2019

2019 Regulatory Wrap-Up and a Look Forward to 2020

Presented by Benefit Comply

- Welcome! We will begin at 3 p.m. Eastern
- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.
- You will be able to submit questions during the webinar by using the “Questions” or “Chat” box located on your webinar control panel.
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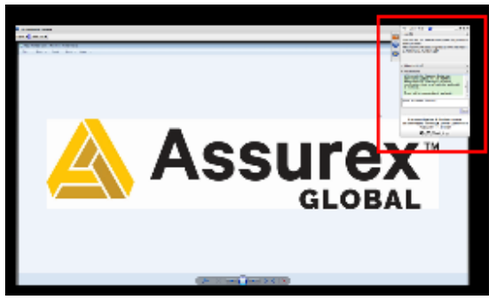

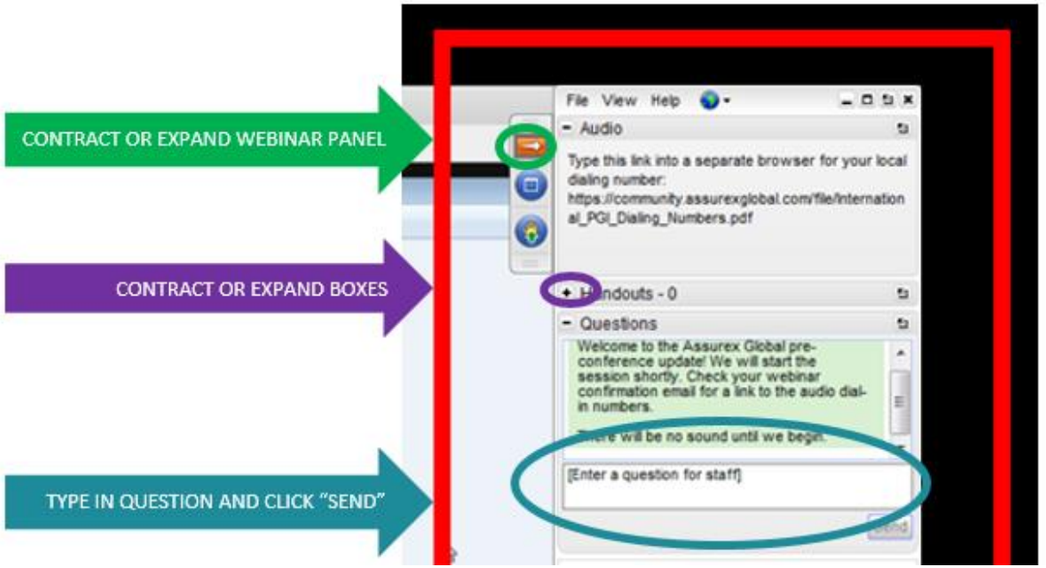

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2019 Compliance Year in Review

Agenda

- Action in the Courts
- Regulatory Review
- Things to Watch for in 2020

Action in the Courts

Action in the Courts

- *Texas v. United States*
  - Texas district court judge ruled entire ACA is unconstitutional
    - Opinion states individual mandate of the ACA is unconstitutional and inseverable from the rest of the ACA, so the entire law is invalid
  - Background
    - In 2010, Supreme Court upheld the individual mandate under the taxing clause
    - In 2017, Congress reduced the individual mandate penalty to $0 (effective 2019)
    - In Feb. 2018, *Texas v. Azar* filed by Republican state attorneys general and governors from 20 states
      - Argued since penalty was reduced to $0, it cannot be a tax
    - Department of Justice (DOJ) decided not to defend the individual mandate
    - Democratic state attorneys general from 16 states and D.C. allowed to intervene to take up defense of the law
    - Jan. 2019, state defendants and U.S. House file appeal
      - Argued that even if individual mandate found unconstitutional, it is severable from the rest of the ACA
    - Jul. 2019, 3-judge panel 5th Circuit Court of Appeals held a hearing

