



Keeping the Edge –  
Hot Topics in Employee Benefits for 2020 and Beyond  
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DFW ISCEBS  
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# ISCEBS Membership

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# Program Agenda

- 1 Regulatory Updates
- 2 ACA Updates
- 3 State Activity
- 4 Legislative Updates and Forecasting
- 5 Question and Answer Session



## Section 1

### Regulatory Updates

# Why would an employer consider an ICHRA?

Seven rationales for ICHRA establishment



## Would an employer rather:

1. Retain traditional group health plans, OR
2. Write a *tax-favored check*?

# Health Reimbursement Arrangements

## Final rule on Individual Health Reimbursement Arrangements (HRAs)

On June 13, 2019, the Trump Administration released a final rule in response to President Trump's Executive Order 13813 which called for the expansion of HRAs



**Creates two NEW types of HRAs**

*\*New rule does not affect existing HRAs*



### Individual Coverage HRA (ICHRA)

New rule allows integration of HRA with individual health insurance coverage purchased either on- or off-exchange

### Excepted Benefit HRA

An HRA employees can use to pay for out-of-pocket health expenses and certain premiums; \$1,800 annual limit & only in combination with a GHP

#### Effective date

Final and recently proposed ICHRA regulations can be relied on for plan years beginning on or after **January 1, 2020**

#### Realistic employer implementation

January 1, 2021 (some employers may seek to implement midyear 2020)

#### Recent regulations received\*

*Proposed* regulations released September 29, 2019 on ICHRA affordability (ACA employer mandate) and Section 105(h) NDT

\*Employers may generally rely on the proposed regulations until final regulations are issued

# Individual Contribution Health Reimbursement Account (ICHRA)

## Requirements 1 and 2

### 1 One offering to a class of employees

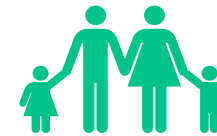


- **Cannot** offer both a group health plan and ICHRA to same class of employees
- **Permissible classes of employees** include:
  - Full-time
  - Part-time
  - Seasonal
  - Each unit of collectively bargained EEs
  - EEs who have not satisfied a waiting period
  - EEs working in same geographic location
  - Salaried
  - Non-salaried
  - Temporary EEs of staffing firms
  - Non-resident aliens with no U.S. income
  - Any group of EEs formed by combining two or more of these classes

### 2 Same terms to same class of employees



- Must offer ICHRA on the same terms (**same amount** and on the **same terms and conditions**) to all employees within the class
- **Exceptions** based solely on:
  - **Participant age:** ICHRA credits offered to older participants can be up to 3x the credits offered to younger participants
  - **Family size:** ICHRA credits may increase as the participant's family size increases



# Individual Contribution Health Reimbursement Account (ICHRA)

## Requirements 3, 4 and 5

### ③ Proof of coverage



- Participants **must enroll** in ACA-compliant individual insurance
- Participants must **substantiate enrollment** in ACA-compliant individual insurance (model attestation form available)

### ④ Opt-out provision



- Must allow participants to **waive future ICHRA reimbursements** for themselves and all family members once per plan year and upon termination of employment

### ⑤ Required notice to participants



- Employers must provide **written notice** to participants 90 days before start of plan year (or no later than the date on which they are first eligible) describing the terms, opt-out provision, premium tax credit eligibility, substantiation requirements, participant responsibilities and other information (model notice available)

# ICRHA Regulations

Interaction of ICHRAs with employer mandate / self-insured nondiscrimination

## Final ICHRA regulations



- Allows applicable large employer members (ALEMs) to integrate an ICHRA with individual health insurance coverage
- ICHRA is considered affordable for an employee for a month if the employee's "required HRA contribution" does not exceed 1/12th of product of the employee's household income and the required contribution percentage
- 4980(H)(b) penalties may apply if the ICHRA is not affordable or does not meet minimum value requirements

## Issues with determining affordability



- **Location:** Determined on an employee-by-employee basis and their place of residence
- **Age:** HRA affordability is based on each employee's age
- **Plan Cost:** Affordability is determined, in part, based on the cost of the HRA affordability plan for that month (e.g., employee contribution in January 2020 would be based on the cost of HRA affordability plan for January 2020)

# Key questions for employers evaluating an ICHRA approach

What factors must the employer consider?



## Budget

- How does the cost and value of ACA insurance compare to your current group plan?
- Can employer maintain or reduce its net cost by adopting an ICHRA?



## Affordability

- Will ACA individual plans be affordable for your employees?
- Can ICHRA credits be set to meet the ACA affordability requirement thus avoiding employer penalties?



## ACA individual market status

- Does a particular ACA rating region present adequate choice (insurers, plans and networks) and value (premiums, actuarial value, out-of-pocket costs)?



## Perceived employee value

- Converting to a defined contribution approach makes the employer subsidy more visible and easily compared; will this help or hinder talent attraction and retention in certain industries?



