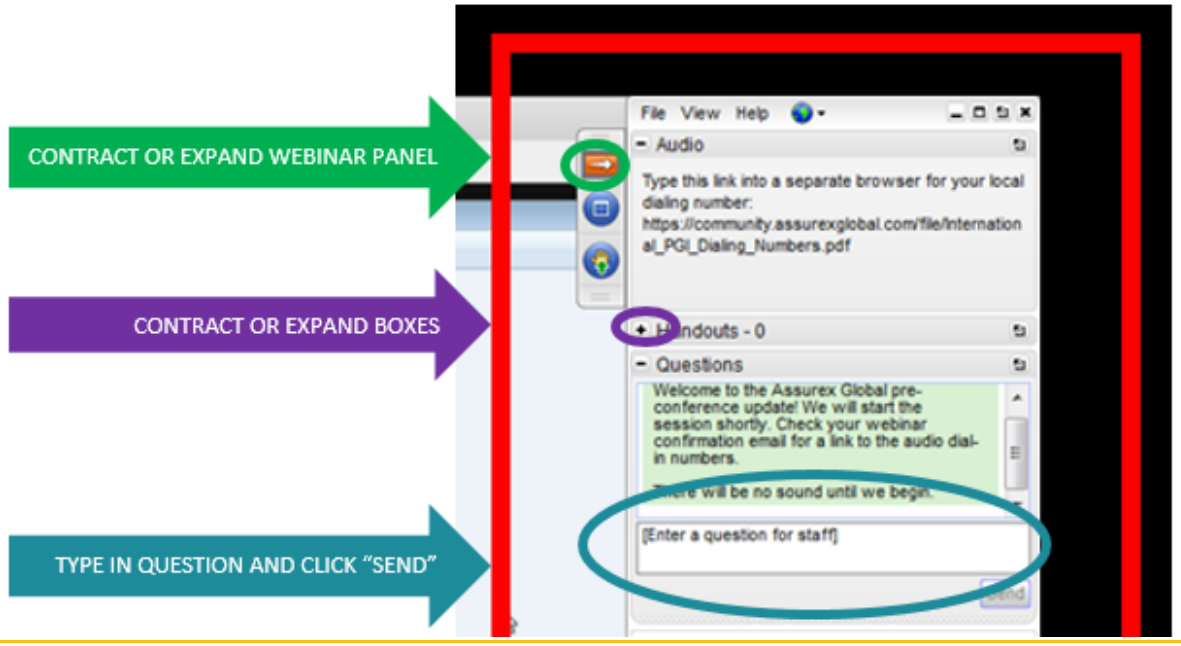
December 20, 2018

2018 Regulatory Wrap-Up and a Look Forward to 2019

Benefit Comply

2018 Regulatory Wrap-Up and a Look Forward to 2019

- 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.
- Slides can be printed from the webinar control panel – expand the “Handouts” section and click the file to download.



December 2018

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Agenda

- Action in the Courts
  - Texas v U.S. ACA Case
  - AARP v EEOC Wellness Case
  - ERISA Lawsuit - Reclassifying Employees to Part-time
  - Tobacco Incentive Cases
- 2018 Regulatory Review
  - AHPs
  - HRAs
  - IRS/SSA/CMS Data Match Program
- Update on IRS §4980H Employer Penalty Collection Efforts
- Things to Watch for in 2019

Action in the Courts

Action in the Courts

- *Texas v. Azar*
  - A Texas district court judge ruled that the entire ACA is unconstitutional
    - The opinion states the individual mandate of the ACA is unconstitutional and inseverable from the rest of the ACA, so the entire law is invalid
  - Background
    - In 2010, the Supreme Court ruled that Congress had the right to impose the individual mandate under its power to tax
    - In 2017, Congress reduced the individual mandate penalty to $0 (eff. 2019)
    - *Texas v. Azar* was filed in Feb. 2018 by Republican state attorneys general & governors from 20 states
      - Argued since the 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 the defense of the law
      - Argued that even if court found individual mandate unconstitutional, the provision is severable from the rest of the law and other ACA provisions should remain

