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End of Year Compliance Round-Up

Benefit Advisors Network

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Agenda

- Washington Update & Future of the ACA (*Texas v. US*)
  - State Individual Mandates
- Compliance in 2019
- What to Expect in 2020
  - Wellness Update
- Final Rule Expanding HRAs

Tax Cuts and Jobs Act

- **Individual Mandate Repealed as Part of Tax Cuts and Jobs Act (effective 2019)**
- Despite President's Tweet—this Does Not Mean Obamacare is Repealed
- Obamacare turned 9 on March 23, 2019
  - ~24M more people covered since the ACA's inception
  - 12M via Marketplace (9M receiving subsidies), 12M via Medicaid expansion
- CBO Predicts 13 Million Fewer Will Be Insured by 2027
  - Marketplace premiums predicted to increase by 10%
- Do Penalties Have That Much Impact?

State Individual Mandates

- States have implemented individual mandates in response to the repeal of the ACA's individual mandate in 2019
- Effective
  - 2019: New Jersey and Washington DC
  - 2020: California, Vermont, and Rhode Island
  - Massachusetts since 2006
    - **HIRD form due by December 15th for employers with 6+ employees in Mass.**
- Most resemble the federal individual mandate before repeal

Compliance in 2019

Districts Courts Block New Contraceptive Coverage Rules

- Jan. 13-14 – Federal district courts in CA and PA issued injunctions blocking implementation of final regulations extending exemptions from the ACA's contraceptive coverage mandate to employers, insurers and other entities with religious or moral objections
- PA court issued a nationwide injunction barring enforcement of the final regulations
  - PA court noted that while federal agencies were authorized (through the HRSA) to define *what* constitutes preventive care under the contraceptives mandate, they were not authorized to define *who* must provide the coverage
  - Court also noted that this reasoning could also call into question a 2011 rule that exempted religious employers from having to provide contraceptives

Cost Sharing Reduction (CSR) Lawsuits

- February 2019 – four decisions in favor of insurers for unpaid CSRs
  - One was a class action that includes 91 insurance carriers
- CSRs are cost-sharing reduction payments designed to repay insurers for cost of providing low-cost health care
  - They are part of the ACA's premium tax credit program
- President had ordered Health and Human Services (HHS) to cease making CSR payments in October 2017
  - Carriers began filing lawsuit shortly thereafter and have been largely successful

Cost Sharing Reduction (CSR) Lawsuits

- Judgments have a common theme: Insurers are entitled to CSRs even if Congress has failed to explicitly appropriate the funds
  - The plain language of the ACA reflect Congress' intent to require HHS to make timely CSR payments to insurers
  - Irrelevant that the ACA establishes a permanent allocation for the premium tax credits; alternative interpretations would frustrate the intent of the law
  - Insurers continue to "silver load" to mitigate damages
- Will the administration reconsider its position on CSR funding to avoid continued silver loading?

Association Health Plan (AHP) Regulation Struck Down

- On March 28, 2019, a Judge in Washington, DC blocked Trump administration's rule expanding Association Health Plans
  - Court found the rules were an end-run around the ACA, citing the President's Executive Order and Secretary of DOL's Op-Ed
- DOL rule unreasonably expanded the definition of "employer" to include groups without any real commonality of interest despite Congress's clear intent that ERISA cover benefits arising out of employment relationships
  - Rule extends ERISA to cover what are essentially commercial insurance transactions between unrelated parties and thus exceeds the statutory authority delegated by Congress in ERISA

PCORI Extension?

- In June 2019, House Ways and Means Committee approved a bill extending the PCORI fee through 2026
- The next step would be consideration by the full House of Representatives
- PCORI fee applies to self-insured and fully insured plans
  - Paid by insurers if insured plan, plan sponsor if self-insured (Form 720)
  - Fee is $2.45 fee per member per year for plan years ending on or after October 1, 2018, and before October 1, 2019

Texas v. United States (aka Texas v. Azar)