## Administration

- ICHRA approach presents an opportunity to substantially reduce administration effort and associated cost

**47%** of employers consider **premium cost** as **#1** consideration\*

**46%** consider **ACA market stability** as **#1** or **#2** consideration\*

\*Source: 2019 Willis Towers Watson Emerging Trends in Health Care Survey; sample included companies with at least 100 employees

# IRS expands preventive care coverage for HSA eligibility purposes

## HSAs becoming more user-friendly with larger pre-deductible offerings

The IRS released Notice 2019-45 expanding the list of preventive care benefits permitted to be provided by an HSA-qualified HDHP prior to an individual having satisfied the applicable minimum annual deductible (self-only or family)



### Preventive care safe harbor

- An HDHP may not provide benefits for any year until the applicable minimum annual deductible is satisfied
- A safe harbor allows for certain preventive care to be provided at no cost before the deductible is satisfied and not disqualify an individual from participating in an HSA
  - Prior to the Notice, the safe harbor included things such as physicals and well-child exams, but did not include services or benefits intended to treat existing illnesses, injuries or conditions



### The new rule

- Allows specified services for chronic conditions to be covered under the preventive services safe harbor and be covered at no or reduced cost prior to the individual meeting their minimum annual deductible
- Employers with HSA-qualified HDHP's may choose to cover these additional preventive services prior to an individual having satisfied the HDHP deductible, but it is not required
- These additional services are not considered preventive care under the ACA

A complete list of services and items for chronic conditions that may be treated as preventive care is included in the Appendix of the Notice

***Review the list of additional preventive services with carriers and TPAs; determine which will be treated as preventive services for those participating in an HSA-qualified HDHP***

# IRS expands preventive care coverage for HSA eligibility purposes

## Additional pre-deductible preventive conditions

As set forth in the Appendix to Notice 2019-45, the list of additional preventive care services and items for chronic conditions that may be treated as preventive care include the following:

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

***Review the list of additional preventive services with carriers and TPAs; determine which will be treated as preventive services for those participating in an HSA-qualified HDHP***

# Administration issues FAQ on prescription drug coupon rule

## Tri-agencies issue FAQ

The DOL, HHS and Treasury have issued an FAQ to address how drug manufacturer coupons for brand-name drugs may be applied for purposes of cost-sharing limits under the ACA



### Issue 1: Notice of Benefit and Payment Parameters

Group health plans may exclude from cost-sharing amounts paid using drug manufacturer coupons for brand drugs that have a medically appropriate generic equivalent. When a generic equivalent is not available, plans count value of coupon towards cost-sharing limit



### Issue 2: HSA qualified High Deductible HP

Drug discounts do not disqualify an individual from being HSA eligible provided that the individual is responsible for paying the costs of any drugs (taking into account the discount) until the HDHP deductible is satisfied



### Issue 3: Conflict between agency guidance

The IRS notes a plan cannot count value of drug coupon towards the HDHP plan cost sharing limit; however, this is contrary to CMS notice which implies that excluding the coupon's value would be prohibited when a generic equivalent is not available or medically appropriate.



### Solution: Interim resolution from the Agencies

The Departments will not take any enforcement action if a group health plan excludes the value of drug manufacturers coupons from counting towards cost-sharing limits even when no medically appropriate generic equivalent is available for a brand name drug



# Mental Health Parity & Addition Equity Act (MHPAEA)

## General requirements



### Overview

Requires health plans providing **Mental Health/Substance Use Disorder (MH/SUD)** benefits to provide those benefits **in parity with Medical/Surgical (M/S)** benefits



### Financial Requirements/Quantitative Treatment Limitations

Group health plans offering M/S benefits and MH/SUD benefits that impose **“financial requirements”** (e.g., deductibles, copayments, coinsurances, out-of-pocket maximums) or **“quantitative treatment limitations”** (e.g., number of visits, days of coverage, days in a waiting period), must apply these requirements/limitations to MH/SUD benefits no more restrictively than the **“predominant”** financial requirements or quantitative treatment limitations applied to **“substantially all”** M/S benefits in the same classification



### Non-Quantitative Treatment Limitations

Group health plans must provide parity with respect to **“non-quantitative treatment limitations” (NQTLs)** (e.g., prior authorization, utilization review)

**MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996 (MHPA) which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.**

# Mental Health Parity (MHPAEA)

## Plan-level requirements

All health plans, regardless of funding methodology, have MHPAEA obligations

Work with WTW to understand your obligations today.

- **DOL expectations for self-insured plans**
  - SPDs/plan document review/accuracy
  - Claims/audit review
  - Program structure does not violate QTL/NQTL rules
  - Appropriate disclosures to participants (medical necessity; benefit denials)
- **DOL expectations for fully-insured plans**
  - Confirmation (with documentation) relative to vendor's compliance with the MHPAEA requirements



A mere review of the plan design and SPD is inadequate; and, ASO vendors may not support compliance reviews

# MHPAEA and the Federal Agencies

Tri-agencies issue final MHPAEA FAQs and disclosure request form

## MHPAEA

### Overview

- The DOL, HHS and Treasury issued finalized FAQs that provide guidance on MHPAEA nonquantitative treatment limitations (NQTLs) and issued a final model disclosure form

### NQTLs

- Group health plans must provide parity between MH/SUD and M/S benefits with respect to NQTLs (prior authorization, utilization review)

### Disclosure

- MH/SUD benefits should be disclosed in SPDs and SBCs
- Model disclosure form may, but is not required to be used by plan participants to request MH/SUD benefit information

## Final Guidance



Plans may include/exclude treatments deemed experimental/investigational, but medical management standards must be applied equivalently across M/S and MH/SUD benefits



Professionally recognized treatment guidelines and step therapy can be used to set dosage limits for prescription drugs, but must be applied to M/S and MH/SUD comparably



Plans may apply a general exclusion for a particular condition or disorder, subject to state and federal laws