Action in the Courts

- *Texas v. Azar* (cont.)
  - Next Steps
    - The judge entered a declaratory judgment, not an injunction
      - The law remains in force while the case moves through the courts
    - CMS issued a statement the day after the decision:
      - …"*there will be no impact to enrollee's current coverage or their coverage in a 2019 plan*" for individual health insurance through Healthcare.gov, or a state public Marketplace
    - HHS also issued a statement:
      - *"…HHS will continue administering and enforcing all aspects of the ACA as it had before the court issued its decision. This decision does not require that HHS make any changes to any of the ACA programs it administers or its enforcement of any portion of the ACA at this time."*
    - California announced plans to appeal the decision if necessary
      - However, with no injunction in place, there may be no reason to appeal until the district court takes further action
      - Intervenor states have asked the judge for clarification on the ruling

Action in the Courts

- *Texas v. Azar* (cont.)
  - What should employers do? - Employers should continue to comply with the ACA
    - IRS is moving forward with its efforts to collect penalties from applicable large employers who did not meet §4980H offer of coverage requirements
    - It will take significant time for this case to be resolved by higher courts
    - Even if the district court judge issues an injunction, it would likely be stayed pending inevitable appeals

Action in the Courts

- *AARP v. EEOC*
  - Background
    - There are two sets of rules wellness plans must follow: (i) HIPAA non-discrimination rules, and (ii) ADA and GINA related EEOC rules
      - The ADA restricts employers from asking disability-related questions or requiring medical examinations unless they are job-related
        - Contains an exception for wellness programs that are “voluntary”
      - EEOC issued final rules for plan years beginning in 2017
        - EEOC rules apply only to wellness programs that include medical testing or ask disability-related questions
        - One of the EEOC rules allows an incentive of up to 30% of the “premium”
  - AARP lawsuit - claiming 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
    - December 2017, the court issued a ruling vacating the current incentive limit effective 1/1/2019

Action in the Courts

- *AARP v. EEOC* (cont.)
  - EEOC has still not responded to court demands - status of lawsuit is up in the air and rules are vacated 1/1/2019
  - What Should an Employer Do?
    - Option 1 - Ignore It – Some are arguing that we are simply back to what existed prior to EEOC rules issued in 2016
      - Some risk of private lawsuits – Argument would be that wellness plan with incentives violates ADA voluntary requirement
      - Very little risk of EEOC enforcement
    - Option 2 - Implement a “Plan B” wellness program
      - Redesign wellness plans so no incentives are tied to medical testing or disability-related questions (e.g. no incentives tied to biometric screenings or health risk assessments)
      - Incentives could still apply to other wellness initiatives such as:
        - Tobacco surcharges with no medical testing
        - Participatory programs such as gym use
        - Walking/exercise programs

Action in the Courts

- *Marin v. Dave & Buster's*
  - Class action ERISA lawsuit alleged that Dave and Buster's cut full-time employee hours in response to the ACA's requirement to offer health coverage to employees working 30 hours
  - ERISA §510 prohibits illegally interfering with an employee's right to attain a benefit under an ERISA plan
  - Dave and Buster's agreed to a $7.425 million settlement

Action in the Courts

- *Acosta v. Dorel Juvenile Group* and *Acosta v. Macy's*
  - DOL enforcement of HIPAA wellness rules
  - In both cases, the DOL claimed that a reasonable alternative standard (or waiver) for a tobacco surcharge was not provided or communicated as required
  - Dorel Juvenile Group Inc required to pay $145,635 in restitution to employees were charged a tobacco surcharge
  - Highlights the importance of treating tobacco surcharges and "smoker rates" as a wellness plan
    - Must notify participants of the availability of a reasonable alternative standard to earn the incentive
      - The notice does not need to describe the details of the available alternative – just that the employee can request it
    - Full incentive must be provided to any employee who completes the reasonable alternative standard, even if they continue to use tobacco

2018 Regulatory Review

2018 Regulatory Review

- Association Health Plans (AHPs)
  - AHPs are a type of multiple employer welfare arrangement (MEWA)
    - State regulations will still generally apply to AHP plans (both fully-insured and self-insured)
  - Rules expand the commonality of interest rules for the purposes of who can join together in an AHP
    - Same trade, industry, line of business, or profession
    - Principal places of business in the same state, or in the same metropolitan area (even if the metropolitan area includes more than one state)
  - AHP will be considered a single ERISA large group plan even if small employers and individual “working owners” participate
    - Avoiding small group and individual health insurance rules (community rating, essential health benefits, etc.) is principal advantage of AHP
  - Groups and individuals cannot be underwritten or rated based on health status

