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ACA: What Stays, What Goes and What Else

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Speaker: Rachel Druckenmiller, Director of Wellbeing, SIG

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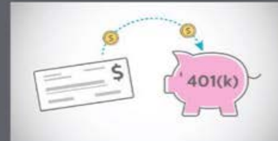
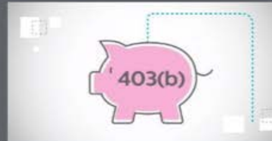


401(k) Retirement Plans



403(b) Retirement Plans

Accident Insurance

Balance Billing

Benefits Health Terms Explained

Cancer Insurance

CDHP with HSA

COBRA Insurance

Commuter Benefits

Critical Illness Insurance

Dental Insurance and User Tips

Disability Insurance

Employee Assistance Programs

Family and Medical Leave Act

Flexible Spending Account

ACA Update

Agenda

- Washington Update & HSA Expansion Legislation
- Compliance Update
- Final Rules on Association Plans

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Washington Update

- **Individual Mandate Repealed as Part of Tax Cuts and Jobs Act (effective 2019)**
- Despite Trump Tweet—this Does Not Mean Obamacare is Repealed
- Political Win for Trump: Most Conservatives View Mandate as Unconstitutional
- CBO Predicts 13 Million Fewer Will Be Insured by 2027
- Do Penalties Have That Much Impact?

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Proposed HSA Expansion Bills

- H.R. 6199: Restoring Access to Medication and Modernizing Health Savings Accounts Act of 2018
  - Carryforward of FSA balances – up to 3x annual FSA limit may be carried over
  - Entitlement to Medicare Part A due to age will not disrupt HSA eligibility
  - Increase HSA contribution limit to out-of-pocket limit (6,650 / $13,300 for 2018)
  - Allow both spouses to make catch-up contributions to the same HSA
  - 60-day grace period rule – HSAs opened within 60 days after gaining HDHP coverage treated as having been opened with the HDHP
  - "Bronze" and catastrophic ("Copper") plans to be treated as HSA-qualified HDHPs
  - Allow Copper plans to be sold to all Marketplace enrollees, not just those under 30
  - Extends moratorium on HIT tax for 2020 and 2021 (already deferred in 2019)

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Proposed HSA Expansion Bills

- H.R. 6311: Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts Act of 2018
  - Up to $250 per year ($500 family) in coverage may be provided before the deducible is met
  - Direct Primary Care (DPC) up to $150 per month ($300 fam.) would not disrupt HSA eligibility
  - Services at on-site or retail medical clinics would not disrupt HSA eligibility (so long as significant medical care benefits are not provided)
  - Spousal FSA enrollment will not disrupt an employee's HSA eligibility as long as the spouse doesn't submit the employee's expenses for reimbursement
  - Employers may allow employees to convert FSA or HRA balances into an HSA contribution upon enrolling in an HDHP (amount is capped at $2,650, 2X for family coverage)
    - Conversion occurring in same year as the FSA or HRA contribution counts against annual HSA limit
  - OTC medical products once again treated as qualified medical expenses
  - Amounts paid for qualified sports and fitness expenses excludable up to $500 (1,000 for joint filers) per year

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Unravelling the ACA

- **Texas v. United States, No. 4: l 8-cv-00167-O (N.D. Tex.)**
- 20 states and 2 individuals claim individual mandate unconstitutional
- U.S. Department of Justice (DOJ) will not defend the constitutionality of the individual mandate, and will argue that the guaranteed issue and community rating rules of the ACA are inseverable from that provision
- When the Supreme Court declared the mandate constitutional in 2012, it did so on the basis that the mandate qualifies as a tax (because it provides at least *some* revenue to the government)
  – Since the Tax Cuts and Jobs Act set the penalty at $0 effective 1/1/19, the argument is that the individual mandate can no longer be described as a tax, thus rendering it unconstitutional

