2019: Second Quarter

Compliance Digest

Compliance Bulletins Released April-June

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This document is designed to highlight various employee benefit matters of general interest to our readers. It is not intended to interpret laws or regulations, or to address specific client situations. You should not act or rely on any information contained herein without seeking the advice of an attorney or tax professional.

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Health & Welfare Plan Reporting & Disclosure Obligations

Published: April 12, 2019

The checklist below provides simple explanations of the various required reporting & disclosure obligations of employer-sponsored health & welfare plans (federal law).

All Welfare Benefit Plans The following are required for all employer-sponsored health and welfare plans (these usually include life and disability plans along with medical and dental, etc.)		
Any Size	SPD	Summary of employee rights and benefits under an employer-sponsored plan. All participants should receive a copy of this within 90 days of becoming covered by the plan and then at least every 5 years after that. Must meet certain content requirements.
Any Size	SMM	Describes material modifications to a plan and reflects changes made to the SPD before the SPD is revised. No later than 210 days after the end of the plan year in which the change is adopted, unless a revised SPD is provided.
Any Size	Notification of Benefit Determination	Claims notices or EOBs.
Any Size	Plan Documents	Must be maintained by the plan administrator (usually the employer) and provided within 30 days of a written request. A copy must be available at the business location. Generally includes, among other things, most recent SPD (and any interim SMMs) and Form 5500 filing, and any contracts or other instruments governing the plan and the plan's operations. This should be updated annually.
Generally, 100+ participants	Form 5500	Generally, applies to employee welfare plans covering 100 or more employees at the beginning of the plan year must submit this electronically to the DOL by the end of the 7th month after the end of the plan year. A one-time 2½ month extension is available by submitting Form 5558 to the IRS by the date the Form 5500 would have otherwise been due.
Generally, 100+ participants	SAR	Narrative summary of information on Form 5500. Distributed to all participants within 9 months of the end of the plan year, or 2 months after the Form 5500 is due. Not required for a plan under which benefits are paid solely from the general assets of the employer or employee organization.

Group Health Plans The following are required for group health plans only, which generally refer to medical, dental, and/or vision plans:		
Any Size	Summary of Material Reduction in Covered Services or Benefits	Summary of group health plan amendments, provided within 60 days of adoption of material reduction in benefits, unless earlier notice is required pursuant to ERISA fiduciary obligation. Consistent with the SBC requirements (see below), any advance notification of a material modification to the SBC will satisfy this requirement.
20+ employees	**COBRA Notices:** If you have a COBRA administrator, it is probably handling all these notices on your behalf. However, you should be familiar with the requirements as the employer is ultimately responsible for COBRA compliance. These notification requirements include the following:	
	COBRA Reasonable Procedures	Included in the SPD and General COBRA Notice.
	General COBRA Notice (Initial Notice)	No later than 90 days after the date on which such individual's coverage under the plan commences.
	COBRA Election Notice	Within 44 days after the qualifying event date or loss of coverage if provided by the plan.
	Notice of Unavailability of COBRA	Notice that individual is not entitled to COBRA coverage. Provided within 14 days after the plan administrator (employer) receives notice of a qualifying event.
	Notice of Early Termination of COBRA	As soon as practicable after determining that coverage will end.
	COBRA Conversion Notice	Where required, within 180 days of the end of the COBRA coverage period.
Any Size	**HIPAA Notices:** There are various required notifications and some are issued from the insurer although the ultimate responsibility for disclosure is the plan sponsor's.	
	Special Enrollment Rights	Include with enrollment materials.
	Notice of Privacy Rights	Include with initial enrollment materials; again within 60 days after a material change; upon request; send a reminder every three years. However, if health benefits are provided through an insurance contract with a health insurance issuer or HMO, the plan must merely maintain a notice and provide such notice upon request.
	Wellness Program Disclosure	Where required, within 180 days of the end of the COBRA coverage period.
Any Size	WHCRA Notice	This should be provided upon initial enrollment and on an annual basis.
Any Size	QMCSO or NMS	Includes various requirements when a medical child support order has been received and describes the plan's qualification process. Should be included in the certificate/SPD.
Any Size	NMHPA (Newborn's and Mother's Health Protection Act)	This should be included in the certificate/SPD.
Any Size	Michelle's Law	If a plan covers dependents past age 26 or certain dependents such as grandchildren based on student status, Michelle's Law will apply and the disclosure will be required. This disclosure should be included in the certificate and the SPD.

Group Health Plans The following are required for group health plans only, which generally refer to medical, dental, and/or vision plans:		
Any Size	Medicare Part D: Participant Notice	Discloses the "creditable" status of prescription drug coverage to participants. Must be provided in specific time frames, including annually and at initial enrollment. Your insurance carrier will let you know if your plan is Creditable or Non-Creditable. It is important to note that the font and page requirements for this notice are very specific, so it is best to use the sample notice from the government website.
Any Size	Medicare Part D: Disclosure to CMS	This disclosure must be sent through the CMS website within the first 60 days of the plan year; within 30 days after termination of the prescription drug plan; and 30 days after any change in creditable status of the prescription drug plan.
Any Size	MSP Reporting	This disclosure is to CMS for purposes of coordination of benefits for Medicare-enrolled individuals. Unless the plan is both self-funded and self-administered, the carrier or TPA will be doing this disclosure.
Any Size	CHIPRA	This notice must go out before the first day of the plan year on an annual basis. Usually included in the enrollment materials. Disclosure to the state Medicaid or CHIP programs must also be completed once model forms are available from the respective states.
51+	MHPA/MHPAEA	Employers claiming a cost exemption must provide notice to the DOL and participants.

Patient Protection And Affordable Care Act (PPACA) – Health Care Reform These notices generally apply to medical plans only.		
Any Size	Grandfathered Health Plans	This notice should be provided to all plan participants in all plan materials (including the SPD and enrollment materials).
Any Size	Patient Protection Disclosure	Non-grandfathered plans that require designation of a primary care provider; can be provided with the open enrollment materials.
Any Size	Claims, Appeals and External Review Process	Non-grandfathered plans are subject to new and additional requirements including, among other things, new notices of adverse benefit determinations and external review decisions. These changes should be documented in the certificate of insurance/SPD (self-insured plans need to coordinate with TPAs).
Any Size	Advance Notice of Rescissions	Notice of at least 30 calendar days is required to an individual before coverage may be retroactively cancelled (rescinded). Coverage may only be rescinded in limited circumstances (e.g., fraud).
Any Size	SBC and Uniform Glossary	This is a summary of the health plan benefits that must be provided to all participants and beneficiaries. The DOL provides a model template. Plans must provide to newly eligible individuals (e.g., new hires, special enrollees) and in connection with renewal.
Generally employers filing 250+ Form W-2	W-2 Reporting	Many employers will be required to report the value of health insurance coverage provided to employees on the employee's Form W-2. Employers that file fewer than 250 Form W-2s for the preceding calendar year are not subject to he report requirement in the current calendar year.

Patient Protection And Affordable Care Act (PPACA) – Health Care Reform These notices generally apply to medical plans only.		
Any Size	Comparative Effectiveness/PCOR Fee	For self funded health plans (including HRAs), there is a fee to fund a Patient-Centered Outcome Research program that equals $1 in the first year ($2 in year two, $2.08 in year three) multiplied by the average number of lives insured under a group health plan policy. Form 720 should be filed each July 31 for the calendar year immediately following the last day of the plan year. The insurance carriers are responsible for paying and reporting this fee for fully-insured plans. Expected Sunset - Plans that renew prior to 10/01/19
All Employers Subject to the FLSA	Notice of Coverage Options	Notice of the new Marketplace, regardless of whether the employer offers a health plan, to each new employee at the time of hire. For 2014, the DOL will consider a notice to be provided at the time of hire if the notice is provided within 14 days of an employee's start date.
Large Employers	6055/6056 Reporting	First effective in 2016 for the 2015 calendar year: • A report to the IRS and to a primary insured reporting which individuals are enrolled in minimum essential coverage for individual mandate purposes, handled by the carrier for an insured plan and by the employer for a self-funded plan; • An information return to the IRS and to all full-time employees that reports the terms and conditions of the employer-sponsored health plan coverage, handled by large employers for employer penalty purposes.