- July 2019 – Oral Arguments heard in 5th Circuit (New Orleans)
- 20 states and 2 individuals claim individual mandate is unconstitutional due to changes made by the Tax Cuts and Jobs Act
  - Dec. 2018: Judge O'Connor (TX) rules that entire ACA is unconstitutional
- Court has allowed "intervenor states" to appeal
  - Intervenors: CA, CO, CT, DC, DE, HA, IA, IL, KY, MA, MI, MN, NJ, NY, NC, NV, OR, RI, VT, VA, WA
  - Plaintiffs: TX, AL, AR, AZ, FL, GA, IN, KS, LA, MO, NE, ND, SD, SC, TN, UT, WV
- Jan. 2019: Intervenor states appeal to the 5th Circuit
  - Government's brief on March 25 asked the court to strike down entire ACA

Cadillac Tax Repeal

- July 17, 2019 – House votes 419-6 to repeal the Cadillac Tax
  - HR 748: Middle Class Health Benefits Tax Repeal Act of 2019
- What is the Cadillac Tax?
  - A 40% tax on cost of health coverage that exceeds threshold amounts
    - Thresholds were $10,200 Single, $27,500 Family (per year)
    - Currently $11,200 Single, $30,100 Family
  - Thresholds based on total cost of coverage, plus employer and pre-tax employee contributions to HRAs/FSAs/HSAs
  - Intended to help finance ACA expansion and encourage employers to offer lower-cost plans
- Cadillac Tax originally effective 2018; delayed twice (currently to 2022)

Executive Order on Protecting and Improving Medicare for Our Nation's Seniors

- Originally named Protecting Medicare From Socialist Destruction
  - President described healthcare as being "under threat" from Medicare for All proposals
- October 2019 Order proposes changes to Medicare to guard against Democratic healthcare proposals that would reduce coverage for seniors
  - Strengthens Medicare Advantage (private Medicare insurance) plans, which cover about 1/3 of the country's 61 Million Medicare enrollees
  - White House: Goal is to have more affordable options, encourage wider use of telehealth services, promote wellness benefits and bring payments in Medicare fee-for-service program in line with payments for Medicare Advantage

CMS Price Transparency Rules

- In November 2019, CMS released a final rule that will require hospitals to publicize their standard charges for items and services starting January 1, 2021
- CMS also released a new proposed rule that would require health plans and TPAs to make available to consumers personalized out-of-pocket cost information for all covered health care items and services, as well as publish the in-network negotiated rates with their network providers
  - These rules could impose new reporting requirements on providers and payers and reflect CMS's desire to bring greater price transparency across the health care industry

CMS Price Transparency Rules

- Under the final rule, plans would need to publicize standard charges for all items and services online, including minimum and maximum negotiated charges, and discounted cash prices for at least 300 "shoppable services"
  - Of the 300 shoppable services, CMS will specify 70 services and the hospital will select 230 hospital services

CMS Price Transparency Rules

- Under the proposed rule, most group health plans, including self-insured plans, and health insurance issuers would need to disclose price and cost-sharing information to participants
  - Participants would be entitled to personalized out-of-pocket cost information for covered health care items and services, which will aid consumerism
  - Public would have access to the in-network negotiated rates with their network providers and historical payments of allowed amounts to out-of-network providers
- These rules are likely to be subject to challenge, including lobbying and lawsuits

Single Payer is Not the Answer

- State attempts:
  - Vermont: Quietly Abandoned
  - Colorado: Single Payer Amendment (Failed)
  - California: Abandoned When Determined It Would Cost 2X Current State Budget
- Mercatus report showed Medicare-for-all could save $2 trillion over 10 years?
  - The $2 trillion figure assumes provider payments reduced to Medicare levels, negotiation with prescription drug manufacturers will generate significant savings, and administrative costs will be cut from 13% to 6%
  - Alternative scenario where cost control not as effective? $3.25 trillion **increase** over 10 years

What to Expect in 2020?