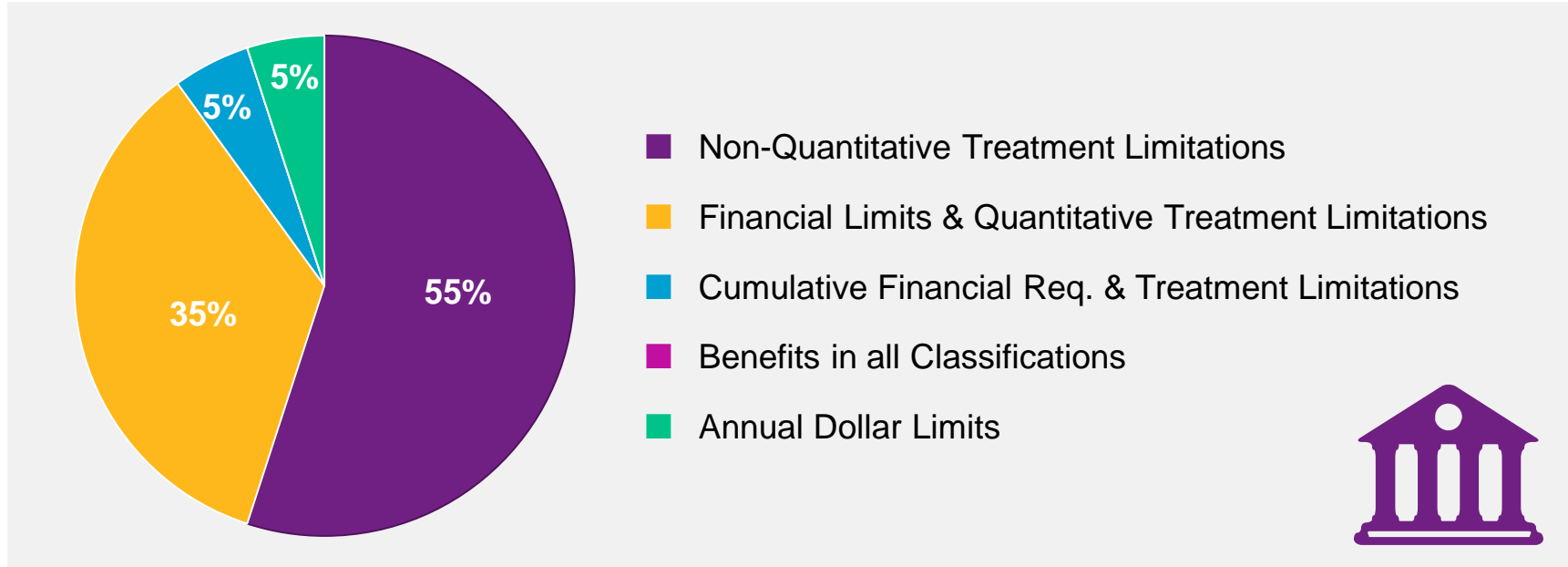


Factors used to determine network adequacy must be applied to M/S and MH/SUD benefits comparably

**Review plans to confirm compliance with MHPAEA**

# MHPAEA and the DOL

DOL MHP investigative focus – enforcement by topic – FY 2018 (DOL)\*



## FY 2018 Enforcement Fast Facts:\*

- Of those 285 closed investigations in FY 2018, 115 involved plans subject to MHPAEA and were, therefore, reviewed for MHPAEA compliance
- Of these 115 investigations where MHPAEA applied, **EBSA cited 21 violations for MHPAEA noncompliance.**
- EBSA advisors answered 127 public inquiries in FY 2018 related to MHPAEA (and have answered 1,445 inquiries related to MHPAEA since 2011).

## HIPAA Enforcement and Penalties

Notification of Enforcement Discretion regarding HIPAA civil monetary penalties

- Previously, under regulations implementing the HITECH Act, HHS set minimum and maximum penalty amounts for four different penalty tiers
- HHS has decided it will now apply separate calendar-year limits for each penalty tier

### This rule would...

- **Focus:** Reduce the dollar caps for violations of identical provisions in a calendar year from \$1.5 million to the amounts in the corresponding penalty tier

Tier	Description	Penalty
1	Did not know, and would not have known of the violation	\$25,000
2	Violation due to reasonable cause and not willful neglect	\$100,000
3	Violation due to willful neglect and was timely corrected	\$250,000
4	Violation was due to willful neglect that was not corrected	\$1.5 million

*The new penalty structure is effective immediately and is subject to annual inflation adjustments*

## HIPAA Enforcement and Penalties

### Inflation Adjustments to the HIPAA Civil Monetary Penalty Scheme

- **HHS has increased the civil monetary penalties for HIPAA violations due to inflation, in accordance with the Inflation Adjustment Act. This rule increases the CMPs for HIPAA violations that occurred on or after February 18, 2009.**
- **The rule for the inflation adjustments for 2020 was issued on January 17, 2020.**

Civil Monetary Penalties – The Four-Tier Violation Platform				
Level of Culpability	Penalty Per Violation		Identical Violations	Max. Penalty Per Calendar Year
	Minimum	Maximum		
▪ Covered Entity <u>Did Not Know</u> and By Exercising Reasonable Diligence Would Not Have Known of Violation	\$119	\$59,522	\$25,000	\$1,785,651
▪ Violation Due to <u>Reasonable Cause</u>	\$1,191	\$59,522	\$100,000	\$1,785,651
▪ Violation Was Due to <u>Willful Neglect and Corrected</u> Within 30 Days of When Covered Entity Knew or Would Have Known of Violation	\$11,904	\$59,522	\$250,000	\$1,785,651
▪ Violation Was Due to <u>Willful Neglect and Not Corrected</u> Within 30 Days of When Covered Entity Knew or Would Have Known of Violation	\$59,522	\$1,754,698	\$1,500,000	\$1,785,651

# HIPAA Disclosures & the Novel Coronavirus

Certain disclosures are permitted without authorization from the patient



The novel Coronavirus (2019-nCov) has become a global pandemic:



- Global Infections – **4,392,599**  
**Confirmed cases**



- Global Deaths – **295,445**  
**Confirmed deaths**



- WHO Risk Assessment:

- China – **Very high**
- Regional Level – **Very High**
- Global Level – **Very High**