General Employment Law Notices Not required to be issued by group health plans specifically; not an exhaustive list.[1]		
15+ employees for 20+ calendar weeks (current or preceding year)	ADEA (20 employees)	Usually posted.
	ADA	
	PDA	
	GINA	
50+ employees	FMLA Notices	If you have an FMLA administrator, it is probably handling all of these notices on your behalf. However, the employer is ultimately responsible for FMLA compliance. These notification requirements include the following:
	General Notice	In addition to the posted notice requirement, notice of employer and employee general rights and responsibilities with respect to FMLA.
	Nonpayment of Premiums	When an employee's premium payment is more than 30 days late and employer intends to drop coverage.
	Other Notices	Examples are: Eligibility notice, Rights and Responsibilities notice, Certification form, Designation notice.
Any Size	USERRA Notices	In addition to the posted notice requirement, this notice should be provided at the beginning of any leave for uniformed service and may be provided along with the COBRA election notice.

1 Discuss these notices with your employment counsel.

Other Document Requirements		
Any Size	Cafeteria Plans	Written plan document is required if offering benefits on a pre-tax basis. Annual nondiscrimination testing must be performed.
Any Size	Self-Insured Reimbursement Plans	Any self-insured reimbursement plan (e.g., major medical, dental, FSA, HRA) must have a written plan document and is subject to nondiscrimination rules under Code Section 105(h).
Any Size	HIPAA Privacy & Security Policies	All self-insured health plans and fully insured group health plans that create or receive PHI/e-PHI (other than summary information) must implement privacy and security procedures. Does not apply to fully-insured plans that to not create or receive PHI/e-PHI.
Any Size	HIPAA Privacy and Security Plan Amendments	For plans subject to the HIPAA privacy and security rule (see above), ensure plan documents contain information on privacy and security rules rule.
Any Size	HIPAA Business Associate Agreements	Health plans should have business associate agreements with their business associates who use and disclose PHI/e-PHI for certain health plan functions including claims processing, legal advice, consulting and actuarial determinations.
Any Size	Medicare Part D Application for Subsidy	Applies only to retiree health plans providing prescription drug coverage. Plans may apply for a retiree subsidy from CMS within 90 days from the start of the plan year.
Any Size	Record Retention	ERISA plans are subject to record retention requirements. General rule is to retain records for 8 years.
Any Size	Record Retention – Grandfathered Plans	Grandfathered group health plans must retain record of grandfathered status for as long as the plan claims that status.



Court Strikes Down Association Health Plan Rules

Published: April 15, 2019

On March 28th, 2019, a Federal District Court in the District of Columbia struck down significant portions of the Department of Labor's (DOL's) Association Health Plan (AHP) Final Rule. Specifically, the Court found the DOL "failed to reasonably interpret" ERISA when issuing these rules by:

- expanding the definition of "employers" to include disparate groups of employers with no other commonality of interest other than geographic location; and
- bringing working owners without employees within ERISA's framework.

This ruling effectively eliminates the expansion of AHPs to certain employers and working owners who do not meet the original parameters to be a part of an AHP.

It is now up to the DOL to determine whether, considering this ruling, the Final Rule can continue to stand.

Background

The Department of Labor published a final rule on June 21, 2018 creating flexibilities for employers and working owners to band together to sponsor a single AHP. The final rule allows multiple employers to jointly sponsor a single group health plan by expanding ERISA's definition of "employer." Prior to the Final Rule, unrelated employers had to generally meet three criteria in order to be deemed a bona fide association and thereby able to sponsor one large group health plan. Those criteria were:

- whether the group of employers came together for purposes other than just benefits;
- whether the employers shared a commonality of interest; and
- whether the employers, either directly or indirectly, exercised control over the program.

The intention of the Final Rule was to help groups of small employers form a single health plan and avoid small group market rating, maintain greater flexibility in benefits, and reduce premiums and administrative expenses.

Court Ruling and Agency Follow-Up

The Court invalidated two key provisions of the Final Rule based on overreach by the regulators when crafting these regulations and essentially creating an "end run around the ACA." Notably, the Court found the Final Rule scraps ERISA's statutory background and historic focus on employee benefit plans that arise from employment relationships through the expanded definition of an "employer." The Court also noted that the rules were designed to avoid the most stringent requirements of the ACA, which remains the law of the land. For these reasons, the Court vacated the Final Rule's provisions expanding the definition of "employer" to include associations of disparate employers and expanding membership in such associations to include working owners.

Due to a severability provision, the Court remands the case to the DOL to determine whether the stricken provisions of the regulations affect the viability of the rest of the Final Rule.

The Employee Benefits Security Administration (EBSA), a division of the Department of Labor, released a series of FAQs addressing the current state of the Final Rule considering the March 28th decision. While disagreeing with the decision and contemplating possible appellate action, EBSA issued these FAQs to confirm that participants in AHPs will still have their benefits paid in accordance with their policies. Furthermore, the FAQs confirm that the District Court's decision does not lessen state oversight of AHPs.

The EBSA FAQs can be found here: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/ahp-q-and-a-court-ruling.pdf

Next Steps

This ruling strikes a blow for entities looking to form association health plans as allowed under the Final Rule. While the market has been slow to respond with association coverage solutions for employers, this latest ruling will likely further stall these arrangements. Nevertheless, associations (and association health plans) are still able to form under the rules in existence prior to the Final Rule. Association plans that looked to the Final Rules as a basis for forming an association based on geography only or providing coverage to working owners with no employees will want to carefully review their position.





ACA Legal Challenges Continue

- This article is intended to provide you with an update on current legal challenges to invalidate the ACA.
- There is no immediate impact to employer-sponsored health plans or other requirements under the ACA.

Published: April 16, 2019

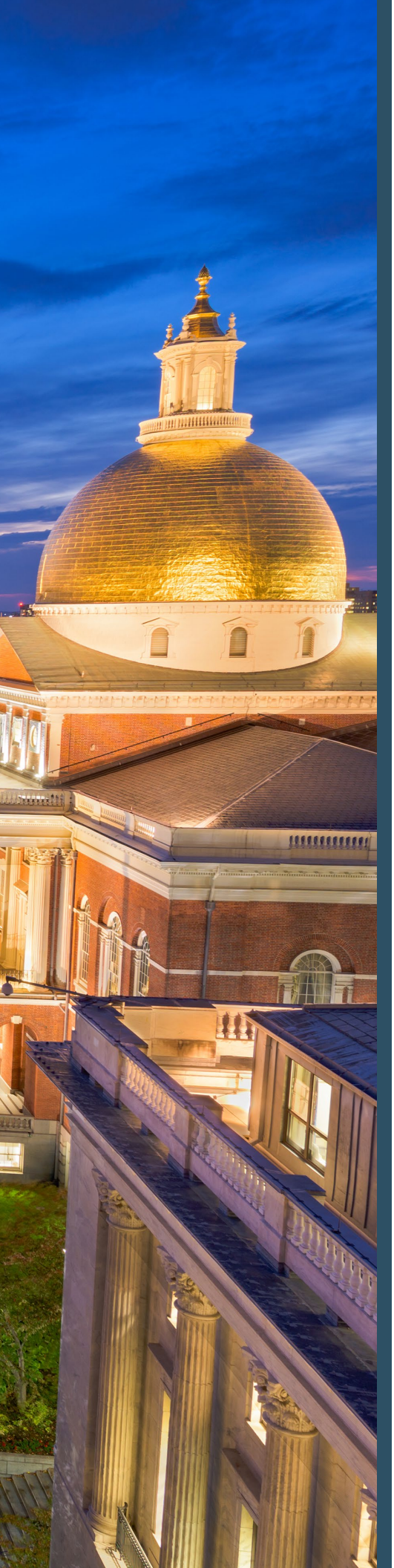
In 2018, a Texas Court ruled in favor of 20 Republican state attorneys general ("AGs") to invalidate the Affordable Care Act ("ACA"). Sixteen Democratic AGs and now the House of Representatives (as of January 2019) are joined in defending the ACA and appealing the Texas court's decision. The case is currently on appeal in the 5th Circuit.