2020 HSA and ACA OOP Limits

	2020 (single/family)	2019 (single/family)
Annual HSA Contribution Limit	$3,550 / $7,100	$3,500 / $7,000
Minimum Annual HDHP Deductible	$1,400 / $2,800	$1,350 / $2,700
Maximum Out-of-Pocket for HDHP (applies to all in-network benefits)	$6,900 / $13,800	$6,750 / $13,500
ACA Maximum Out-of-Pocket Limits	$8,200 / $16,400	$7,900 / $15,800

- ACA requires family plans to have an embedded individual OOP limit
- Embedded OOP limit rule applies to all non-grandfathered group health plans, including HDHPs

Interaction between HSA Rules and ACA OOP Limits

- Recap:
  - **HSA Rule**: Family HDHPs cannot have embedded deductible less than $2,800
  - **HSA Rule**: OOP limit for family HDHP coverage cannot exceed $13,800 in 2020
  - **ACA Rule**: Family coverage (whether HDHP or non-HDHP) must have an embedded individual OOP limit that does not exceed $8,200 in 2020
- This means that for the 2020 plan year, an HDHP subject to the ACA out-of-pocket limit rules may have a $6,900/$13,800 out-of-pocket limit (and be HSA-compliant) so long as there is an embedded individual out-of-pocket limit in the family tier no greater than $8,200 (so that it is also ACA-compliant)

Expanded Preventive Care Safe Harbor for HSAs

- IRS has expanded the preventive care safe harbor for HSA-eligible individuals for *specific* care for *specific* chronic conditions
  - Participants may receive these services before satisfying the HDHP deductible and remain HSA qualified
- Goal is to encourage receiving routine care with a lower cost barrier; expanding the definition to include certain chronic conditions encourages necessary care and mitigate consequences of not receiving care

Expanded Preventive Care Safe Harbor for HSAs

For Individuals Diagnosed with	Preventive Care for Specified Condition
Asthma	Inhaled corticosteroids, peak flow meter
Congestive heart failure and/or coronary artery disease	Beta-blockers
Congestive heart failure, diabetes, and/or coronary artery disease	Angiotensin Converting Enzyme (ACE) inhibitors
Depression	Selective Serotonin Reuptake Inhibitors (SSRIs)
Diabetes	Insulin and other glucose lowering agents
Diabetes	Retinopathy screening
Diabetes	Glucometer, Hemoglobin A1c testing
Heart disease	Low-density Lipoprotein (LDL) testing
Heart disease and/or diabetes	Statins
Hypertension	Blood pressure monitor
Liver disease and/or bleeding disorders	International Normalized Ratio (INR) testing
Osteoporosis and/or osteopenia	Anti-resorptive therapy

2020 Affordability Guidance, Other Limits

- Affordability Percentage for 2020: 9.78%, down from 9.86% for 2019
- Employer mandate penalties for 2020: $2,570 / $3,860 (projected)
- FPL Safe Harbor for Calendar Year 2020 Plans
  - $12,490 FPL (2019) × 9.78% ÷ 12 months = $101.79 / month
- 2020 health FSA election limit: $2,750

2019 ACA Reporting Forms & Instructions

Changes and Highlights for 2019

- Suspension of 1095-B to Employees
- IRS is granting penalty relief for employers who fail to furnish a Form 1095-B to individuals, provided that the reporting entity:
  - Posts a notice prominently on its website stating that individuals may receive a copy of their 2019 1095-B upon request, accompanied by an email address, phone number and a physical address the request can be sent; and
  - Furnishes an individual with a Form 1095-B within 30 days of a request
- Relief primarily applies to insurers and non-ALEs that sponsor self-insured plans

2019 ACA Reporting Forms & Instructions

Changes and Highlights for 2019

- Form 1095-C, Line 15. The section 4980H "affordability" safe harbor percentage threshold is adjusted to 9.86% for plan years beginning in 2019, up from 9.56%.
- "Plan Start Month" on Form 1095-C remains optional for 2019
- Interim Rule for Multiemployer plans remains in place for 2019 (Codes 1H/2E)
- Instructions remind employers that there is no specific code to enter on Line 16 to indicate that a full-time employee waived coverage – a safe harbor code should be used, if applicable, otherwise Line 16 should be left blank
- Forms 1095-C filed with incorrect dollar amounts on Line 15 may fall under the safe harbor for *de minimis* errors, which generally applies if no single amount in error differs from the correct amount by more than $100