Action in the Courts

- *Texas v. United States* (continued)
  - 5th Circuit Court of Appeal Decision
    - Dec. 2019, court found the individual mandate unconstitutional and sent the case back to federal district court judge (O'Connor) in Texas to re-evaluate whether the mandate is severable from the rest of the ACA
      - *"We [direct] the district court to employ a finer-toothed comb on remand and conduct a more searching inquiry into which provisions of the ACA Congress intended to be inseverable from the individual mandate....it is no small thing for unelected, life-tenured judges to declare duly enacted legislation passed by the elected representatives of the American people unconstitutional. The rule of law demands a careful, precise explanation of whether the provisions of the ACA are affected by the unconstitutionality of the individual mandate as it exists today"*
      - *"The relief the plaintiffs sought in the district court was a universal nationwide injunction ... Now [the defendants] have changed their litigation position to argue that relief in this case should be tailored to enjoin enforcement of the ACA in only the plaintiff states -- and not just that, but that the declaratory judgment should only reach ACA provisions that injure the plaintiffs"*

Action in the Courts

- *Texas v. United States* (continued)
  - What's next?
    - Justice O'Connor will need to reconsider in accordance with the appellate court decision
    - Appellate court decision might be appealed to the Supreme Court
      - Next Supreme Court session begins October 2020
    - Final decision is unlikely until after the next election
  - State individual mandates
    - California, D.C., Massachusetts, New Jersey, Rhode Island and Vermont

Action in the Courts

- *New York et. al v. U.S. Department of Labor*
  - Association health plans (AHPs)
    - Prior to new DOL rule, small employers had to meet a narrow commonality of interest test in order to be treated as a single large group health plan
      - Each small employer was subject to the insurance rating and underwriting rules
    - New rule (finalized Jul. 2018) expanded the types of groups that can form a large group (businesses in the same industry, businesses located in the same state or common metropolitan area, working owners)
      - Each AHP treated as a single plan for determining whether large group health plan rules apply (essential health benefits and modified community rating)
  - Mar. 2019, D.C. federal court invalidated two major provisions of DOL AHP rule
    - Judge sent the rule back to the DOL
    - Apr. 2019, DOL filed an appeal
    - Department announced it will not pursue enforcement actions against plans who acted in reliance on the final rule before the district court decision (fully-insured AHPs)
  - Aug. 2019, North Carolina passed a law permitting AHPs

Action in the Courts

- *AARP v. EEOC* (Review)
  - AARP lawsuit – claimed 30% “penalty” means the plan is not “voluntary”
    - Court required EEOC to issue new rules or provide information to defend current rules meet voluntary status
    - Dec. 2017, court issued a ruling vacating the current incentive limit effective Jan. 2019
- *AARP v. Yale*
  - Class action lawsuit on behalf of over 5,400 workers at Yale University arguing violation of the ADA and GINA
    - $1,300 a year for failing to participate in wellness program involving biometric screenings and family medical history
  - What should employers do?
    - Option 1 – Ignore it until we receive further guidance or court rulings
    - Option 2 – Implement alternatives

Action in the Courts

- *DeOtte v. Azar* (Justice O'Connor)
  - Jun. 2019, national injunction on enforcement of the contraceptive mandate arguing the mandate violates the Religious Freedom Restoration Act (RFRA)
- Contraceptive exemption granted by agencies for any employers with moral or religious objection
  - Various federal courts granted injunctions, primarily for failure to follow administrative procedural rules
- What does this mean for employers who prefer not to provide contraceptive coverage at no cost?
  - Religious organizations are exempt
  - Nonprofit and closely held organizations could still use the accommodation process
  - Others with a religious or moral objection – discuss with counsel while things are being sorted out

Regulatory Review

Regulatory Review

- Two New HRA Options
  - Current types of HRAs
    - HRA integrated with a group medical plan
    - Limited-purpose HRA
    - Retiree-only HRA
    - Qualified small employer HRA (QSEHRA)
  - New HRA options – effective Jan. 2020
    - Excepted benefit HRA (EBHRA)
      - Limited stand-alone HRA
    - Individual coverage HRA (ICHRA)
      - HRA integrated with individual health coverage or Medicare that can also be set up to reimburse other §213(d) qualifying medical expenses

Regulatory Review

- Excepted Benefit HRA (EBHRA)
  - Stand-alone HRA that qualifies as an excepted benefit
    - Available to reimburse all §213(d) expenses (other than premiums), not just excepted benefits (i.e. dental and vision) - don't confuse with an HRA that reimburses only "excepted benefits"
    - Maximum benefit cannot exceed $1,800 for the plan year (indexed annually)
  - Stand-alone
    - Employee and dependents do not need to be covered by a group medical plan (integration not required)
    - Employees must be eligible for (but not necessarily enrolled in) both the employer's group medical plan and the HRA
  - Very similar to a general-purpose health FSA, except:
    - Funded solely by employer contributions
    - Higher annual employer contribution limit ($1800 rather than $500)
    - Allows for unlimited carryover and spend-down provisions (health FSAs allow for a $500 carryover)