Recently, the U.S. Department of Justice (DOJ) filed a two-sentence letter with the 5th Circuit expressing its agreement with the lower court's decision to strike the ACA in its entirety. This is a departure from the Administration's earlier position that only the individual mandate, guarantee issue and community rating requirements under the ACA were invalid, allowing the rest of the ACA to stand.

What does this Mean?

The 5th Circuit will hear the appeal and consider all filed briefs and arguments (filed by all parties to the case and other interested parties, including the DOJ, the group of Republican AGs, the group of Democratic AGs, and the House of Representatives) and determine whether to uphold or reject the lower court's decision. Whichever way the Fifth Circuit rules, there will be an appeal to the Supreme Court to make a final determination on the status of the ACA. As the appeals process takes time, it is uncertain whether the case will reach the Supreme Court before the 2020 election.

For now, the ACA remains the law of the land and employers should continue to comply with the various aspects of the law.



Massachusetts Publishes Family & Medical Leave Rules

Published: May 3, 2019

The Massachusetts Department of Family and Medical Leave ("DFML") has recently published regulations for public comment and a guide for employers. A synopsis of significant, new, and clarifying information follows.

The Basics

In 2018, Massachusetts enacted legislation to create a statewide Paid Family and Medical Leave ("PFML") program providing benefits beginning in January 1, 2021 and July 1, 2021. With limited exception, all employers with employees in Massachusetts will be required to provide paid family and medical leave benefits to their employees through:

- The state program; or
- An approved private plan.

If providing benefits through the state program, employers will begin to remit premium payments to the state beginning July 1, 2019.

Employers may opt to provide an approved private plan to employees. These arrangements must be approved by the DFML. If the employer secures approval on or before July 1, 2019, the employer will not be required to contribute to the state program beginning July 1, 2019.

Approved Private Plans

To comply with PFML requirements employers may either participate in the state program or provide benefits through an approved private plan option.

A private plan must:

- Be approved by the state,
- Provide paid leave benefits to employees that are equal to or greater than the benefits provided by the PFML,

- Cost employees the same or less than what they would pay under the state's plan, and
- Provide equal or better rights and protections as those provided under the state's program.

If an employer already provides a paid leave benefit to its workforce, the employer may be eligible to receive an exemption from collecting, remitting, and paying contributions to the state's paid family or medical leave program.

An employer can apply for an exemption from the medical leave contribution, family leave contribution, or both. An employer will be able to apply for these annual exemptions through its MassTaxConnect account beginning April 29. For Quarter 1 only, the deadline for a private plan exemption that will be in effect for first quarter contributions for paid family and medical leave is September 20, 2019 (extended from original date of June 30, 2019). This will allow employers additional time to contemplate private plan options. Going forward, the DMFL will continue to accept applications on a rolling basis but applications must be approved in the quarter prior to the quarter in which they go into effect. It should be noted that contributions to PFML begin on July 1, 2019 and the September 20, 2019 extension of the exemption application deadline only impacts the contribution requirements if the exemption request is approved. If the exemption request is denied, the impacted business will be responsible for remitting the full contribution amount from July 1, 2019 forward. Therefore, DFML recommends that businesses in the Commonwealth consult with their tax advisors as to the implications associated with applying for a private plan exemption that may or may not be approved.

A private plan may be provided through an insurance policy or through self-insurance. If an employer's plan provides for insurance, the forms of the policy must be issued by a Massachusetts licensed insurance company. At this point the carriers have not yet responded with new products in the marketplace.

If an employer's plan is in the form of self-insurance, it appears that MA will require the employer to secure a bond in some amount and form as approved by the state. The rules are vague as to what is required to self-insure a PFML plan, and hopefully additional guidance is forthcoming.

Employers applying for an exemption will receive an immediate approval or denial of exemption.

- If the exemption is approved, the employer will be asked to upload a copy of the plan on which the exemption is based.
- If the exemption is denied, the employer will be notified why it was denied. If the employer disagrees with the basis for denial, the employer may request a follow-up review

Required Contributions

Massachusetts employers with a workforce of any size, that do not adopt an approved private plan, must pay PFML contributions to the state beginning July 1, 2019.

The total contribution for an employee is 0.63% of qualifying earnings (capped at the Social Security maximum, currently $132,900). For this purpose, qualifying earnings means:

- Wages paid to an employee; and
- Payments to covered business entities to covered contract workers.

If the employer has at least 25 covered individuals (i.e., employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. The employee is responsible for the cost of the family leave benefits. The following illustrates the breakdown:

- Medical Leave Contribution: 0.52% of eligible payroll deduction
  - Employer: At least 60% of the medical leave cost is paid by the employer
  - Employee: No more than 40% of medical leave can be deducted from the employee's wages.

- Family Leave Contributions: 0.11% of eligible payroll deduction
  - May be paid entirely from employee wages (no employer contribution required).

If the employer has fewer than 25 covered individuals in Massachusetts, the employer is not required to contribute toward to medical leave portion of the benefit. The employees maximum share of the medical leave benefit remains 40%. The employer is responsible for remitting contributions to the state on behalf of their workers. Businesses that issue 1099s for more than 50% of their workforce must remit contributions for their 1099 workers ("covered individuals") as well as their employees. If your business has 25 or more workers in total, you must pay the employer share of the contribution for family and medical leave for both employees and covered individuals.

Employers are responsible for remitting all contributions following each quarterly report filed with DFML through MassTaxConnect. The DFML has created a calculator to allow employers to estimate the required contributions they will need to remit. The DFML has also created a tool to assist employers in the determination of whether they are responsible for paying the employer share.

Workforce Notification

The DFML has released the mandatory PFML workplace poster. The poster explains the benefits available to an employer's workforce and must be displayed in the workplace in a location where it can be easily read. The poster must be available in English and each language which is the primary language of 5 or more individuals in the employer's workforce



if such translations are made available from DFML.

Notifying Massachusetts W-2 Employees

Employers need to notify each of their Massachusetts W-2 employees in writing about available PFML benefits on or before June 30, 2019. Employers must also issue this notice to each employee within 30 days of their first day of employment. The notice must be written in the employee's primary language.

Employers must obtain from each employee a written statement acknowledging receipt of the notice or a statement indicating the employee's refusal to acknowledge the notice.

This notice must contain:

- An explanation of the availability of family and medical leave benefits
- The employee's contribution amount and obligations
- The employer's contribution amount and obligations
- The employer's name and mailing address
- The employer identification number assigned by DFML
- Instructions on how to file a claim for family and medical leave benefits
- The mailing address, email address, and telephone number of DFML

Notifying Massachusetts 1099-MISC Contractors

Employers need to notify each Massachusetts 1099-MISC contractor who provides services to the employer, in writing, about available benefits when the employer enters into a contract for services. The notice must be written in the contractor's primary language.

Employers must obtain from each contractor a written statement acknowledging receipt of the notice or a statement indicating the contractor's refusal to acknowledge the notice. There are specific content requirements applicable to notifying 1099 contractors that should be reviewed, if applicable.

Failure to notify employees and contractors

Failure to provide the required notifications may result in the following fines:

- First violation: $50 per W-2 employee or 1099-MISC contractor
- Subsequent violations: $300 per W-2 employee or 1099-MISC contractor

Reporting and Documentation

All employers will be required to file quarterly reports through MassTaxConnect beginning in October 2019. Reporting and documentation guidelines will be announced prior to July 1, 2019.

In the meantime, we expect the following information will be required:

Massachusetts workforce information
(this includes any Massachusetts 1099-MISC contractors):

- Name
- Social Security number
- Wages paid or other payments for services

Employer:

- Federal employer identification number (FEIN)

General Timeline Of Upcoming PFML Events

- April 29, 2019: Approved plan applications available to employers
- May 2019: State to hold at least 2 public hearings on the regulations
- June 30, 2019: Notification to employees and 1099-MISC contractors
- July 1, 2019: Final regulations issued, and payroll deductions begin
- October 31, 2019: Contributions due for July – September
- January 1, 2021: All leave is available except family leave to care for a family member with a serious health condition
- July 1, 2021: Family leave is available to care for a family member with a serious health condition

Employer Action

Employers should read all the available information from the DFML and work with labor counsel, leave vendors, payroll processors and any other related business advisors to make sure they are compliant with the PFML by the requisite dates. In addition, employers should continue to monitor the DFML website for additional guidance and regulations. We will continue to monitor this issue as well and will keep employers updated as applicable.