2018 Regulatory Review

- Association Health Plans (cont.)
  - Who can participate in an AHP?
    - Any size business
    - Most working owners, even if they have no employees
  - Other rules
    - AHP must be “controlled” by employer members - health insurance carriers cannot form an AHP
    - AHPs cannot be formed solely for the purpose of offering benefits; must also have another “substantial business purpose”
    - Nondiscrimination rules
      - Prohibit discrimination based on health factors
      - AHP prohibited from premium rating at the employer level

2018 Regulatory Review

- Association Health Plans (cont.)
  - Who is going to bring these plans to market?
    - Geographic plans (e.g. chambers of commerce, regional business groups)
    - Industry-based plans
  - Will AHPs lower plan costs?
    - Plans that offer limited benefits (AHPs not subject to essential health benefits rules) may have lower premiums
    - AHPs set up to attract better risk groups may benefit from experience rating
    - Limited administrative savings possible - current MLR rules already require small group plans to pay out 80% of premium
  - AHP rollout will vary from market to market
    - Health insurance markets vary significantly from state to state
    - Some states fighting the AHP expansion

2018 Regulatory Review

- Health Reimbursement Arrangements (HRAs)
  - IRS, DOL and HHS issued proposed regulations designed to expand the use of HRAs
    - Allow HRAs to be used to pay for individual health insurance policies
    - Create a new type of limited excepted benefit HRA
    - Allow employees to have premiums for some types of individual policies reimbursed on a pre-tax basis through a §125 cafeteria plan
  - Effective in 2020 – final regulations expected in 2019
  - Background
    - Current regulatory guidance prohibits employers from paying for an employee's individual health insurance policy, and requires that HRAs be integrated with group health insurance policies

2018 Regulatory Review

- Health Reimbursement Arrangements (cont.)
  - Option #1: HRA integrated with individual insurance coverage
    - Allow employer to provide tax-free funding to employees' HRA accounts to purchase individual health insurance policies
    - Employers cannot offer both a traditional group health plan and an HRA integrated with individual insurance to the same employees
    - Affordable care act issues - HRA would be considered an offer of coverage for satisfying §4980H(a); and if HRA also provides minimum value and is affordable, would also satisfy §4980H(b) requirements
  - Option #2: Excepted benefit HRA
    - Currently employers are prohibited from offering a stand-alone HRA unless it reimburses claims only for limited expenses such as dental and vision
    - New rules would allow a stand-alone HRA to reimburse all §213(d) expenses up to $1,800 for the plan year (indexed annually)
- Pre-Tax Payment of Individual Health Insurance Premiums
  - Employers may also allow employee to pay individual health coverage premiums on a pre-tax basis through a §125 cafeteria plan

2018 Regulatory Review

- Contraceptive Coverage Exemption
  - Background
    - ACA requires all non-grandfathered plans to offer preventive coverage with no cost-sharing, including contraceptive coverage
    - Exemption for religious employers, and an “accommodation process” for certain nonprofit and closely held entities with religious objections
  - Exemption expansion
    - HHS released interim final rules in October 2017 providing a complete exemption for non-governmental employers with a religious objection and non-governmental employers (not publicly traded) with a moral objection
      - Accommodation process became optional
    - HHS released final rules in 2018 re-affirming the expansion

2018 Regulatory Review

- Contraceptive Coverage Exemption
  - Court action
    - U.S. District Judge granted a preliminary injunction for failure to follow administrative procedural rules when issuing the interim final rules
    - Federal appeals court recently upheld the injunction in the states that brought the action
  - What does that mean for employers who would 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

2018 Regulatory Review

- IRS/SSA/CMS Data Match Program
  - Background
    - CMS began an employer data match program, the purpose of which was to help identify Medicare eligible individuals who were also eligible for employer sponsored coverage
    - Employers who received a letter from CMS were required to report detailed employee and enrollment data to CMS
  - Data match employer reporting program has been suspended
    - First indication was when CMS shut down the reporting website!