- **Permitted** – Treatment of the patient or a different patient
- **Permitted** – Public health activities
- **Permitted** – Health authorities
- **Permitted** – At the direction of a PHA, to a foreign agency
- **Permitted** – To persons at risk
- **Permitted** – Disclosures to friends, family, and others involved in an individual's care
- **Permitted** – Disclosures to prevent a serious and imminent threat
- **Not Permitted** – Disclosures to the media or other not involved in the care of the individual

**Minimum Necessary** – Excepting disclosures for the care of the individual, for most disclosures, a covered entity must make reasonable efforts to **limit the information disclosed to that which is the “minimum necessary” to accomplish the purpose.**

A woman with dark hair, wearing a light-colored button-down shirt, is looking down at a tablet computer she is holding. The background is a blurred meeting room with several people seated around a table, some with laptops open. The lighting is warm and focused on the woman.

## Section 2

### ACA Updates

## IRS releases 2020 affordability rate for ACA employer mandate

Percentage of Income used to determine whether employer-sponsored group health coverage is “affordable”

### Affordability Rate

2019	2020	Change
9.86%	9.78%	-0.8%

### Federal Poverty Line

2019	2020	Change
\$12,490*	TBD	

\*To satisfy FPL, the employee-only cost share in the lowest cost plan offering minimum essential coverage must be less than 9.78% (2020, indexed) of the FPL for a single individual, divided by 12. FPL guidelines in effect 6 months prior to the beginning of the plan year can be used to set employee cost share amounts.

### Updates and Changes

- The 2020 affordability percentage **decreased** from the 2019 rate
- Coverage is deemed affordable if an employee’s premium share for single coverage of the lowest cost medical plan option that meets minimum value standards does not exceed 9.78% of his/her “household income”
- An employer may avoid potential ACA penalties through three affordability safe harbors: Form W-2, Rate of Pay, or Federal Poverty Line\*

→ Use the 2020 affordability threshold of 9.78% to determine affordability of 2020 medical plans

# ACA Employer Mandate Penalties

ACA employer shared responsibility penalty (ESRP) amounts for 2019 and 2020

## ESRP

- Penalty is calculated monthly, the annual penalty is the sum of 12 months of penalties
- Applicable Large Employers (ALE) who do not offer minimum essential coverage (MEC) to at least 95% of its full-time employees and their dependents may be subject to the **4980H(a) penalty**
- ALEs that offer MEC to at least 95% of their full-time employees, but coverage is not affordable or provide minimum value may be subject to the **4980H(b) penalty**

## ESRP Amounts

### 2019

4980H(a)	Change	4980H(b)	Change
\$2,500	+\$180	\$3,750	+\$270

### 2020

4980H(a)	Change	4980H(b)	Change
\$2,570	+\$70	\$3,860	+\$110



**Continue to comply with employer mandate and be aware of the change in penalty amounts**

# ACA Enforcement

## IRS Enforcing the ACA Information Reporting Requirements



### IRS Letters 972CG

#### Triggers

- Applicable large employers (ALEs) who filed forms 1094-C and 1095-C with the IRS past the original due date

#### Penalty assessment period

- IRS is sending notices for the 2017 ACA reporting period

#### Responding to Notices

- **Total agreement** - check box A if in agreement with penalty
- **Partial disagreement** - check box B
- **Total disagreement** - check box C
- If Box B or C is checked, employer submits a signed statement and include supporting documents to explain disagreement with proposed penalty



### 2017 Penalty for late or incorrect filings

Filing date	Penalty
Within 30 days of the filing deadline (March 31)	\$50 per return
After 30 days of the original due date but prior to August 1	\$100 per return
After August 1	\$260 per return

The IRS is currently sending enforcement letters for 2017. 2018 enforcement should start in the coming months. Also, the IRS has started sending demands for PCORI underpayments, so keep an eye out for these statements, as well.



# ACA Information Reporting

## Filing Deadlines

### Furnishing returns to individuals

- The IRS extended the due date from January 31, 2019 to **March 2, 2020** for providing Forms 1095-C and 1095-B to individuals



### Furnishing returns to the IRS

- The due dates for filing Forms with the IRS remain unchanged
- Employers filing electronically must file by **April 1, 2020** and those filing by paper must submit returns by **February 28, 2020**



### Good faith transition relief

- The IRS also extended transition relief for those employers that can show they made good faith efforts to comply with reporting requirements
- Relief applies only to incorrect or incomplete information reported on the Forms and not failures to timely file returns



***Notwithstanding the extensions provided, the IRS encourages employers and other coverage providers to furnish 2019 statements as soon as they are able***

# Summary of Benefits and Coverage

## DOL and HHS Issue New SBC Template

### Summary of Benefits and Coverage Template

- The DOL and HHS have issued an updated template, instructions and other materials related to the ACA requirement for most group health plans to provide a Summary of Benefits and Coverage (SBC) to individuals eligible for or enrolled in the plan.
- The new SBC template is required to be used for plan years beginning on or after January 1, 2021.
- The SBC language on MEC has been updated for the elimination of the individual mandate penalty.
- The Departments released a new Coverage Example Calculator, along with a guide for each coverage example calculation scenarios.