For more information visit:

For DFML Website: https://www.mass.gov/orgs/department-of-family-and-medical-leave

For Regulations: https://www.mass.gov/files/documents/2019/03/29/3-29-19%20Draft%20Regulations%20for%20Public%20Comment_0.pdf;

For Employer Guide: https://www.mass.gov/guides/a-guide-to-paid-family-and-medical-leave-for-massachusetts-employers

For MassTaxConnect: https://mtc.dor.state.ma.us/mtc/_/

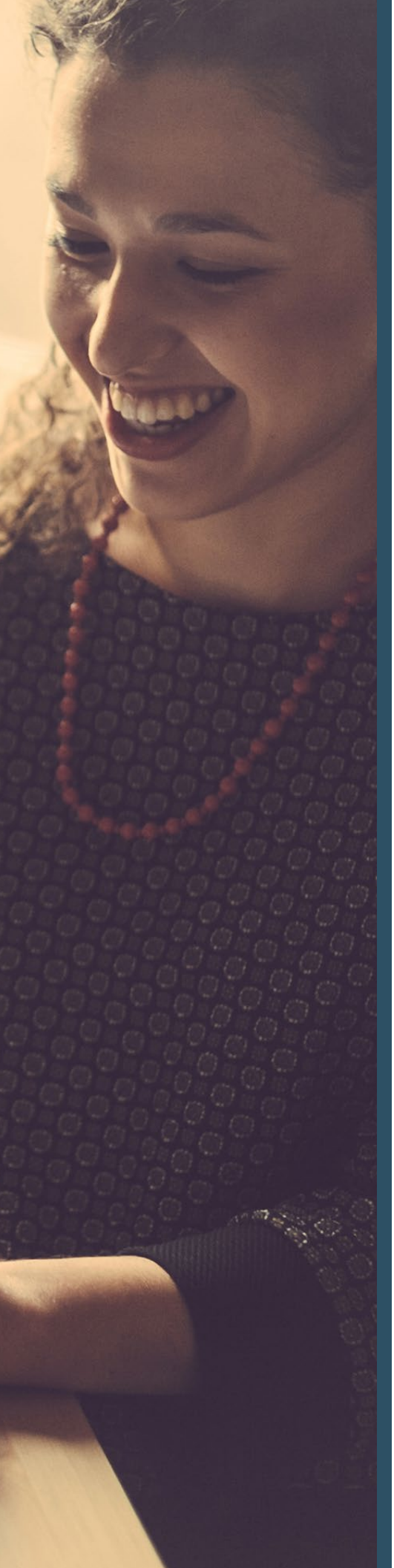
For Exemption Information: https://www.mass.gov/info-details/exemptions-from-paid-family-and-medical-leave-for-private-plans

For Contribution Calculator: https://calculator.digital.mass.gov/pfml/contribution/

For Employer Share Determination Tool: https://www.mass.gov/decision-tree/determine-if-youre-responsible-for-the-employer-share-of-pfml-contributions

For Workplace Poster: https://www.mass.gov/files/documents/2019/03/21/20190321_DFML%20Notice_FINAL.pdf

For Workplace Poster in Other Languages & template notification: https://www.mass.gov/info-details/informing-your-workforce-about-paid-family-and-medical-leave



Self-Funded Health Plans and Cross-Plan Offsetting

Published: May 6, 2019

A recent court decision highlights an administrative process known as cross-plan offsetting. Briefly, cross-plan offsetting is a mechanism used by third-party administrators ("TPAs") to resolve overpayments to a provider made through one plan by withholding (or reducing) payment to the same provider through another plan.

Based on the court's ruling, employers should review and understand whether their TPA engages in cross-plan offsetting and whether there is language in the plan documents to support this practice. Further, it is advisable to review whether to continue cross-plan offsetting or "opt-out" of this practice.

The following FAQs are intended to explain cross-plan offsetting and highlight some of the issues identified with this practice.

What is "Cross-Plan Offsetting?"

A TPA may determine that it overpaid a provider when reimbursing a claim for a group health plan. Instead of seeking recoupment for the specific overpayment from the provider, the TPA reduces a future payment made by another group health plan to that provider by the amount owed. This practice is generally applied to out-of-network providers.

What Has Changed?

On January 15, 2019, in Peterson v. UnitedHealth Group, Inc., the court determined that the cross-plan offsetting was impermissible when the written plan terms did not authorize this practice. Because the court determined the plan documents lacked authorization, it did not have to address whether the practice of cross-plan offsetting itself violated ERISA.

Does Cross-Plan Offsetting Violate ERISA?

According to the court, cross-plan offsetting, as a practice, violates ERISA unless the plan documents specifically authorize it. If the documents are silent, vague, or have broad interpretative authority (without express authorization), the practice is not permissible.

Example

ABC Company and DEF Company sponsor self-funded group health plans administered by TPA.

Brenda Flores, a participant in the ABC Company Health Plan, goes to an out-of-network doctor, Dr. Kyle. The bill is $1,500. The bill is submitted and the TPA mistakenly pays $2,000 to the provider (versus the $1,500 owed). The TPA requests $500 reimbursement from Dr. Kyle but the reimbursement is not made.

Cindy Smith, a participant in the DEF Company Health Plan, goes to the same doctor, Dr. Kyle, who is also out-of-network under the DEF plan. The bill is $1,000. The bill is submitted and the TPA pays $500 to Dr. Kyle (thereby recouping the $500 paid on behalf of Brenda Flores under the ABC plan).

Reporting to the ABC Company by the TPA reflects that it paid $1,500 on behalf of Brenda Flores. Reporting to the DEF Company by the TPA reflects that it paid $1,000 on behalf of Cindy Smith.

The question the court did not answer directly is whether cross-plan offsetting, even with appropriate plan language, violates ERISA. The court expressed concern that cross-plan offsetting is in some tension with the requirements of ERISA. While not deciding the issue, the court recognized that at the very least, the practice approaches the line of what is permissible.

The Department of Labor is also concerned that this practice raises ERISA issues, both violations of fiduciary duty as well as prohibited transactions (self-dealing) as outlined in their amicus brief. So, while the court did not rule on these issues, the Department may take a harder look at TPA practices and payments when auditing employer-sponsored group health.

Will Removing Cross-Plan Offsetting Affect Plan Costs?

Perhaps. Typical administrative service agreements from TPAs indicate that a TPA will make reasonable efforts to recover any overpayments, but that it is only liable in the case of its gross negligence or willful misconduct. In this case, an employer will generally be responsible for paying for the overpayment where the TPA does not recover it from the provider using ordinary efforts. This could result in increased costs to the plan.

The plan may be able to engage in "same-plan" offsetting. This means, within the same plan, offsetting overpayments made to an out-of-network provider for one plan participant by reducing a separate payment made to the same provider for a claim of another participant in the same ERISA plan. This practice, which should be disclosed in the plan documents, likely does not trigger similar ERISA issues that cross-plan offsetting does. However, as most plan claims are paid in-network, the potential for the TPA to be able to offset claims with the same out-of-network provider under the same plan may be limited. Further, plans must provide appeal rights to participants in the event they receive a balance bill for offset amounts in dispute.

What Should Self-Funded Plans Do?

Self-funded health plans may receive letters from their TPAs regarding cross-plan offsetting practices. Some TPAs will provide the plan sponsor the opportunity to "opt-out" of cross-plan offsetting practices.