Update on IRS §4980H Collection Efforts

IRS §4980H Collection Efforts

- Two Separate Employer Mandate Rules and Penalties
  - §4980H(a)
    - Applicable large employers (ALEs) must offer minimum essential coverage to 95% (70% in 2015) of full-time employees and their dependent children
    - Penalty applies if any full-time employee enrolls through a public Exchange and qualifies for a tax subsidy (i.e. receives a PTC)
    - 2018 penalty - $193.33/mo. ($2,320/yr) times total number of full-time employees, not counting the first 30 (first 80 in 2015)
  - §4980H(b)
    - ALEs must offer coverage that provides minimum value AND is affordable to all full-time employees each month
    - Penalty applies for each full-time employee who enrolls through a public Exchange and qualifies for a tax subsidy (i.e. receives a PTC)
    - 2018 penalty - $290/mo. ($3,480/yr) for each full-time employee who receives a PTC

IRS §4980H Collection Efforts

- Solve For (a) First:
  - You must be able to answer the question “Has the employer set eligibility rules so that there will never be more than 5% of full-time employees not offered coverage in a given month?”

- §4980H(a) Payment Examples – 250 Full-Time Employees
  - Margin of error – 12.5 full-time employees (5% of 250)
  - Offers coverage to less than 95% of full-time employees for one month:
    - 220 X $193.33 = $42,532.60
  - Offers coverage to less than 95% of full-time employees for the entire year
    - 220 X $2320.00 = $510,400.00

IRS §4980H Collection Efforts

- IRS §4980H Collection Efforts
  - The IRS started sending Letter 226J in Nov. 2017 to employers to begin the collection process for employers who failed to meet 2015 §4980H requirements
  - Letter 226J is a “proposed assessment,” not an actual collection letter
  - Proposed assessments are based on data provided to the IRS by the employer on Forms 1094-C and 1095-C
  - IRS has started sending 2016 letters
- Letter 226J Observations
  - Most proposed assessments are due to reporting mistakes rather than to actual violations of §4980H(a) requirements
    - Failure to mark “Yes” in Part III, Column (a) indicating coverage was offered
    - Failure to check Box C of Line 22 indicating 4980H transition relief for 2015
  - IRS will respond with one of a number of different letter 227s decision
    - 227K = IRS accepts the employer’s appeal and no further assessment
    - 227L = IRS accepts some of the dispute and the assessment is reduced
    - 227M = IRS does not accept dispute and assessment remains

IRS §4980H Collection Efforts

- More Letter 226J Observations
  - Know who you listed as your business contact on your 2016 Form 1094 – that is who will get the Letter 226J from the IRS
  - If you receive a letter 226J respond quickly and ask for an extension – IRS is granting a 30 day extension in almost all cases
  - Solve for §4980H(a) – Review your eligibility rules and definitions of full-time employees to make sure you are offering coverage to 95%
  - Check for danger areas
    - Employee classifications (independent contractors, seasonal employees, short term hires)
    - Controlled group and affiliated service group relationships
- More information at http://226jsupport.com/

IRS §4980H Collection Efforts

- Letter 5699
  - IRS is reaching out to employers who appear to be applicable large employers and did not report
- §6055/6056 Penalties
  - Employers who fail to file a Form 1094-C or 1095-Cs could face a penalty of up to $270/form for failure to file with the IRS + $270/form for failure to provide a copy to individuals

Things to Watch for in 2019

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- Proposed Changes to Form 5500
  - In 2016, the DOL proposed major changes to the Form 5500
    - Filing requirement for health & welfare plans with less than 100 participants
    - Much more detail on health plans
    - Certification of compliance with a variety of benefits rules
    - More-detailed financial and vendor reporting
  - Changes were originally proposed to take effect for 2019 plan year reporting
    - DOL has delayed release of changes until date TBD
- Possible IRS HSA Guidance on Impermissible Coverage
  - Individuals ineligible to make tax-free contributions to HSA accounts if they are also covered by other “impermissible coverage” (e.g. PPO plan that is not an HDHP, spouse’s health FSA, Medicare, etc.)
  - New benefits offerings may cause HSA-eligibility problems (e.g. telemedicine, concierge medical services, etc.)
  - IRS regulations have not addressed some of these new benefits, putting HSA contribution eligibility in question

Things to Watch for in 2019

- Possible Delay or Elimination of Cadillac Tax
  - Tax has been delayed a number of times (currently delayed until 2022)
  - Bipartisan support for elimination – the problem is the budget impact
- Resolution of *AARP v. EEOC* Case
  - We hope!
- Final HRA Regulations
- Closely Watch the Texas ACA Case

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