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Texas v. United States

- The plaintiffs argue that the individual mandate is *inseverable* from the rest of the ACA, and therefore the entire statute and all of its implementing regulations should be invalidated
- Under Obama, the DOJ argued that if the individual mandate is unconstitutional, it is severable from the ACA's other provisions, except for the guaranteed issue and community rating rules
  - Current DOJ (Jeff Sessions) agrees with the prior DOJ regarding severability – i.e., the court should declare the pre-existing conditions protections and other consumer protections to be unconstitutional
  - Immediate relief not requested – should take effect 1/1/19

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Texas v. United States

- DOJ has a longstanding, bipartisan commitment to defending the law when non-frivolous arguments can be made in its defense
- Several career federal lawyers withdrew from the case shortly before it was filed, which suggests that the arguments made were meritless

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Fixing the ACA

- **Undo Sabotage and Expand Affordability of Health Insurance Act**
- Introduced by the three Ranking Members of Energy and Commerce, Ways and Means, and Education and the Workforce Committees
  - Goal is to expand affordability and restore stability to the ACA Marketplaces
- Undoing Sabotage
  - The Act would rescind the regulations designed to expand Association Health Plans (AHPs)
  - Protect consumers with preexisting conditions by requiring short-term limited duration insurance (STLDI) to comply with guaranteed issue, community rating, essential benefits, and other ACA rules
  - Various provisions to protect the Marketplace, ACA Navigators

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Fixing the ACA

- **Undo Sabotage and Expand Affordability of Health Insurance Act**
- Expanding Affordability
  - Expand eligibility for premium tax credits (PTC) beyond 400% of the federal poverty level (FPL) and increase PTC for all income brackets
  - Expand eligibility for cost sharing reductions (CSRs) from 250% to 400% FPL and make CSRs more generous for those below 250% FPL
  - Fix the "family glitch" – i.e., base "affordability" on family coverage
- Is this ACA 2.0? Maybe a 2.0% chance of passing…

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Fixing the ACA

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Single Payer is not the Answer

- **Colorado: Single Payer (Failed)**
- **California: Abandoned When Determined It Would Cost 2X Current State Budget**
- **Vermont: Quietly Abandoned**

- No Model For Single Payer for 350M That Works

- No Model for Federal Government Success as **Market Participant**

- Mercatus report showed Medicare-for-all could save $2 trillion over 10 years?
  - The $2T 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? $3.25T **increase** over 10 years

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Tax Cuts and Jobs Act – Tax Credit for Paid Leave

- New business tax credit for employers that offer paid FMLA-type leave
- To qualify, employer must allow all "qualifying" full-time employees at least 2 weeks of annual paid family and medical leave (pro-rata for part-time employees)
  - Employer does not have to be subject to FMLA; policy must include non-interference language
  - Must provide at least 50% of employee's regular wages
  - Vacation leave, personal leave, or other medical or sick leave would not be considered family and medical leave, nor would state-mandated leave
  - Payments under STD/salary continuation may qualify for the credit if leave is FMLA-qualified
- Employee is "qualifying" if he/she has been employed for at least 1 year, and who, for the preceding year, had compensation not in excess of 60% of the compensation threshold for highly-compensated employees ($120,000 for 2018)
  - Credit equals to 12.5% of the amount of wages paid, increased by 0.25% for each point over 50% (but not to exceed 25% of the wages paid)
  - Up to 12 weeks of leave taken into account per year
- Effective for wages paid in 2018 and 2019 (provision sunsets after 2019)

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Short-Term Spending Bill

- **Extension of Continuing Appropriations Act, 2018**
- Cadillac Tax delayed until 2022
  - Previously delayed from 2018 to 2020 under the PATH Act
  - 40% tax on value of health coverage in excess of $10,200 (single) / $27,500 (fam)
- 2.3% Medical Device Tax Suspended for 2018 and 2019
  - Was also suspended for 2016 and 2017
- HIT Tax (Health Insurance Industry Tax) Suspended for 2019
  - Was suspended for 2017, in effect for 2018
  - Applies to fully insured medical, dental and vision plans
  - One of the HSA expansion bills suspends it for 2020 and 2021 as well