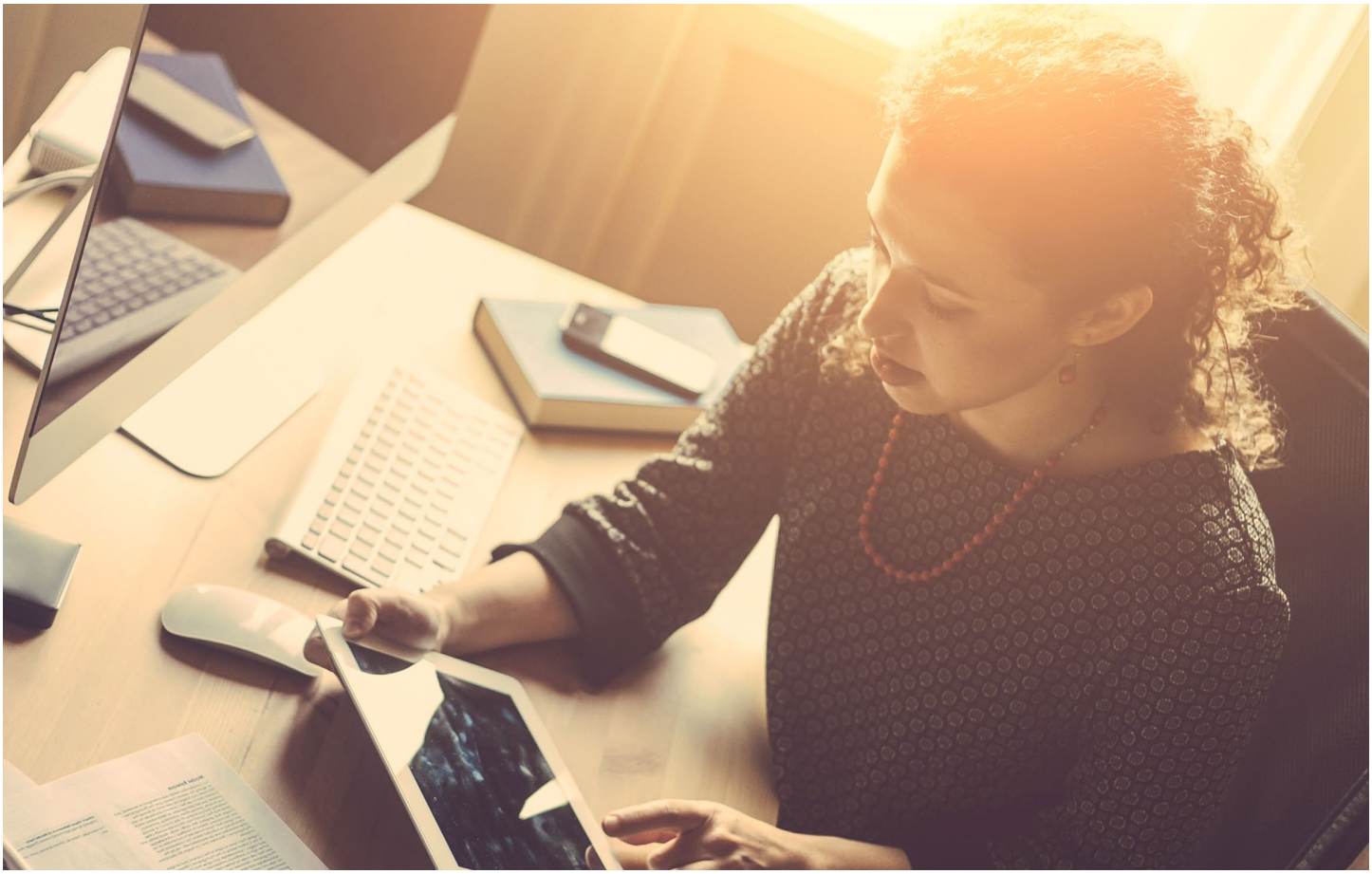
Regardless of whether you received a notification or not, employers with self-funded plans should ask their TPAs whether they engage in cross-plan offsetting.

If the TPA does not use cross-plan offsetting, there is no issue.

If the TPA uses cross-plan offsetting, then the employer (as plan sponsor and plan fiduciary) should consider the following:

- **An Opt-Out of cross-plan offsetting is available.** If the TPA permits the employer/plan sponsor to opt-out, employers should decide whether they think the potential benefit to cross-plan offsetting is greater than their risk tolerance for a potential ERISA violation.
  - **Opting out.** Opting out of cross-plan offsetting is the most conservative approach considering the court's ruling and DOL's interpretation. If choosing to opt-out, keep records of the decision and monitor TPAs to ensure that they are administering the plan consistent with the written plan terms.
  - **Opting in.** Employers who stick with cross-plan offsetting should ensure that their plan document and summary plan description specifically authorize and outline the cross-plan offsetting process. Consider making the TPA a claims fiduciary with respect to the plan. There is a heightened risk of DOL intervention and/or litigation from providers. We recommend employers continuing cross-plan offsetting review this decision with counsel.

- **No Opt-Out Available.** If the TPA does not permit the employer to opt-out, the employer should be comfortable with the practice or consider moving to another TPA. We recommend employers choosing to permit cross-plan offsetting review this decision with counsel. Plan documents should include language authorizing the practice.





2019 PCOR Fee Filing Reminder for Self-Insured Plans

Published: May 22, 2019

The PCOR fee filing deadline is **July 31, 2019** for all self-funded medical plans and HRAs for **plan years ending in 2018**.

Please note, this is the final filing and payment for some plans. Plans ending in January through September of 2019 will have one more filing on July 31, 2020. We will send a reminder next year for the final filing and payment.

The plan years and associated amounts are as follows:

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2017 – January 31, 2018	$2.39/covered life/year	July 31, 2019
March 1, 2017 – February 29, 2018	$2.39/covered life/year	July 31, 2019
April 1, 2017 – March 31, 2018	$2.39/covered life/year	July 31, 2019
May 1, 2017 – April 30, 2018	$2.39/covered life/year	July 31, 2019
June 1, 2017 – May 31, 2018	$2.39/covered life/year	July 31, 2019
July 1, 2017 – June 30, 2018	$2.39/covered life/year	July 31, 2019
August 1, 2017 – July 31, 2018	$2.39/covered life/year	July 31, 2019
September 1, 2017 – August 31, 2018	$2.39/covered life/year	July 31, 2019
October 1, 2017 – September 30, 2018	$2.39/covered life/year	July 31, 2019
November 1, 2017 – October 31, 2018*	**$2.45/covered life/year**	July 31, 2019
December 1, 2017 – November 30, 2018*	**$2.45/covered life/year**	July 31, 2019
January 1, 2018 – December 31, 2018*	**$2.45/covered life/year**	July 31, 2019

* Final Due Date/Payment for these Plan Years

For the Form 720 and Instructions, visit: https://www.irs.gov/forms-pubs/about-form-720

The information is reported in Part II.

Please note that Form 720 is a tax form (not an informational return form such as Form 5500). As such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third-party administrators, cannot report or pay the fee.

Short Plan Years

The IRS issued FAQs that address how the PCOR fee works with a self-insured health plan on a short plan year.

Does the PCOR fee apply to an applicable self-insured health plan that has a short plan year?

Yes, the PCOR fee applies to a short plan year of an applicable self-insured health plan. A short plan year is a plan year that spans fewer than 12 months and may occur for a number of reasons. For example, a newly established applicable self-insured health plan that operates using a calendar year has a short plan year as its first year if it was established and began operating beginning on a day other than Jan. 1. Similarly, a plan that operates with a fiscal plan year experiences a short plan year when its plan year is changed to a calendar year plan year.

What is the PCOR fee for the short plan year?

The PCOR fee for the short plan year of an applicable self-insured health plan is equal to the average number of lives covered during that plan year multiplied by the applicable dollar amount for that plan year.

Thus, for example, the PCOR fee for an applicable self-insured health plan that has a short plan year that starts on April 1, 2018, and ends on Dec. 31, 2018, is equal to the average number of lives covered for April through Dec. 31, 2018, multiplied by $2.45 (the applicable dollar amount for plan years ending on or after Oct. 1, 2018, but before Oct. 1, 2019).

See FAQ 12 & 13, https://www.irs.gov/affordable-care-act/patient-centered-outcomes-research-trust-fund-fee-questions-and-answers





HIPAA FAQs for Health Apps

Published: May 29, 2019

Technological advancements over the last several years have made it easier than ever for employers and employees to collect, store, manage, organize, or transmit health information via applications and other software (collectively, "apps"). The Office of Civil Rights ("OCR"), the entity responsible for enforcing the Health Insurance Portability and Accountability Act ("HIPAA"), recently issued FAQs concerning HIPAA's applicability to apps. The FAQs clarify that once protected health information ("PHI") has been received by an app that is neither a covered entity nor a business associate, the information is no longer subject to the protections of the HIPAA rules.