Due Dates for Calendar Year 2019 ACA Reporting

- Forms 1095-C must be furnished to individuals by March 2, 2020
  - Requests for a 30-day extension of time to furnish employee statements are available, but they're not automatic and a reason for delay must be provided
  - IRS will not respond to extension requests when due date already extended
- Forms 1094-C and 1095-C must be filed with the IRS by Feb. 28, 2020 if by paper, or March 31, 2020 if filing electronically
  - An automatic 30-day extension of time to file with the IRS is available by completing Form 8809
  - No signature or explanation is required for the extension; however, it must be filed on or before the due date of the returns
  - Under certain hardship conditions an additional 30-day extension may apply; however, requests for additional extensions of time to file information returns are not automatically granted

Employer Mandate Penalty Letters (226J)

- IRS currently focusing on CY2017
- Letter 226J includes:
  - Proposed penalty by month and whether it's under the "A" or "B" penalty
  - List of employees who received a subsidy each month and who were not reported as being within a "safe harbor"
  - Actions the IRS will take if the ALE does not respond timely
- Response due within 30 days of receipt
  - IRS will respond with one of five versions of Letter 227
  - Response to Letter 227 due within 30 days of receipt
  - If no response, IRS will issue a notice and demand for payment

Failure to Report Letter (5699)

- **IRS contacting employers it believes should have filed ACA forms**
  - Letter received for 2015, 2016 and 2017
  - Recipients have 30 days to respond and indicate:
    - They were an ALE and already filed under a different EIN;
    - They were an ALE and have included the forms with the response (paper filers only); or
    - They were an ALE and will file by "X" date (if longer than 90 days, explanation is required)
- Employers should talk to ERISA counsel before responding

Failure to File Timely Letter (972CG)

- IRS proposing penalties for 2017 filing year for late filings, filings with incorrect or missing TINs, or filings remitted via paper when electronic filing was required (i.e., when submitting 250+ forms)
- 5 penalty tiers
  - TIN: if missing or incorrect tax identification number
  - Failure to file electronically: applies to each form over 250 that was filed by paper instead of electronic
  - Tier 1: returns filed after the due date but within 30 days
  - Tier 2: returns filed after the due and after 30 days, but before August 1
  - Tier 3: returns filed after August 1
- Generally have **45 days** to respond

Failure to File Timely Letter (972CG)

- In response must indicate if in full agreement, partial agreement, or total disagreement with the penalty
  - If partially agree or totally disagree, must submit signed statement explaining why failure was due to reasonable cause and not willful neglect
  - Consult with ERISA counsel before responding
- Penalty amounts (IRS currently enforcing 2017):
  - TIN: $260/form
  - Failure to file electronic: $260/form
  - Tier 1 (corrected w/in 30 days): $50/form
  - Tier 2 (corrected by August 1): $100/form
  - Tier 3 (corrected after Aug. 1): $260/form

Wellness Update

AARP v. EEOC

- August 2017 – Federal court in Washington, DC orders EEOC to reconsider limits placed on wellness incentives under ADA and GINA
- September 2017 – EEOC advised the court that anticipated effective date of further rulemaking would be 2021
- December 2017 – Court vacates 30% incentive limits effective 1/1/19
- March 2018 – EEOC status update: No plans to issue revised regulations by a particular date certain
- October 2018 – anticipated timetable of June 2019 for proposed regs

What's Next for Wellness?

- Design wellness plans that don't tie incentives to medical exams or disability-related inquiries?
  - Employers could avoid potential exposure by tying incentives to activities such as tobacco user surcharges with no medical testing, participatory programs such as health seminars or gym use, and activity-based programs such as walking challenges
- However, wellness programs designed to comply with existing rules, specifically the 30% cap, are unlikely to be challenged by the EEOC
  - Previous EEOC enforcement action targeted very aggressive plans with incentives far outside of the 30% limit
- Continue to monitor developments

Final Regulations Expanding HRAs

Final Rule for Individual Coverage HRAs

- Final rule effective January 1, 2020 allows employers of all sizes to offer an HRA that is integrated with individual health insurance coverage or Medicare (an "ICHRA")
- Employers cannot offer employees a *choice* between group coverage and an ICHRA, although ICHRAs may be offered on a class basis or to employees hired after a certain date (after 1/1/2020)
- DOL estimates that once employers fully adjust to the new rules, roughly 800,000 employers will adopt ICHRAs to pay for insurance for approximately 11 million employees and their family members

