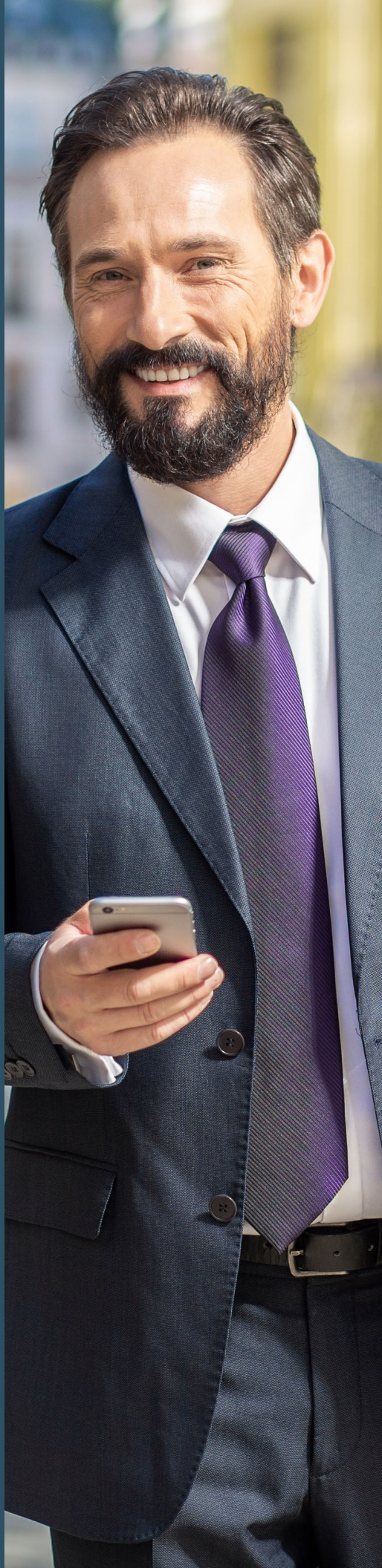

2019: Year in Review

Compliance Digest

Compliance Bulletins Released January - December

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2019 Compliance Bulletins

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ACA Still In Force, But With Uncertain Fate

Published: January 18, 2019

On December 14, 2018, a Texas district court invalidated the entire Affordable Care Act ("ACA"). This includes the Individual Mandate, Employer Penalty, mandated benefits such as the prohibition against preexisting condition exclusions, taxes such as the PCOR fee, the establishment of the Marketplace and offering of subsidies, and reporting such as Form 1095-C reporting. The ruling does not constitute a final determination and the decision will be appealed. Therefore, there is no immediate impact.

Absent further direction, all provisions of the ACA remain in effect, including:

- The Employer Mandate and associated annual reporting on Forms 1094-C and 1095-C (due to employees by March 4, 2019 for calendar year 2018).
- Insurance market reforms, including the prohibition on preexisting condition exclusions, limitation on waiting periods, prohibition on lifetime and annual dollar limits, and coverage for children up to age 26.
- Availability of premium tax credits to assist certain low-to-middle income individuals in purchasing health insurance through the Marketplace.

This article summarizes this history of the challenges to the ACA and the potential effect a final ruling may have on its future.

Background

One of the ACA's major provisions is that Americans must have health insurance or pay a penalty. That provision was challenged and, on June 28, 2012, the Supreme Court ruled that the Individual Mandate is not a valid exercise of Congress' power under the Commerce Clause (i.e., the federal government cannot force individuals to buy insurance), but nevertheless upheld it due to Congress' power under the Taxing Clause (i.e., the federal government has broad authority to monetarily penalize individuals).

Numerous efforts to repeal the ACA have all failed. However, in December 2017, Congress, through the Tax Cuts and Jobs Act, changed the Individual Mandate Penalty to $0, beginning January 1, 2019.

In a renewed effort to strike down the ACA, on February 26, 2018, Texas Attorney General Ken Paxton and 19 other Republican state attorneys general filed a lawsuit which charged that Congress' changes to the law in last year's tax bill rendered the entire ACA unconstitutional. The reasoning is as follows:

- **Step One:** If the Individual Mandate, per the Supreme Court, is only constitutional because it constitutes a tax, and if that tax has effectively been eliminated, then the Mandate sans tax that remains on the books is therefore unconstitutional.

- **Step Two:** Invalidating the Mandate should invalidate the whole ACA because the law cannot function the way Congress intended without the Mandate in place.