Overview

Health plans are considered covered entities under HIPAA and must comply with HIPAA's Privacy and Security Rules. Briefly:

- The rules prohibit covered entities and business associates from using or disclosing PHI when not for treatment, payment, or health care operations purposes without participant authorization. Covered entities and business associates are also prohibited from using or disclosing more information than necessary and must keep PHI safe.

- "Business Associates" include various third-party vendors who create, store, use, transmit, or access PHI on behalf of the group health plan. Wellness vendors and cloud providers that use PHI for functions such as consulting and analyzing health plan data are business associates. As such, the group health plans must have business associate agreements in place with these vendors before PHI may be shared.

- PHI is health information created or received by a covered entity or employer which relates to the health or payment for health care of an individual and identifies the individual (or the information can be used to identify the individual).

- The Security Rule operationalizes the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that "covered entities" must put in place to secure individuals' electronic PHI ("ePHI").

HIPAA FAQs for Health Apps

Recently, OCR issued guidance in the form of FAQs to address common questions concerning HIPAA compliance related to the use of third-party health apps. Notably, the FAQs clarify the following:

- Once health information is received from a covered entity, at the individual's direction, by an app that is neither a covered entity nor a business associate under HIPAA, the information is no longer subject to the protections of the HIPAA Rules. In other words, if the individual's app was not provided by or on behalf of the covered entity (and, thus, does not create, receive, transmit, or maintain ePHI on its behalf), the covered entity should not be liable under the HIPAA Rules for any subsequent use or disclosure of the requested ePHI received by the app.

- If, on the other hand, the app was developed for, or provided by or on behalf of the covered entity – and, thus, creates, receives, maintains, or transmits ePHI on behalf of the covered entity – the covered entity could be liable under the HIPAA Rules for a subsequent impermissible disclosure because of the business associate relationship between the covered entity and the app developer.

Under HIPAA's individual right of access, individuals can direct a covered entity to transmit their ePHI to a third-party app in an unsecure manner or through an unsecure channel. The FAQs established that a covered entity transmitting ePHI to a third-party app via an unsecure manner or channel will not be responsible for unauthorized access to the ePHI while in transit, so long as the transmission was at the individual's request. For example, an individual may request his or her unencrypted ePHI be transmitted to an app as a matter of convenience. In this case, the covered entity would not be responsible for unauthorized access to the ePHI while in transmission to the app. However, the OCR specified that in this situation, the covered entity should advise the individual of the potential risks involved the first time the individual makes the request.

Finally, the OCR stressed that a covered entity is not allowed to refuse to disclose ePHI to an app chosen by an individual, even when the covered entity is concerned about the app's security or how the app will use or disclose the ePHI. The HIPAA Privacy Rule broadly prohibits covered entities from refusing to disclose ePHI to a third-party app selected by the individual, if the ePHI is "readily producible in the form and format used by the app." For example, a covered entity is not permitted to deny an individual's request to transmit their ePHI to a third-party app because the app does not encrypt the ePHI when stored in the app.

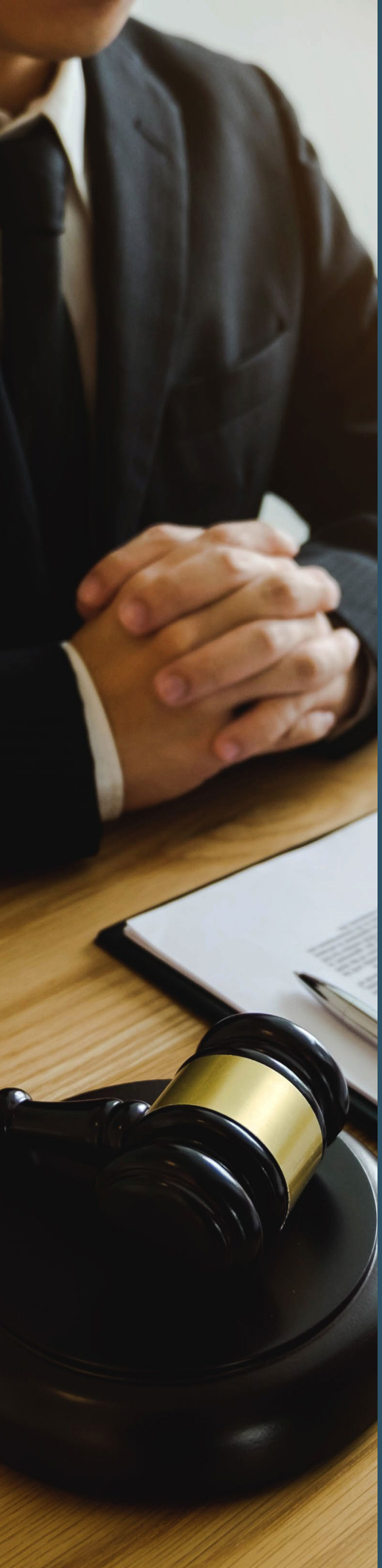
Employer Action

Employers, as plan sponsors of a health plan, should understand their responsibility under HIPAA as a covered entity and their relationship with any technology used to create, receive, maintain, or transmit ePHI. Accordingly, it is important for employers to:

- Be aware that technology offered to employees through the group health plan is likely subject to the HIPAA Privacy and Security Rules.

- Ensure any third-party vendors who transmit create, store, use, transmit, or access PHI on behalf of the group health plan understand their responsibilities under the HIPAA Privacy and Security Rules and confirm there are business associate agreements in place with these vendors.

- Abide by HIPAA's individual right of access, which allows individuals to direct their ePHI to any third-party app and request the ePHI be transmitted using an unsecure method or channel.



Court Provides Fiduciary Duty Guidance to Health Plans

Published: June 24, 2019

While ERISA fiduciaries have often been challenged for allowing an ERISA retirement plan to pay excessive fees and expenses (such as in the context of a 401(k) plan), such claims have rarely been raised against ERISA fiduciaries of a group health plan. However, the Department of Labor ("DOL") recently sued a group health plan raising excessive fee arguments (Acosta v. Chimes District of Columbia, Inc., et al.). In the decision, the court ruled in favor of the plan and fiduciaries, finding the plan fiduciaries met their obligations in relation to fees and set forth guidance on how fiduciaries should review health plan fees and expenses.

Background

Under ERISA, persons or entities who exercise discretionary control or authority over plan management or plan assets and anyone with discretionary authority or responsibility for the administration of a plan, are subject to fiduciary responsibilities. Plan fiduciaries for group health plans often include the plan sponsor and plan administrators.

ERISA's fiduciary duties include acting solely in the interest of plan participants and beneficiaries and for the exclusive purpose of providing benefits, defraying reasonable administrative expenses. Fiduciaries must carry out plan functions prudently based on the prevailing circumstances, and in accordance with written plan terms.

The Case

Chimes DC maintained a self-funded health and welfare benefit plan for the benefit of its employees. Chimes contracted with a third-party administrator (TPA) to process claims and assist with other components of plan operations. The TPA was paid a per-employee-per-month (PEPM) fee as well as a set percentage of total plan assets (consisting of employee and employer contributions). Although other issues were present in the case, the DOL charged Chimes with ERISA fiduciary violations alleging that Chimes did not monitor the group health plan's fees and expenses.

Despite DOL's arguments to the contrary, the court found that Chimes met its fiduciary duties to prudently select and monitor its TPA, and paid reasonable fees for services to the plan.



