[3] No. of cases: 56

[4] No. of cases: 66

[5] No. of cases: 63

[6] No. of cases: 58

[7] No. of cases: 53

[8] No. of cases: 1 7

Group life base for automotive sector

[1] No. of cases: 86

[2] No. of cases: 72

[3] No. of cases: 63

[4] No. of cases: 86

[5] No. of cases: 47

[6] No. of cases: 76

Useful links

Demographic information and macro-economic indicators
CIA World Factbook (please select the country to review)
World Bank Group (please select the country to review)

Social Security Benefit:
https://www.ssa.gov/

Internal Revenue Service
https://www.irs.gov/

More information on Prudential Financial, Inc.

Your Local Link to IGP in United States
Go to partner page on www.igpinfo.com

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