***Use the new template for plan years beginning on or after January 1, 2021  
(Fall of 2020 OE for calendar year plans)***

### Useful Internet Links for SBC Questions

Updated Template -  
<https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/SBC-Template-Accessible-Format-11-2019.pdf>

Updated Instructions -  
<https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Group-Instructions-11-2019.pdf>



## 2020 Outlook for the ACA – The Employer Mandate

The ACA continues its death march in the courts

**The fate of the ACA hangs in the balance in 2020, as the law is subject to review by the 5<sup>th</sup> Circuit Court of Appeals, and potentially the Supreme Court of the United States**



### ACA lawsuit

- In *Texas v United States*, Texas and 17 other states, claim that the individual mandate is unconstitutional citing the Supreme Court's 2012 decision that the ACA is a tax. With the tax reduced to zero, the plaintiff's allege the ACA is invalid in its entirety.
- Justice Reed O'Connor, a Texas federal judge, ruled for the plaintiffs, declaring the entire ACA to be invalid
- CA appealed and the case was sent to the 5<sup>th</sup> Circuit Court of appeals; oral arguments were held and a decision is expected soon.

***All ACA taxes could be under review in the coming year, as the courts deliberate the Texas v. U.S. case – Stay tuned in for updates on the progress of the litigation***

## ACA Section 1557

OCR issues new proposed rule to revise prior interpretation of Section 1557

Section 1557 of the ACA prohibits “covered entities” from discriminating on the basis of race, color, national origin, sex, age or disability in health programs and activities receiving federal financial assistance (FFA).

The proposed rule would eliminate major parts of the regulation, making significant changes Section 1557 – eliminations include:

- The definitions section of the current rule (eliminating definitions of key terms such as “covered entity” and “on the basis of sex”);
- Specific nondiscrimination protections based on sex, gender identity, and association;
- Major language access requirements (such as a requirement that covered entities include translated taglines on notices and significant communications to consumers);
- Notice requirements that require covered entities to post information about Section 1557 and nondiscrimination at its locations and on its website;
- Requirements to have a compliance coordinator and written grievance procedure to handle complaints about violations; and
- Various enforcement-related provisions (such as protections against intimidation and retaliation).