Best Practices

The analysis used by the court is instructive for other plan fiduciaries as it provides some guidelines and best practices to implement when choosing and retaining service providers. Below is a list of the best practices, including those identified by the Chimes court, which a fiduciary should implement to meet its fiduciary duties to prudently select and monitor service providers:

Selecting a Service Provider

- Issue a Request for Proposal ("RFP") to more than one vendor to better understand the market and compare services and pricing
- Compare firms based on the same information, such as services offered, market experience, performance guarantees, unique expertise (e.g., Service Contract Act experience), and costs.
- Obtain detailed information about the service provider systems, financial condition, and experience with groups of similar size and complexity
- Ask for references to speak with current clients of the vendor
- If the vendor is new to the plan, ask for an operational review of systems to determine compatibility with the plan functions
- Consider the implementation process and identify challenges which may cause a difficult transition
- Include performance guarantees in the contract to establish accountability and provide recourse if problems arise

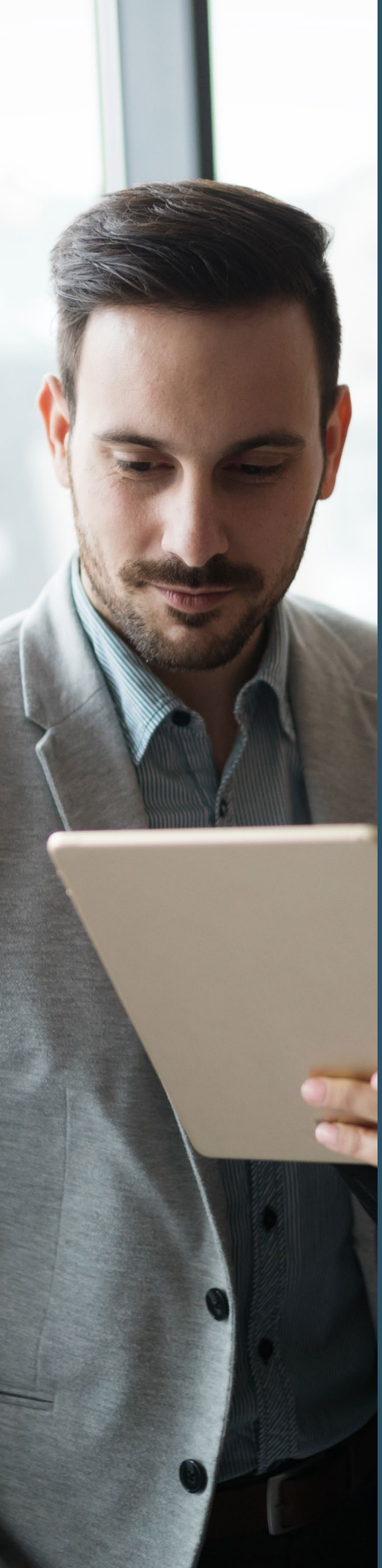
Monitoring Service Providers

- Receive regular and frequent reports detailing service activities
- Seek timely correction of issues
- Ensure corrections are made retroactively and prospectively, if necessary and to the extent possible given the circumstances
- Monitor performance guarantees and assess whether terms were met; if performance guarantees are not met, discuss corrections and any recourse for failure
- Be prepared to switch service providers if poor performance is affecting the plan

As stated by the DOL and the court, ERISA fiduciaries do not have to choose the cheapest option or routinely issue an RFP to potential vendors to act prudently. However, plans must demonstrate prudence and diligence in vetting and choosing service providers that provide a good fit for the organization's unique challenges. Once a service provider is chosen, fiduciaries must hold them accountable for delivering effective services, and ensure they are paying reasonable fees.

Employer Action

This case is a reminder that all ERISA fiduciaries are held to the same high fiduciary standards regardless of whether they are administering a group health plan or a retirement plan. Plan sponsors should implement a process that allows them to prudently select and regularly monitor plan service providers. One key factor in any prudent process is engaging with an experienced consultant that can provide fee and service benchmarks for the industry and periodically issue an RFP to ensure the services and fees align with regular market standards.



Individual Coverage HRAs

Highlights from the Final Rule

Published: June 28, 2019

The Departments of Labor, Health and Human Services, and the Treasury (collectively, "the Departments") finalized rules creating two new Health Reimbursement Arrangement (HRA) options available to employers beginning January 2020. These final rules generally follow the proposed guidance (issued in October 2018) with some notable changes.

This article addresses individual coverage HRAs. Excepted benefit HRAs are discussed in a separate update.

Briefly, beginning with the first plan year on or after January 1, 2020, employers are permitted to offer an individual coverage HRA. This is an arrangement where the employer integrates individual health insurance coverage with an HRA when other traditional group health plan coverage is not offered, subject to certain conditions.

While individual coverage HRAs may not be a benefit strategy for all employers, some employers may want to consider this new option as part of their 2020 renewal planning.

The following highlights some of the key provisions of the final rules, including notable changes from the proposed guidance. The final rule is lengthy and dense and includes numerous examples. Employers interested in pursuing an individual coverage HRA should review the final rule and supporting guidance and work with their benefits consultant and third-party administrators to understand the various requirements.

HRA Integrated With Individual Health Insurance Coverage

Generally, pre-2020, existing law barred most employers from offering (and paying for) individual health insurance policies. However, these final rules create a mechanism by which employers may, in lieu of traditional group health insurance coverage, offer an HRA to reimburse individual health insurance premiums for employees (an individual coverage HRA).

The following six conditions must be met in order to offer an individual coverage HRA:

1. Participants (and dependents) must be enrolled in permitted individual health insurance coverage to receive benefits under the HRA.

2. No traditional group health plan may be offered to a classification of employees that is also offered an individual coverage HRA.

3. Individual coverage HRAs must be offered on the same terms to all participants within a classification, except where deviation is permitted by the rules.

4. There must be an opportunity for eligible participants to opt-out and waive future reimbursements each year.



5. Reasonable procedures must be in place to substantiate individual health insurance coverage.

6. Employers must provide and comply with notification requirements.

Each of these conditions are discussed below.

1. Permitted Individual Health Insurance Coverage.

The final rule generally mirrors the proposed rules requiring every individual covered by an Individual Coverage HRA to enroll in individual health coverage to receive the benefits.

For this purpose, an individual coverage policy qualifies regardless of whether it is purchased inside or outside the federal or a state-based Exchange (also called "the Marketplace").

The final rule differs from the proposed in that catastrophic coverage, Medicare Part A, B, or C and fully insured student health insurance coverage also qualify as permitted individual health coverage, if certain conditions are met (discussed below).

However, the following are not considered individual health insurance coverage and cannot be integrated with an individual coverage HRA:

- coverage consisting solely of excepted benefits,
- short-term limited duration insurance,
- other non-HRA group coverage,
- self-funded student health coverage,
- healthcare sharing ministries, and
- TRICARE.

2. Permitted Classifications, Minimum Size Rule

A plan sponsor that offers an individual coverage HRA to a class of employees must offer such coverage on the same terms to each participant within the class (with limited exceptions).

Permitted classifications.

The final rule modifies the proposed classifications by adding new categories and removing a proposed "under age 25" classification. Per the final rule, the following classifications are permissible:

- Full-time;
- Part-time;
- Employees working in the same geographic locations (generally the same insurance rating area, state or multi-state region);
- Seasonal employees;
- Employees in a unit of employees covered by a collective bargaining agreement;
- Employees who have not satisfied a waiting period;
- Non-resident aliens with no U.S.-based income;
- Salaried workers **(new)**;
- Non-salaried workers (such as hourly workers) **(new)**; or
- Temporary employees of staffing firms **(new)**.

Note regarding definition of Full-Time, Part-Time and Seasonal Employees.

For purposes of defining "full-time employee," "part-time employee," and "seasonal employee," the rule requires the use of either:

- The definitions under the employer mandate (Code Section 4980H); or
- The definitions as used in the nondiscrimination rules for self-insured health plans (Code Section 105(h)).

The elected definition must be included in the HRA plan document and consistent across all classifications (i.e., if the 4980H definition is used for full-time employees, it must be used for part-time and seasonal employees). Additionally, the definition used should be established prior to the start of the plan year to which the definition will apply and be applied consistently throughout the year. The final rule clarifies that mid-plan year adjustments to the definitions used to identify the classes of employees for this purpose **are not permitted**.

Minimum size rule.

Additionally, the final rule takes further steps to prevent adverse selection by imposing a minimum class size rule. This rule applies when a plan sponsor offers a traditional group health plan to one class of employees and an individual coverage HRA to at least one other class of employees and the following classifications are used (or any combination that includes one of these classifications):

- Full-time;
- Part-time;
- Salaried;
- Non-salaried; or
- A class is based on a geographic location smaller than a state.

The minimum class size is based on the number of employees in the classification eligible for the individual coverage HRA at the beginning of the plan year.