On June 7, 2018, in a departure from the Justice Department's custom of fighting to uphold all reasonable laws, then U.S. Attorney General Jeff Sessions indicated in a brief that it would not participate in the defense of this lawsuit. While the Administration did call on the court to invalidate the Individual Mandate, guarantee issue requirement, and community rating requirement, it indicated that the remaining provisions should stand. It also asked the court to hold off on a broad ruling until after December 15, the end of this year's Marketplace open enrollment period, to avoid introducing "chaos in the insurance markets."

In May 2018, the court allowed the attorneys general from Democratic-leaning states to "intervene" in the case and defend the law. California Attorney General Xavier Becerra led the challenge with 15 other states and the District of Columbia. They refuted the Republican attorneys' general claim, noting that the ACA and its Individual Mandate have already survived two reviews by the Supreme Court and over 70 unsuccessful repeal attempts in Congress.

In addition, there is ongoing parallel litigation over the DOJ's decision not to defend the ACA.

The December 14, 2018 Decision

In Texas v. Azar, Judge O'Connor, a George W. Bush appointee who sits in the Northern District of Texas, came to three conclusions:

- the plaintiffs had standing to sue so the case was properly before the court;

- with the penalty at $0, the Individual Mandate is no longer permissible under Congress' taxing power and is unconstitutional; and

- the Individual Mandate is essential to and inseverable from the entire ACA, meaning the entire ACA is invalid.

Judge O'Connor's ruling does not enjoin the ACA which means that the ACA's provisions remain in effect for the time being.

From here, the case will likely move to the Fifth Circuit Court of Appeals and then the Supreme Court where a final decision might not be made until 2020 or later.

Next Steps

While impossible to determine the final outcome, Judge O'Connor's arguments have been met with criticism, even by conservative legal scholars. In King v. Burwell (the most recent case before the Supreme Court challenging the validity of the ACA), Chief Justice Roberts alluded that the Court's current majority favored keeping the law intact:

> *Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter.*

If the ACA is invalidated, the effects will be far-reaching, with the ACA touching almost every aspect of the American health care system (e.g., community rating and Medicaid expansion). In part, it would significantly impact employers who, among other things, would no longer have to evaluate affordability, define full-time employees as those working at least 30 hours per week, limit their waiting periods to 90 days, or file Forms 1095-C.

We will be monitoring this litigation and provide updates of further developments.

Contraceptive Coverage Exemption Rules on Hold by Courts

Published: January 22, 2019

A federal district court in Pennsylvania has issued a nationwide injunction blocking revised rules set to be effective on January 14, 2019 regarding contraceptive services coverage in employer based health insurance. The revised rules would make it easier for private employers to refuse to provide coverage for contraceptive services as part of their health insurance plan for employees. Pending any appeal, the requirement to provide contraceptive services will remain in place for all entities that do not qualify for a religious objection exemption.

Background

Under the Affordable Care Act ("ACA"), all non-grandfathered health plans must cover certain preventive items and services without cost-sharing, including contraceptive services. Churches, religious non-profits, and closely held for-profit organizations with religious objections can qualify for an exemption.

In October 2017, the Departments of Health and Human Services, Labor, and the Treasury (collectively "the Departments") released interim regulations permitting non-governmental employers, institutions of higher education, and individuals with religious or moral objections to cease providing coverage for some, or all, contraceptive services. Despite being effective immediately, these regulations were quickly put on hold by preliminary injunctions issued by two federal district courts. Appeals were filed in those cases.

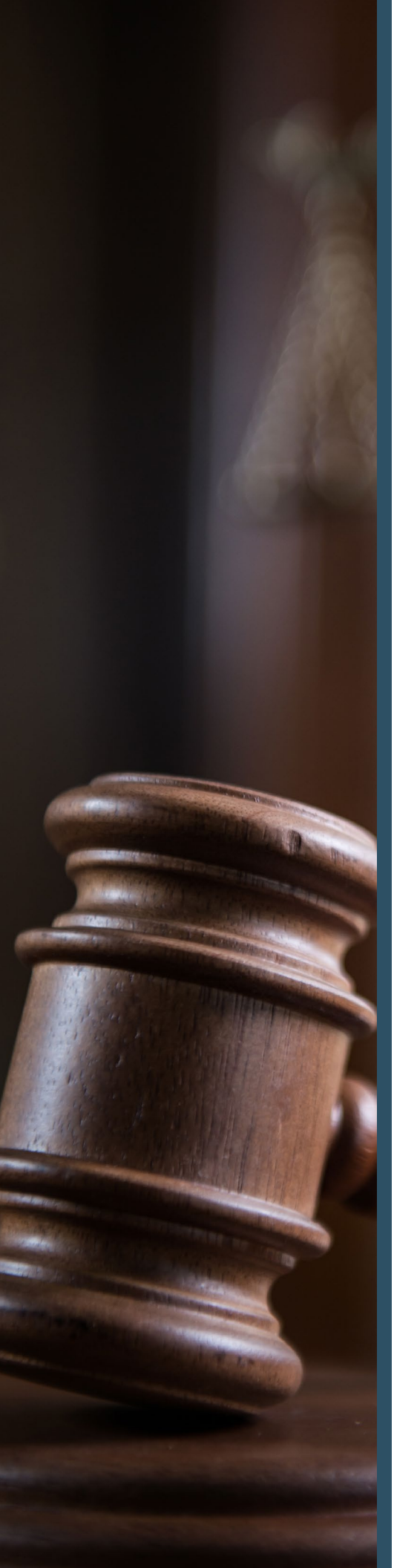
In November 2018, the Departments issued revised final regulations set to go into effect on January 14, 2019, which largely mirrored the October 2017 interim regulations. It is unclear how the publication of the revised final regulations affects the pending lawsuits over the October 2017 interim regulations.