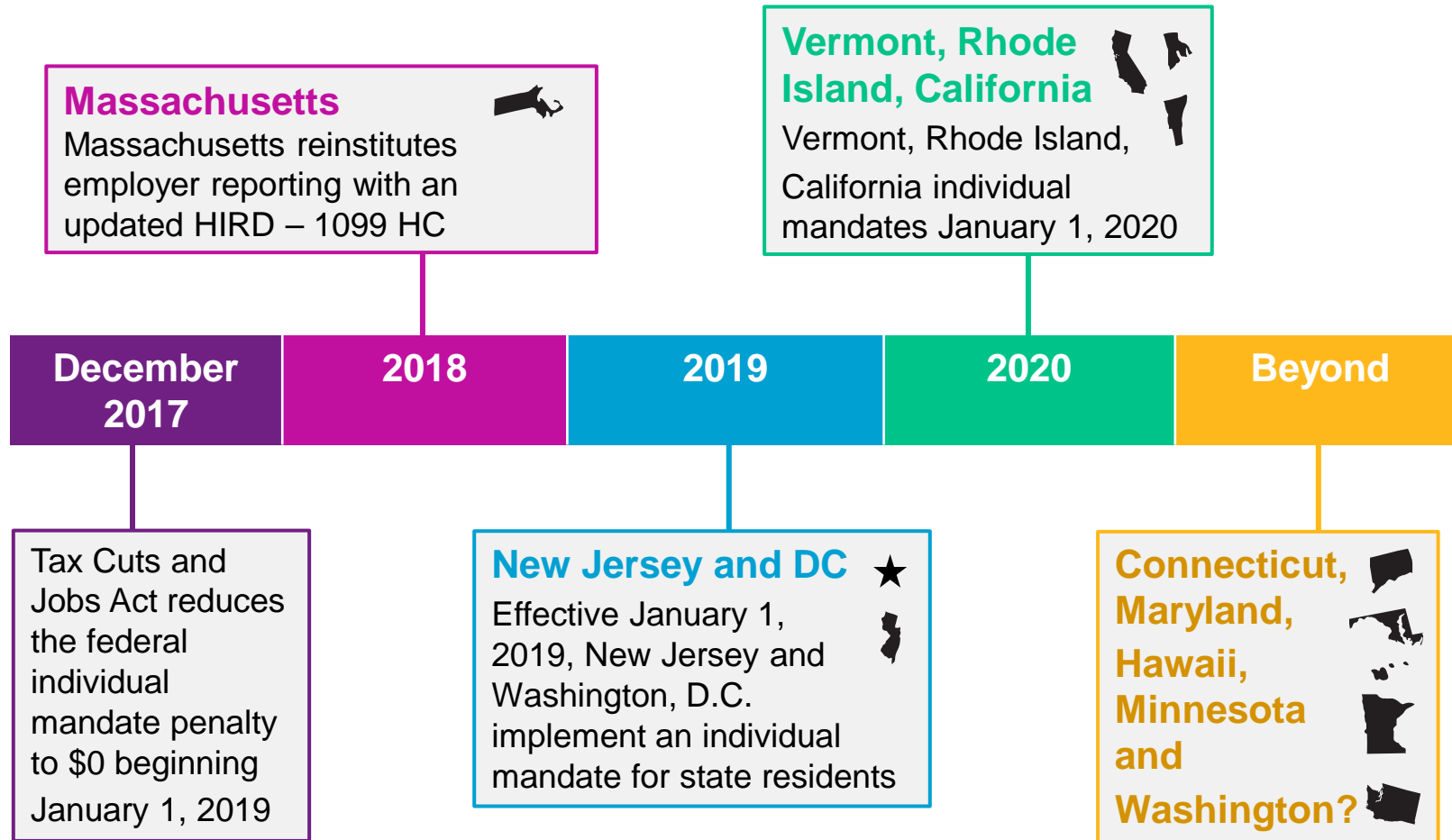


## Section 3

### State Activity

# States with Individual Coverage Mandates

## Potential ACA Repeal Encouraging States to Pass Individual Mandates



# Independent Contractors Make Employment Gains in California

Effective January 1, 2020, CA AB 5 Codifies New “ABC Test” for ICs



- California’s Assembly Bill 5 (AB 5) was passed in late September 2019 and codifies a 2018 CA Supreme Court decision that broadening definition of independent contractors
  - The *Dynamex* case only applied to claims for wages and benefits, establishing the “ABC Test”
  - CA AB 5 codified the “ABC Test” and expanded the application to apply more broadly to CA’s Labor and Unemployment Insurance Codes
- CA employers may be compelled to re-classify certain “independent contractors” as “employees” for California labor law purposes
  - Some occupations are exempt and would still be subject to the current classification criteria
- Court challenges are expected and the full impact of CA AB 5 is yet to be determined
- May result in some California workers being properly classified as independent contractors for federal law purposes (e.g., ERISA, ACA, IRC), but classified as employees for purposes of compliance with California labor law



## Section 4

### Legislative Updates and Forecasting



## The Administration's 2020 budget proposal

2020 budget proposal addresses health care and paid family leave

Implementation of these proposals requires legislative approval, and few items in the 2020 budget proposal are expected to move through the legislative process.

**Priorities: Replace ACA, expand HSAs, enact Medicare reforms, establish paid family leave**

- **ACA** – replace ACA with Cassidy-Graham proposal, including state block grants, minimum premium contributions from premium tax credit users, shorter grace periods for paying exchange premiums, and appropriation request for cost-sharing reductions for exchange coverage
- **HSAs** – Permit contributions by participants in a health plan with an actuarial value of up to 70 percent and allow direct primary care fees to be paid from the HSA
- **Other health care** – transparent health billing, reduce prescription drug costs, and increase DOL funding for investigations of risky AHPs and MEWAs
- **Medicare** – permit Medicare beneficiaries with HDHPs to contribute to HSAs
- **Paid family leave** – Six weeks of paid family leave to new parents; states would use unemployment insurance as a base to design and administer paid leave program



# Surprise Medical Billing

Senate, S. 1895

## Comparison of Surprise Billing Legislation, per Committee



Provision	Senate HELP Committee (S. 1895)
Settings	Emergency and post stabilization care and nonemergency care in in-network facilities; applies to fully insured and self-funded plans. Includes air ambulance services.
Hold harmless	Limits consumers to in-network cost sharing, deductibles, out-of-pocket maximum.
Ban on balance billing	Applies to providers.
Payment standard	Median in-network rate for insurer.
Dispute resolution	None.
Interaction with state laws	Defers to state payment standard for state-regulated group and individual plans.
Enforcement	State enforcement; federal enforcement as fallback. Federal enforcement through civil money penalties.

At least six surprise medical bills have been introduced in the 116<sup>th</sup> Congress; four with bipartisan support. Two bills have been advanced by their committees. The Alexander-Murray bill was approved by the Senate HELP Committee by a large bipartisan majority and the Pallone-Walden bill was approved by the House Energy and Commerce Committee.

# Surprise Medical Billing

House, H.R. 2328

## Comparison of Surprise Billing Legislation, per Committee

Provision	House Energy and Commerce Committee (H.R. 2328)
Settings	Emergency and post stabilization care and nonemergency care in in-network facilities; applies to fully insured and self-funded plans. Does not include air ambulance services.
Hold harmless	Limits consumers to in-network cost sharing and out-of-pocket maximum.
Ban on balance billing	Applies to providers.
Payment standard	Median in-network rate for insurer for 2019, inflated for future years.
Dispute resolution	Binding arbitration for cases over \$1,250 with other restrictions.
Interaction with state laws	Defers to state payment standard for state-regulated group and individual plans, but patient coinsurance is based on lesser of state or federal payment standard.
Enforcement	State enforcement; federal enforcement as fallback. Federal enforcement through civil money penalties.



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## 2020 Outlook for the ACA – The Cadillac Tax

The Cadillac Tax is on its way to the auto auction

Under ACA, employer-sponsored health benefits whose value exceeds specified thresholds would have been subject to an excise tax in 2022. This Cadillac Tax would equal 40 percent of the value of health benefits exceeding certain limits; projected at \$11,200 for single and \$30,150 for family coverage in 2022.

### Cadillac Tax

- President Donald Trump signed a bill Dec. 20 repealing the Affordable Care Act's (ACA) "Cadillac tax."
- The Senate voted 71-23 to approve the spending bill that included a repeal of the ACA's excise tax on high-cost, employer-sponsored healthcare plans, also known as the "Cadillac tax." The House of Representatives approved the bill, H.R.1865, in a 297-120 vote earlier.
- The tax was set to take effect in 2022.



*A bill to repeal the Cadillac Tax was signed by the president on December 20, 2019*

# Wellness Update

## Status of *AARP* Litigation and issuance of new EEOC rules



- ***AARP v. EEOC***: As of January 2019, the adjective “voluntary,” as applied to clinically oriented wellness programs (e.g., screenings and risk assessments), is reinterpreted to mean truly voluntary.
  - The specific reinterpreted definition of “voluntary” is not yet known.
  - It may be interpreted to mean that no financial inducement or penalty whatsoever can accompany clinically-oriented wellness.
  - However, using the “reasonable person” standard, it is possible that giving employees, for example, a \$150 gift card might be considered an appropriate thank-you for voluntary participation.
  - It is unknown whether this reinterpretation will be competed by the EEOC during formal rule-making, or whether by the courts on a case-by-case basis.
- EEOC initially proposed a schedule for promulgating new rules including promised updates in March and May and finalization in August, 2018.
- However, late in 2019, the DOJ, on behalf of EEOC, filed a new motion, reserving EEOC's right to dispose of the whole matter (*AARP* did not oppose).
- EEOC has now acknowledged that these programs must be voluntary, which seems to have satisfied the *AARP*.