Regulatory Review

- Individual Coverage HRA (ICHRA)
  - Employee/Dependents must be covered by an individual plan to participate
    - Individual health insurance (exchange or non-exchange), Medicare, catastrophic coverage, etc.
    - NOT: short-term, limited-duration, excepted benefits, TRICARE, or healthcare sharing ministries
  - Employees cannot be offered both an ICHRA and traditional medical coverage
  - ICHRA must be offered on the same terms to all employees in a class
    - Can only classify by list of permitted classifications (full-time, salaried, insurance rating area, collective bargaining, etc.)
    - Can combine classes
    - Minimum class sizes in certain cases

Regulatory Review

- Individual Coverage HRA (ICHRA) Continued…
  - §4980H compliance
    - A compliance ICHRA is considered MEC (minimum essential coverage)
    - Affordable if the difference between the lowest cost silver plan and the employer's HRA contribution meet affordability percentage of employee's household income (same affordability safe harbors apply)
      - Provides minimum value if the coverage is affordable
  - Other rules
    - Substantiation
    - Annual notice
    - Subject to ERISA and COBRA
    - §125 (cafeteria) plan – employees can pay premiums pre-tax if coverage is off-Exchange

Regulatory Review

- PCORI Fees
  - Background
    - ACA created a nonprofit called the Patient-Centered Outcome Research Institute to do health outcome research
    - Partially funded through fees paid by insurers and plan sponsors of self-insured health plans
    - Report and pay fees on excise tax Form 720 by July 31st of the year following the last day of the plan year
  - Plans subject to the fee
    - Most self-insured group health benefits (e.g. medical, HRA), but not excepted benefits
      - Carriers pay the fee on behalf of fully-insured plans
    - IRS website on benefits subject to fee:
      - https://www.irs.gov/newsroom/application-of-the-patient-centered-outcomes-research-trust-fund-fee-to-common-types-of-health-coverage-or-arrangements
  - This is/was the last year (maybe)!
    - No longer in effect for plan years that end on or after Oct. 1, 2019
      - Calendar year plans reported and paid for the last time Jul. 2019 (for the 2018 plan year)

Regulatory Review

- Prescription Drug Manufacturer Coupons and Cost-Sharing Requirements
  - Background
    - Drug manufacturers offer coupons to individuals to reduce copays, and HHS is concerned this practice causes consumers to choose expensive brand-name drugs
  - 2020 Notice of Benefit & Payment Parameters
    - *"Where there is no generic equivalent available or medically appropriate…amounts paid toward cost sharing using any form of direct support offered by drug manufacturers must be counted toward the annual limitation on cost sharing…"*
      - Example: Monthly drug cost is $1000, but coupon reduces the cost to $300. If there is a generic alternative available, only $300 counts toward the OOP maximum
    - Participants may meet out of pocket limits much faster = more expense to the plan
  - Aug. 2019 – FAQ
    - Delayed application of this new interpretation until further guidance is provided for 2021
    - Need to reconcile this rule with the requirement that in order to be HSA-eligible, an HDHP must disregard coupons when determining whether a person has met the minimum deductible

Regulatory Review

- HSA-Eligibility: Expanded Definition of Preventive Coverage
  - HSA-Eligibility: To be eligible to contribute to an HSA, an individual (i) must be enrolled in a qualifying high-deductible health plan (HDHP); (ii) may not have any other “disqualifying coverage”; and (iii) cannot be claimed as a tax dependent by another individual
  - Disqualifying coverage does not include preventive or permitted coverage or insurance
    - Preventive coverage generally does not include any service or benefit intended to treat an existing illness, injury, or condition
  - IRS Notice 2019-45 expanded definition of “preventive coverage”
    - Now includes treatment for some chronic illnesses (e.g. congestive heart failure, osteoporosis, diabetes, hypertension, asthma, depression)