New Developments

Several states and the District of Columbia joined forces to challenge the November 2018 regulations in the same federal district courts in California and Pennsylvania that had issued injunctions against the October 2017 regulations because they were issued without a public comment period in violation of the rulemaking process. On January 13, 2019, the federal district court in California issued an injunction against the new rules, but limited that injunction to the specific states that had filed the lawsuit in that court. On January 14, 2019, the federal district court in Pennsylvania issued an injunction blocking the rules nationwide. The injunctions do not invalidate the regulations, but stop them from going into effect while the appeals process continues.

Employer Considerations

It is expected that the Departments will appeal these latest injunctions. Employers should use caution and consult with counsel before implementing any changes related to contraceptive services that rely on the November 2018 or the October 2017 rules. As always, we will continue to monitor the progress of this issue and provide additional information when available.



Proposed Settlement in Dave & Buster's ERISA Class Action Lawsuit

Published: January 23, 2019

A settlement has been preliminarily approved in the lawsuit filed against Dave & Buster's (D & B) by current and former employees alleging the company's nationwide reduction of employees' work hours was motivated by an intent to reduce costs for the company by restricting employee eligibility for the company health plan. D & B has reportedly agreed to pay more than $7.4 million to workers whose scheduled hours were cut.

Background

The Affordable Care Act (ACA) became law on March 23, 2010. The ACA's employer mandate requires employers with more than 50 full time employees to offer health insurance to 95% of their full-time employees or pay penalties. The ACA defines "full time" as working 30 or more hours a week. Prior to the ACA, many employers offered health insurance to employees who worked at least 35 or 40 hours per week. Those employers were faced with the choice of expanding the eligibility criteria of their health plans, or risking penalties under the ACA.

The Employee Retirement Income Security Act of 1974 (ERISA) places certain duties on private employers that sponsor certain employee benefit plans. One of the protections under ERISA prevents anyone, including an employer, from discriminating against a plan participant for the purpose of interfering with a right or the attainment of a right protected by ERISA. Eligibility for health insurance is protected by ERISA.

Marin v. Dave & Buster's, Inc.

According to the lawsuit filed in May of 2015, in response to the ACA employer mandate, D & B decided to manage its employee work schedules in order to restrict the number of hours employees could work per week. It was alleged that D & B reduced employees' scheduled work hours specifically to limit employee eligibility for health insurance for the purpose of minimizing costs imposed by the ACA. There were two outcomes of the schedule reductions that became the subject of the lawsuit:

- Some employees that were enrolled in D & B's group health plan lost eligibility
- Some employees that were eligible to enroll for D & B's group health plan lost eligibility

The lawsuit was significant because it alleged that D & B violated ERISA when it chose to reduce its employees' scheduled hours to avoid the ACA penalties, on the theory that intending to eliminate or prevent eligibility for the health insurance plan was prohibited interference under ERISA §510. Initially, D & B denied all the claims made in the lawsuit and tried to have the case dismissed. The Court denied the motion to dismiss and the parties proceeded with the litigation while negotiating a settlement. Ultimately, a settlement was reached and preliminarily approved by the court on December 18, 2018. A final approval hearing is scheduled in May of 2019.