# Wellness Update

## Suspect plan provisions

The main types of employer wellness program features impacted by the court's ruling in *AARP v. EEOC* are:



**Biometric screenings** (and any other medical examinations) for employees and spouses;



**Disability-related inquiries directed at employees** (which might include some questions on an HRA, depending on how questions are worded);



**Family medical history questions** (HRA questions that ask about the manifestation of disease or disorder in an employee's family member and/or HRA questions that ask an employee's spouse about his or her own manifestations of disease or disorder); and



**Any other features that involve genetic information** (i.e., an employee's genetic tests, the genetic tests of the employee's family members, biometric screening results of the employee's spouse).



# Wellness Update

## Considerations on the current state of wellness

### 1. Are outcomes-based wellness dead, as a practical matter?

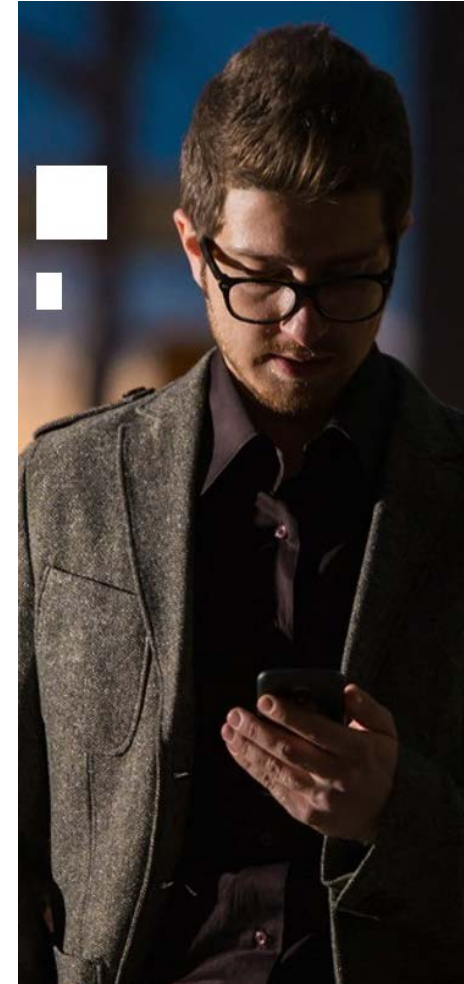
- Outcomes-based wellness programs are still permitted; however, the issue is how to price the inducements so that they remain “voluntary.”
- Penalty/incentive maximum will probably be set so low most employees would prefer to sacrifice the dollars than subject themselves to inspection by a wellness vendor.
- Participation-based programs are on safer ground, as employees tend to have fewer objections to these.

### 2. The maximum allowable penalty/incentive will be set low.

It is unclear what the ultimate “magic number” will be for incentives; however, it is likely to be far less than that what large companies and most outcomes-based programs currently charge, and could be \$0.

### 3. If indeed they pursue rulemaking, the EEOC is likely to fall way behind. Don't wait for them.

- Because the EEOC missed its hard deadline for the promulgation of new rules by December 31<sup>st</sup>, 2018, all rules governing incentives for clinical wellness programs were “vacated.”
- Employers now have no guidance in what constitutes “voluntary,” and must self-define the term for purposes of wellness program inducements.



# Wellness Update

## Considerations on the current state of wellness

### **4. This is not going away. It is not going to be reversed on appeal, nor will both houses of Congress pass a law that effectively moots the voluntariness provisions in current regulations.**

- As a legal matter, the last motion just made by EEOC clears the way for them to appeal the original decision. However, that appears unlikely.
- The EEOC has admitted on motion that clinical wellness programs need to be voluntary, which was the heart and substance of the legal controversy.
- There is little chance an appeal would succeed. The DC Circuit is not employer-friendly, and the burden of proof switches to EEOC and is a higher standard besides.
- The only hope for the wellness industry lies with Congress, and there are no bills out of committee at this time proposing any changes on the wellness front lines.

### **5. Companies will be getting sued by employees in 2020.**

High incentive/penalties will pose a risk that any in-house counsel should find completely unacceptable. There is no shortage of willing aggrieved participants or available plaintiff's attorneys to represent them.



# Wellness Update

## Employer options post-AARP and pre-rule promulgation by the EEOC



### 1. Give employees more choices:

One way to make wellness program participation truly voluntary is by giving employees the option of earning the same incentive in a way that does not involve biometric screenings or HRAs (such as education requirements).

### 2. Reduce the incentive:

Decreasing the amount of incentives for biometric screenings and/or HRAs not only reduces the risk of not having a voluntary program, prepares the employer up for the future. The EEOC is likely to reduce the maximum incentive under the new regulations.

### 3. Put incentives on hold:

While employers wait for further EEOC guidance, a conservative but safe move is to fully eliminate wellness incentives. Consider directing the incentive budget toward other benefits employees want—financial wellness, more flexible work arrangements, PTO, etc.

### 4. Switch the incentive structure:

Employers can restructure their incentives so that no rewards are specifically tied to biometric screening or HRAs. For example, instead of using blood screenings that test for nicotine, simply ask employees if they use tobacco and adjust premiums accordingly.