- Fewer than 100 employees – class size must be 10 employees or greater
- 100-200 employees – class size must be ten percent (10%) of the total number of employees
- More than 200 employees – class size must be 20 employees or greater

For example, an employer with 100 employees offers a traditional group health plan to full-time employees and an individual coverage HRA to part-time employees. To meet the minimum class size rule, there must be at least 10 part-time employees eligible for the individual coverage HRA at the start of the plan year (regardless of how many enroll).

Special new hire rule.

The final rule permits employers to offer newly hired employees an Individual Coverage HRA, while grandfathering existing employees in a traditional group health plan, subject to certain conditions.

3. Same Terms & Permitted Variation

If an employer offers an individual coverage HRA to a permitted classification of employees, the HRA must be offered on the same terms to all participants within the classification, with limited exception.

Generally, there is no federal cap on the maximum amount that can be contributed to an individual coverage HRA. Employers may contribute as little or as much as they want. However, employers generally must make the same dollar amount available to all participants in the individual coverage HRA unless an exception exists. Permitted exceptions include different contribution amounts based on family size, the participant's age, and eligibility date.

Permitted variations.

- **Variation due to number of dependents.** The final rule retains the proposed rule guidance permitting variance in the HRA contribution based on the number of dependents a participant enrolls in the individual coverage HRA so long as the amount attributable to the increase in family size is available to all in the same class with the same number of participants.
- **Variation due to age.** Both the proposed and final rules permit an employer to offer more individual coverage HRA dollars to participants based on the age, as individual health insurance premiums generally increase based on age. However, the final rule includes a limitation:
  - The maximum dollar amount made available under the terms of the HRA to the oldest participant cannot be **more than three times (3x) the maximum amount available to the youngest participants.**
  - While varying contributions by age is permitted, variations must be applied equally to all participants who are the same age.
- **New Hires:** These rules also permit employers to vary HRA contribution amounts based on eligibility. Specifically, an employee eligible mid-year may receive prorated amounts based on the number of months they are eligible for the HRA. The method used to determine this prorated amount must be the same for all participants in the same classification.

4. Opt-Out Provisions

Employers offering an individual coverage HRA must allow employees an opportunity to opt-out or waive enrollment every year. Even if an individual opts out of the individual coverage HRA, the employer may be shielded from incurring ACA penalties under 4980H if the coverage meets affordability and minimum value standards. See the ACA discussion below.

5. Substantiation of Coverage

The final rules require employers to establish reasonable procedures to verify that participants and dependents are (or will be) enrolled in individual health insurance coverage for the plan year before releasing HRA funds and that the expenses are not otherwise reimbursed. Employers may rely on either:

- documentation from a third-party that the individuals covered by the HRA had coverage (e.g., EOB or insurance card), or

- an attestation from the participant of coverage through an individual policy. A model form has been provided for this purpose. For the model attestation visit: https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/completed-rulemaking/1210-AB87/individual-coverage-model-attestation.docx

The final rules clarify that an employer may rely on the participant's assertions about having individual coverage based on the documentation or attestation, unless the employer has actual knowledge that the individual covered by the HRA is not (or will not be) enrolled in individual health insurance coverage for the plan year or the month, as applicable.

6. Notice Requirements

The final rules require employers to provide written notice to all employees (including former employees) who are eligible for the individual coverage HRA.

This notice must be provided at least 90 days prior to the start of the plan year and must meet content requirements outlined by the regulation. The notice includes, among other items:

- a description of the HRA,
- contact information,
- the maximum dollar amounts available,
- opt-out and waiver rights,
- effect of the coverage on availability of any premium tax credit,
- reimbursement rules, and
- the substantiation rules.

This notice must be distributed in a manner reasonably calculated to ensure actual receipt by participants. For new HRAs established less than 120 days prior to the beginning of the first plan year, the notice may be provided no later than the date on which the HRA will first take effect for the participant. For individuals that become eligible after the beginning of the plan year, the notice must go out no later than the effective date of the coverage.

The Departments issued a 6-page model notice that can be used to meet this requirement. For the model notice, visit: https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/rules-and-regulations/completed-rulemaking/1210-AB87/individual-coverage-model-notice.docx.

Other Considerations for Individual Coverage HRAs

ERISA.

The final rules clarify that ERISA will generally apply to the HRA, but not to the underlying individual health insurance coverage. Therefore, the HRA (but not the individual coverage) remains subject to all ERISA requirements (including reporting and disclosure requirements and COBRA). To prevent ERISA applicability to the underlying individual coverage, an employer must:

- provide annual notice that ERISA Title I does not apply to the individual coverage;
- ensure enrollment is voluntary,
- not endorse, select, or limit the options available to employees (providing general information about or educational information is not endorsing), and
- not receive any consideration in the form of cash or otherwise in connection with the employee's selection or renewal of any individual health insurance coverage.

IRS 105(h)Nondiscrimination.

While the flexibilities that permit employers to vary contributions for certain employees may give rise to discrimination issues under current IRS Code Section 105(h) rules, the IRS is expected to provide safe harbor guidance to alleviate the discrimination issue.

ACA Employer Mandate and Affordability.

An offer of an individual coverage HRA counts as an offer of Minimum Essential Coverage ("MEC") under the employer mandate. An employer must contribute sufficiently to an individual coverage HRA for the MEC to be considered affordable. The final rule provided further details on how affordability should be calculated for individual coverage HRAs. Generally, the coverage will be affordable for an employee if the employer's annual HRA contribution is large enough to allow the employee to obtain the lowest cost silver plan on the Exchange without having to contribute monthly toward the premium in an amount greater than the following:

(Participant's household income X current affordability percentage) ÷ 12

The Affordability percentage changes annually. In 2019, plans are considered affordable if the employee's share of the contribution does not exceed 9.86% of their household income.

Future guidance is expected from the IRS to assist Applicable Large Employers (ALEs) in calculating the ACA's affordability and minimum value standards. This guidance is expected to extend the existing affordability safe harbors (W-2, Rate of Pay, and Federal Poverty Level) to employers offering an individual coverage HRA.

An individual who is offered an individual coverage HRA that is affordable and meets minimum value will not be eligible for a Premium Tax Credit (PTC) on the Exchange.

The IRS is expected to provide more information on how the employer mandate applies to individual coverage HRAs.

COBRA.

An HRA is a group health plan generally subject to the COBRA continuation coverage requirements. If an individual elects COBRA continuation coverage, the employer must provide for the continuation of the maximum reimbursement amount for an individual at the time of the COBRA qualifying event and by increasing that maximum amount at the same time and by the same increment that it is increased for similarly situated non-COBRA beneficiaries. The final rules do not modify these long-standing IRS rules.

Medicare.

The individual coverage HRA may reimburse individuals for Medicare premiums, but may not limit other reimbursements to only expenses not covered by Medicare. Individual coverage HRAs may limit reimbursement only to premiums or non-premium medical care expenses (e.g., cost-sharing), or may decide which particular medical care expenses will be reimbursable (and which will not) under the terms of the plan. Unlike the proposed rules, the final rules allow employers to offer an individual coverage HRA to participants that are otherwise Medicare eligible without violating the Medicare Secondary Payer (MSP) rules and anti-duplication rules.

The individual coverage HRA (as the group health plan) will be the primary payer and Medicare will be the secondary payer. Generally, most group health plans are subject to MSP rules which prohibit offering Medicare-eligible individuals financial incentives to decline enrolling in the group plan because it causes Medicare to become the primary payer. However, the final rules clarify that offering an individual coverage HRA does not violate MSP rules because the HRA is the group health plan. Note, the final rules do not permit an employer to create an employee classification based solely on Medicare eligibility, but Medicare-eligible employees within a classification must be offered the same HRA benefits as other employees.

HHS intends to issue additional guidance clarifying this coordination of benefits and the associated reporting requirements.

State Law.

Some state insurance laws (such as Oregon and Texas) may bar employers from purchasing (directly or indirectly) health insurance coverage from the individual market on behalf of employees. The final rules confirm that the states' authority to regulate individual insurance markets remain unaffected. Therefore, prohibitions at the state level remain valid and may limit this HRA option in certain areas.

Employer Action

Employers may consider whether individual coverage HRAs may be a viable option for their employee benefit plan strategy for 2020 or beyond.

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