Employer Considerations

As with most settlements, there is unlikely to be any admission of wrongdoing on the part of D & B or any bright lines established by the court. However, the D & B litigation and preliminary settlement serve as an important reminder of the ERISA fiduciary rules and potential consequences when these rules aren't followed. While the employer mandate forced many employers to evaluate their plan eligibility rules to understand potential penalty exposure and risks, as the D&B case illustrates, careful consideration of the ERISA fiduciary rules should also be a part of this evaluation.

2019 Federal Poverty Guidelines Announced

Published: January 25, 2019

HHS recently announced the 2019 Federal Poverty Level (FPL) guidelines which, among other things, establish the FPL safe harbor for purposes of the Affordable Care Act (ACA) employer mandate. For 2019, the FPL safe harbor is **$102.62**/month in the lower 48 states, $128.18/month for Alaska, and $118.15/month for Hawaii.

As a reminder, a plan can use poverty guidelines in effect within 6 months before the first day of the plan year for purposes of affordability. As the FPL guidelines were announced after the start of the calendar year, plans beginning on January 1, 2019 use $99.75/month for the lower 48 states ($124.72 Alaska and $114.70 Hawaii). The increased threshold applies to plan years beginning on or after February 1, 2019.

Background

Large employers may be subject to the employer penalty under the ACA if they do not offer affordable, minimum value coverage to all full-time employees and at least one full-time employee receives a subsidy in the Marketplace. The FPL is relevant to this penalty in two ways:

1. **Affordability Safe Harbor**
   For affordability purposes, a large employer satisfies the FPL safe harbor with respect to an employee for a calendar month if the employee's required contribution for the large employer's lowest cost self-only coverage that provides minimum value does not exceed 9.5% (indexed at 9.86% for 2019) of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12.

2. **Subsidy Eligibility**
   An individual is only eligible for a subsidy in the Marketplace if he or she is within 100-400% of the FPL and is not offered affordable, minimum value group coverage.

Indexed Amounts

The following are the 2019 HHS poverty guidelines:

2019 Poverty Guidelines for the 48 Contiguous States and DC

Persons in family/ household	Poverty guideline
1	$12,490
2	$16,910
3	$21,330
4	$25,750
5	$30,170
6	$34,590
7	$39,010
8	$43,430

For families/households with more than 8 persons, add $4,420 for each additional person.

2019 Poverty Guidelines for Alaska

Persons in family/ household	Poverty guideline
1	$15,600
2	$21,130
3	$26,660
4	$32,190
5	$37,720
6	$43,250
7	$48,780
8	$54,310

For families/households with more than 8 persons, add $5,530 for each additional person.

2019 Poverty Guidelines for Hawaii

Persons in family/ household	Poverty guideline
1	$14,380
2	$19,460
3	$24,540
4	$29,620
5	$34,700
6	$39,780
7	$44,860
8	$49,940

For families/households with more than 8 persons, add $5,080 for each additional person.

Affordability Safe Harbor and Subsidy Eligibility 2019 Results

Based on new 2019 levels:

- For affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The FPL is $12,490 for a single individual for every state (and Washington D.C.) except Alaska or Hawaii. So, if the employee's required contribution for the calendar month for the lowest cost self-only coverage that provides minimum value is **$102.62** (9.86% of $12,490/12) or less, the employer meets the FPL safe harbor.

- For subsidy eligibility purposes, the applicable FPL is the FPL for the state in which the employee resides. 100 – 400% of the FPL is **$12,490 – $49,960 for a single individual and $25,750 – $103,000 for a family of four** for every state (and Washington D.C.), except Alaska or Hawaii.

DOL Penalties Increase for 2019

Published: January 28, 2019

IThe Department of Labor (DOL) published the annual adjustments for 2019 that increase certain penalties applicable to employee benefit plans.