ICHRAs – General Rules

- ICHRAs must be offered on same terms for all employees in a class
- ICHRA contributions are unlimited, unlike QSEHRAs
- Employee and dependents participating in an ICHRA must be enrolled in either individual market coverage or Medicare
  - ICHRA may be used for Marketplace or non-Marketplace coverage
  - ICHRAs may reimburse Medicare premiums (e.g., Parts B and D) and Medicare Supplement premiums without violating the Medicare Secondary Payer rules
  - Employers can maintain their traditional group health plan for existing enrollees, with new hires offered only an ICHRA
  - ICHRAs that reimburse only premiums do not disrupt HSA eligibility
    - Choice of HSA-compatible ICHRA may be offered

ICHRAs – General Rules

- ICHRAs are eligible employer-sponsored plans for purposes of the ACA's employer mandate
  - ICHRAs are "minimum essential coverage"
  - ICHRAs can provide "affordable" minimum value coverage
- Carryover of unused amounts permitted
  - When an employee changes classes, amounts under an ICHRA may transfer without violating the "same terms" requirement
- Variations in employer contributions permitted by age and number of dependents
  - Increases based on age may not exceed 3X the amount available to the youngest participants

ICHRAs – General Rules

- Employees may pay for the remainder of their individual (non-Marketplace) coverage pre-tax through a cafeteria plan without the individual plan being considered a group health plan for ERISA and ACA purposes
  - Ability to pay pre-tax must be offered on the same terms and conditions
- ICHRAs and Excepted Benefit HRAs are subject to ERISA, COBRA and HIPAA to the same extent as traditional HRAs

Permitted Classes for Individual Coverage HRAs

- Employers may offer an ICHRA on a class basis to:
  - Full-time vs. part-time employees
  - Employees in the same geographic area
    - For example, the same rating area, state, or multi-state region
  - Seasonal employees
  - Collectively bargained (union) employees
  - Employees who have not satisfied a waiting period
  - Salaried vs hourly
  - A combination of two or more classes
    - FT, PT and Seasonal can be defined under Section 105(h) or 4980H

Minimum Class Size (MCS) Requirement

- MCS requirement applies if an employer offers a group health plan to one or more classes of employees and offers an ICHRA to one or more other classes
- Applies to "applicable classes," which are full-time, part-time, salaried, hourly, or employees in the same rating area, unless:
  - the geographic area defining the class is at least one State; or
  - if FT vs. PT, the MCS requirement applies only to the class offered the ICHRA
- MCS requirement also applies if the class comprises at least one of the applicable classes with any other class, unless the class is the result of a combination of one of the applicable classes and a class of employees who have not satisfied a waiting period

Minimum Class Size (MCS) Requirement

- Minimum number of employees in a class subject to the MCS requirement is determined before the start of the plan year and is:
  - **10**, for an employer with fewer than 100 employees;
  - **10%** of the total number of employees, for employers with 100 to 200 employees;
  - **20**, for an employer with more than 200 employees
- Employer size is determined in advance of the plan year based on the number of employees that the employer reasonably expects to employ on the first day of the plan year
- MCS requirement is satisfied based on the number of employees in the class offered the ICHRA as of the first day of the plan year
- MCS requirement does not apply to the "new hire" subclass

Final Rule for Excepted Benefits HRAs

- Effective January 1, 2020, Final Rule treats certain types of HRAs as "excepted benefits" that are not subject to ACA requirements
- Employees offered an Excepted HRA must also be offered Non-Excepted group health plan coverage by the employer
- Employer may offer up to $1,800 per year to reimburse employees for out-of-pocket medical expenses, including premiums for:
  - Limited scope dental or vision benefits;
  - Short-term, limited-duration insurance plans; and
  - COBRA coverage
- Excepted benefit HRA cannot reimburse premiums for individual market health coverage, coverage under a group health plan (other than COBRA), or Medicare

IRS Priority Guidance Plan for 2020

- Guidance on HSAs for preventive care for chronic conditions (issued)
- Regulations under §§4980H and 105(h) related to HRAs (issued)
- Guidance under Section 125 on Health FSAs
- Guidance on contributions to and benefits from paid family and medical leave programs
- Guidance under Section 4980I (Cadillac Tax)
- Guidance regarding procedures for Certified Professional Employer Organizations
- DOL also plans to propose changes to grandfathered plan rules

Questions?

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