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Compliance Update

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2019 HSA and ACA OOP Limits

	2019 (single/family)	2018 (single/family)
Annual HSA Contribution Limit	$3,500 / $7,000	$3,450 / $6,900
Minimum Annual HDHP Deductible	$1,350 / $2,700	$1,350 / $2,700
Maximum Out-of-Pocket for HDHP (applies to all in-network benefits)	$6,750 / $13,500	$6,650 / $13,300
ACA Maximum Out-of-Pocket Limits	$7,900 / $15,800	$7,350 / $14,700

- 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

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Employer Mandate and Reporting

- Safe harbor for *de minimis* errors: Forms 1095-C filed with incorrect dollar amounts on Line 15 (employee required contribution), may fall under the safe harbor for *de minimis* errors, which applies if no single amount in error differs from the correct amount by more than $100
  - If the safe harbor applies, employer is not required to correct Form 1095-C to avoid penalties
  - However, if recipient elects for safe harbor not to apply, employer must issue corrected Form
- Penalty relief for good-faith errors continues for 2017 reporting
- FPL Safe Harbor for Calendar Year 2019 Plans
  - $12,140 FPL × 9.86% ÷ 12 months = $99.75 / month
- Projected employer mandate penalties for 2019: $2,500 / $3,750

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Employer Mandate Penalty Letters

- Employers are receiving penalty letters (226J) for CY2015
- 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

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Employer Mandate Penalty Letters

- **What should I do if I receive Letter 226J?**
  - Review the letter and its attachments carefully against the information reported on Forms 1094-C/1095-C
- **If you agree** with the proposed amount, sign and return Form 14764 and remit payment or wait for a Notice and Demand
- **If you do not agree** with the proposed amount, sign and return Form 14764 by the response date shown on the letter
  - Include a signed statement explaining why you disagree with the proposal
- Consider engaging ERISA counsel to respond

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Letter 5699

- **IRS contacting employers it believes should have filed ACA forms**
  - Letters going out for 2015 and 2016
  - 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

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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 advises court that anticipated effective date of further rulemaking would be 2021
- December 2017 – Court vacates 30% incentive limits effective 1/1/19
- March 30, 2018 – EEOC status update: No plans to issue revised regulations by a particular date certain

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ADA Insurance Safe Harbor

EEOC v. Flambeau Inc.*, and *Seff v. Broward County, FL

- Courts in *Flambeau* and *Seff* held that the ADA's "insurance safe harbor" provision applies to wellness programs in a way that allows employers to penalize employees who do not answer disability-related questions or undergo medical examinations (e.g., employees who refuse to complete an HRA and/or biometric screening)
- EEOC believes both cases were wrongly decided
- EEOC rejects the idea that the safe harbor could apply to employer wellness programs, since employers are not using information in a manner required by the safe harbor
  - Final rules explicitly state that the safe harbor provision does not apply to wellness programs even if they are part of an employer's health plan

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ADA Insurance Safe Harbor

EEOC v. Orion Energy Systems

- Employees had to complete HRA and use Range of Motion machine
- Employee refused to participate and was required to pay 100% cost of medical coverage
  - If employee had participated, employer would have paid 100% of premium of coverage
  - Employee was later terminated
- In September 2016, the court in Orion agreed with the EEOC that the ADA's safe harbor did not apply to Orion's wellness program, but concluded that it was still voluntary
  - EEOC hadn't yet drafted regulations specifying 30% limits

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What's Next for Wellness?