Regulatory Review

- Health Plan ID Number (HPID)
  - Self-insured employers were required to get an HPID
    - HIPAA requires covered entities to follow specific standards for certain electronic transactions
      - Employer-sponsored group health plans are HIPAA covered entities
    - Self-insured health plans originally required to obtain an HPID from CMS
      - Nov. 2014 for large health plans
      - Nov. 2015 for small health plans
      - Plans then required to provide certification to CMS that the plan is correctly processing certain electronic transactions
  - First delay
    - Requirement was delayed by CMS on the eve of the deadline (Oct. 31, 2014)
  - Formal removal
    - Dec. 2018, HHS issued proposed regulations to rescind the requirement
    - Oct. 2019, HHS issued final regulations
      - No required action for employers; HHS will deactivate HPIDs

Regulatory Review

- Transparency in Coverage Reporting
  - Proposed rule issued in response to Trump's Executive Order - Improving Price and Quality Transparency in American Healthcare to Put Patients First
    - Requires group health plans to provide:
      - Estimate of an individual's cost-sharing liability for a covered item or service, including underlying information necessary to calculate the estimate;
      - Notice of any required prerequisite for the item or service; and
      - Notice explaining limitations applicable to the individual's cost-sharing liability estimate
    - Model notice - https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-draft-model-disclosure.pdf
    - Employers offering self-insured group health plans will have to comply
      - Carriers will handle this on behalf of fully-insured plans
  - Not effective until 1 year after final rules are issued

Regulatory Review

- Employer Reporting
  - Continued IRS enforcement of §4980H employer mandate and associated employer reporting
  - Employer reporting guidance
    - As in previous years, IRS extended due date to Mar. 2, 2020 (instead of Jan. 31, 2020) for employers and insurance companies to provide 2019 Form 1095s to individuals
    - Penalty relief remains available for good faith reporting errors
    - New relief this year related to providing Form 1095s to certain individuals
      - IRS recognized individuals no longer need proof of minimum essential coverage for their tax returns
      - Form 1095s completed solely to comply with §6055 coverage reporting (e.g. small employers offering self-insured coverage) can meet distribution requirements simply by making them available upon request
        - Distribution relief not available to applicable large employers preparing Form 1095-Cs on behalf of full-time employees

Regulatory Review

- Other Regulatory Action
  - Further clarification on mental health parity requirements (esp. non-quantitative treatment limitations)
  - Proposed rules reducing nondiscrimination requirements under §1557 (including a simplification of the definition of “gender”)
    - Caution: The definition of “sex” and “gender” is being argued not only for purposes of §1557 application, but also more generally under Title VII and IX
  - Medicare mandatory reporting under §111 now includes prescription drug information
    - Reporting typically handled by carrier or TPA (for self-insured plans)
      - No action required of employers unless prescription drug plans are self-administered
    - Carriers/TPAs may reach out to employers requesting additional information
  - New SBC templates and instructions released for use beginning in 2021 (very few changes)

Things to Watch for in 2020

Things to Watch for in 2020

- New EEOC Rules
  - Fall agenda suggested a Notice of Proposed Rule Making for previously rescinded wellness regulations under the ADA and GINA
    - Jan. 2020 proposed release date
    - Deadline has been extended multiple times
    - New EEOC Chair (Janet Dhillon) sworn in
- Surprise Billing Legislation
  - 28 states have enacted consumer protections to address surprise billing
  - 6 federal bills have been introduced since 2019 (4 with bipartisan support)
  - 8 in 10 Americans support legislation aimed to reduce the effects of surprise billing (Kaiser Family Foundation)
- Cadillac Tax Repeal?
- PCORI Fee Return?

Things to Watch for in 2020

- Health Insurance Tax (HIT) Returns
  - HIT is scheduled to resume for 2020
    - The tax, enacted under the ACA, was suspended for 2019
    - Imposed on health insurance carriers (not applicable to self-insured plans)
    - Tax is based on a complex formula - based on size of the carrier, its market share, and other factors
  - What should employers expect?
    - No way to know exactly how much tax each carrier will pay
    - Carriers take different approaches to communicating the HIT to employers
      - Separate line item on bill, administrative expense, no indication
    - Estimates indicate HIT adds between 1.5% and 3% to fully-insured health plan premiums

Things to Watch for in 2020

- 2020 Election
  - What if…
    - Republican – Presidency and Senate, Democratic – House
      - More of the same
      - Doesn't mean no changes
      - Regulatory changes (ICHRA, §1557, AHP)
    - Democratic control
      - Significant legislative changes
    - Republican – Senate, Democratic – Presidency and House
      - Regulatory changes (5500 expansion, fully-insured nondiscrimination, ICHRA)

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