# Health Savings Accounts

## Medicare Entitled Individuals

### Proposed, The Health Savings for Seniors Act (H.R. 3796) (2019-2020) (Democratic approach), would:

- Permit **Medicare beneficiaries** to continue participating in an HSA;
- Limit beneficiaries of the ability to use money in their HSAs toward their **Medicare Part B premiums**, which is at least \$135.50 a month;
- **Charge a penalty** for any withdrawals used to pay for nonqualified health expenses;
  - Under current rules, account holders can use their HSA savings for any purchases after 65, whether they're for medical purposes or not, and simply pay an income tax on the withdrawal as they would with most other investment accounts.
- **Note:** There is a disallowance of the opportunity to use HSA funds to pay for Medicare Part B premiums under this plan. Also, individuals would be prohibited from paying for non-health expenses after 65, which could place older Americans at a disadvantage.

### 2020 HSA Contribution Limits:

Individual - \$3,550

Family - \$7,100



# Health Savings Accounts

Expansion of HSA utilization and other participant account uses



## Proposed, Health Savings Act of 2019 (Senate Bill 12) (2019-2020) (Republican approach), would:

- Rename HDHPs to **HSA-qualified health plans**;
- Allow both spouses to make **catch-up contributions** to the same HSA;
- For Medicare eligible individuals, **Part A participation** would not disqualify HSA participation;
- **Prescriptions** would not be required for HSA reimbursement of medical equipment and over-the-counter drugs;
- **Indian Health Care Services** would not be disqualify HSA participation;
- Individuals (and spouses) covered by on **on-site employer medical clinic** would not be deemed to have prohibited coverage;
- Individuals participating in direct primary healthcare arrangements would not be HSA disqualified (concierge services);
- For family HDHP enrollments, **individual embedded deductibles** would not violate the regulatory requirements;
- Permit HSA payments up to \$1,000 for **fitness classes and equipment**;
- Permit HSA payments up to \$1,000 for **nutritional and dietary supplements**;
- Annual HSA maximum increased to annual **out of pocket limitations**.

# Flexible Spending Accounts

## Clarification of Section § 213(d) applicability to certain genetic testing services

**On May 16, 2019, the IRS released PLR 201933005, which applies to the applicability of IRC § 213(d) to certain genetic testing services.**



Pursuant to § 213(d), only those expenses that arise in the context of “**medical care**” are eligible medical expenses under § 213(d).



In the instance of **genetic testing for ancestry and health disposition**, the health expenses (such as laboratory testing) arising from such testing are proper under § 213(d); however, the non-medical services or items (such as reports that provide general or ancestral information) are not.



Taxpayers may use a **reasonable method** to value and allocate the cost of the health services between services that are medical care and non-medical services or items.



Consider the application of the reasoning in this PLR to other health and wellbeing ancillary products (such as a maternity and fertility management programs).

IRC § 213(d)(1)(A) provides that “**medical care**” is care that is for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body.



# Student Loan Repayment Assistance

IRS clarifies option for to provide for certain student loan repayment assistance



**On August 17, 2018, the IRS released PLR 201833012, which applies to amending a 401(k) plan to offer a student-loan benefit which would make special 401(k) contributions into the accounts of employees who are making student loan repayments.**



Under these programs, eligible employee make qualifying student loan repayments and in exchange the employer makes a qualifying match to the 401(k) account of the employee.



Unlike student loan repayment (SLR) dollars given directly to employees (which are treated as taxable income) employer 401(k) contributions are not taxable.



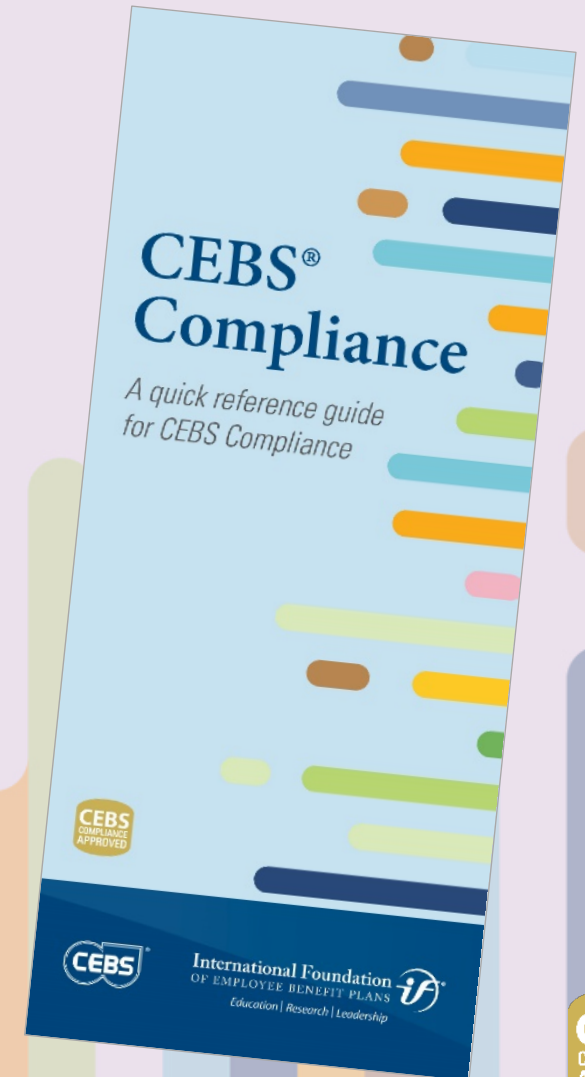
As a result, this approach achieves tax advantages like those associated with traditional tuition-reimbursement benefits but generally denied to student loan repayment benefits.



The PLR specifically dismisses applicability of the contingent benefits rule to these arrangements. The rule provides that an employer may not make other benefits, such as health insurance, stock options, or similar entitlements, contingent on a participant's elective deferrals under a 401(k) plan.

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# Self-Report Your Credits

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- Select the orange box
- Follow the prompts to self report your credits
- Questions? See brochure or contact Customer Service

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THANK YOU!

DFW ISCEBS

May 14, 2020