- For 2018, employers may continue to rely on the EEOC's final regulations; however, as employers begin to prepare for 2019, they again face uncertainty as to their wellness program incentives subject to the ADA and GINA
  - It seems unlikely that EEOC will issue guidance in time for open enrollment
- Given the current state of limbo, employers wishing to avoid exposure could design wellness programs that do not contain incentives tied to medical exams or disability-related inquiries
  - Instead, they could tie all incentives to activities not subject to the ADA and GINA, such as, tobacco user surcharges with no medical testing, participatory programs such as health seminars or gym use that do not contain disability-related inquiries, and activity-based programs with no medical tests such as walking challenges

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What’s Next for Wellness?

- On the other hand, some believe that wellness programs designed to comply with existing rules, specifically the 30% cap, are unlikely to be challenged by the EEOC
- Employers might ask the question – would our employees feel compelled to participate in wellness based on the size of the incentive?
  - If the answer is yes or maybe, the more risk-averse approach would be to reduce incentives paid in 2019 to a level that better supports the argument that the wellness program is “voluntary”
- Employers designing and maintaining wellness programs should continue to monitor developments and work with benefits counsel to ensure their wellness programs comply with all applicable laws

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Final Regulations on Association Health Plans

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Final Regulations on AHPs

- **DOL's New Definition of Employer**
- *Historically*: Association had to be formed for something other than obtaining health insurance coverage – no longer a requirement
- Under final "Commonality of Interest" rules, AHP may be formed
  - Along same Geographic Area (In-State or In-Metropolitan Area)
  - Along same Trade, Industry, Line of Business, or Profession
- Must be formally established and run by employers
- Effective dates:
  - 9/1/18 - All associations may establish a fully insured AHP
  - 1/1/19 - Existing associations that sponsor an AHP may self-insure
  - 4/1/19 - All other associations (new or existing) may self-insure an AHP
- MBWL can help with incorporating documents & related documents

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Final Regulations on AHPs – Highlights of the Final Rule

- Existing bona fide associations may continue to rely on prior DOL guidance
  - Final rule provides an ***additional*** mechanism for an association to sponsor a single ERISA-covered group health plan
  - Important because many bona fide associations experience-rate on an employer-by-employer basis, which is prohibited under the new rules
- AHPs may self-insure under the final rule; however, the DOL anticipates that many AHPs will be subject to state benefit mandates
  - States retain the authority to adopt minimum benefit standards, including standards similar to those applicable to individual and small group insurance policies under the ACA, for all AHPs

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Final Regulations on AHPs

- **Potential Limits Based on State Regulation**
- All AHPs are MEWAs and will need to ensure compliance with existing federal regulatory standards governing MEWAs (such as M-1 filings)
  - DOL intends to reexamine existing reporting requirements for AHPs/MEWAs, including the Form M-1 and possibly the Form 5500
- Final rule does not preempt state insurance law, nor does it create an exemption from existing state regulation for self-insured MEWAs
  - Many states regulate self-insured MEWAs as commercial insurance companies and others prohibit them altogether
  - States regulation of fully insured MEWAs is limited to setting contribution and reserve levels, licensing, registration, and financial reporting to ensure solvency; however, states may regulate the underlying insurance contacts or policies

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Final Regulations on AHPs

- **In the past, states have opposed AHPs due to consumer protection concerns**
- *Adverse selection*: AHPs will be subject to large group rating rules (no EHB requirement) – they could be marketed toward healthier/younger individuals, which could undermine the individual and small group marketplaces
- Other concerns relate to fraud protection from unscrupulous promoters
- States may impose standards to protect consumers and guard against adverse selection, which may cause AHPs to be less attractive to employers
- Some states already prohibit small group members of an association from being rated as large group

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What's Next?

- The new regulations may not significantly increase the number of self-insured AHPs because of existing state MEWA rules
  - Future of AHPs is in the hands of the states
  - Massachusetts and New York AG's have filed a lawsuit challenging the legality of the new regulations
    - 15 other state AGs had signed onto a comment letter opposing the rule; however, they haven't joined the lawsuit at this time
  - New Jersey recently enacted an individual mandate (eff. 2019), which provides that coverage under an AHP will not qualify as minimum essential coverage for purposes of the law unless it complies with state standards

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Questions?

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