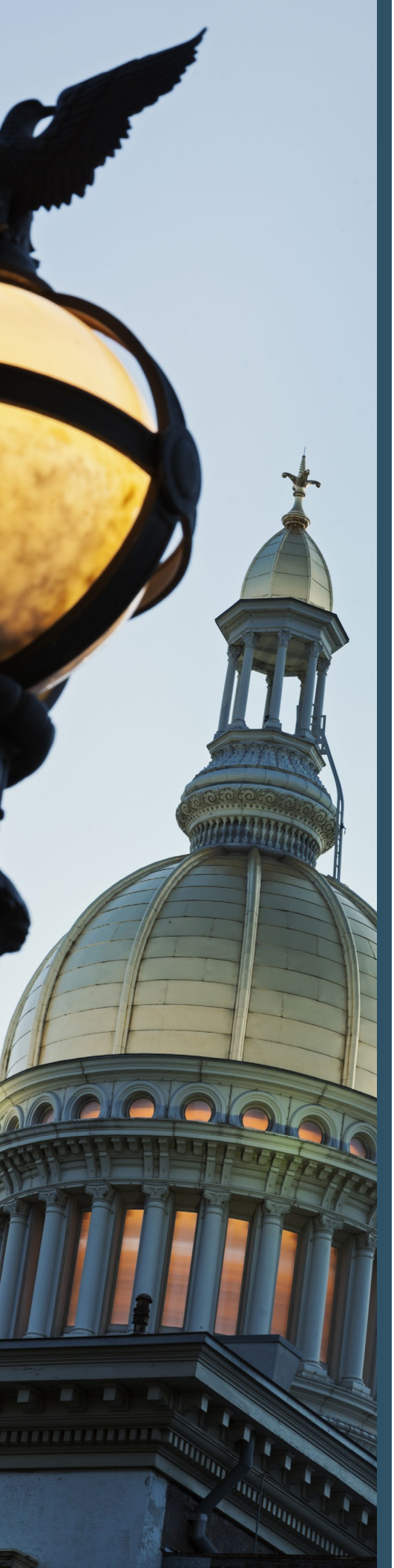
Annual Penalty Adjustments For 2019

The following updated penalties are applicable to health and welfare plans subject to ERISA

Description	2018 Penalty	2019 Penalty
Failure to file **Form 5500**	Up to $2,140 per day	Up to $2,194 per day
Failure of a **MEWA** to file reports	Up to $1,558 per day	Up to $1,597 per day
Failure to provide **CHIP Notice**	Up to $114 per day per employee	Up to $117 per day per employee
Failure to disclose CHIP/Medicare Coordination to the State	$114 per day per violation (per participant/beneficiary)	$117 per day per violation (per participant/beneficiary)
Failure to provide **SBCs**	Up to $1,128 per failure	Up to $1,156 per failure
Failure to furnish **plan documents** (including SPDs/SMMs)	$152 per day $1,527 cap per request	$156 per day $1,566 cap per request
Genetic information failures	$114 per day	$117 per day
De minimis failures to meet genetic information requirements	$2,847minimum	$2,919 minimum
Failure to meet genetic information requirements – not de minimis failures	$17,084 minimum	$17,515 minimum
Cap on unintentional failures to meet genetic information requirements	$569,468 maximum	$583,830 maximum

Employer Action

Private employers, including non-profits, should ensure employees receive required notices timely (SBC, CHIP, SPD, etc.) to prevent civil penalty assessments. In addition, employers should ensure Form 5500s are properly and timely filed, if applicable. Finally, employers facing document requests from EBSA should ensure documents are provided timely, as requested.



New Jersey Updates 2019 Individual Mandate Employer Reporting

Published: January 29, 2019

The state of New Jersey has posted information related to employer reporting under New Jersey's individual health insurance mandate that went into effect January 1, 2019. Initially, starting in early 2020 and relating back to 2019, certain employers with New Jersey employees must remit to the state the same Forms 1095-C and 1094-C provided to the Internal Revenue Service (IRS) for 2019.

Background

The New Jersey Health Insurance Market Preservation Act (the "NJ Act") requires most New Jersey residents to maintain health insurance, starting January 1, 2019. Failure to do so, absent an exemption, will result in an individual penalty imposed by the state when a person files his or her 2019 New Jersey Income Tax return. This New Jersey individual insurance mandate essentially replaces the individual mandate imposed under the Affordable Care Act (ACA), which was effectively eliminated starting in 2019 under the Tax Cuts and Jobs Act.

As with the ACA, the NJ Act requires certain employers and insurance carriers to report to covered individuals and to the state in affirming that such individuals had actual health coverage in a calendar year.

What's New

Recently, the state of New Jersey updated its "Information for Employers" website with respect to the New Jersey Health Insurance Mandate. Notably, beginning with CY 2019, employers must provide the same Forms 1094-C and 1095-C to the state of New Jersey as they provide to employees (and perhaps other individuals otherwise covered under an employer-sponsored plan) and to the Internal Revenue Service (IRS) under the ACA. The Forms are to be sent to the New Jersey Division of Taxation by February 15, 2020. This deadline actually precedes the general deadline by which such Forms need to be filed with the IRS under the ACA.

Employer reporting under the NJ Act applies to all employers that withhold and remit New Jersey Gross Income Tax for New Jersey residents, including employers located outside of the state. However, the NJ Act employer reporting is optional for employers who are not required to submit IRS Forms 1095-C or 1095-B to employees. That would generally consist of any employer under 50 employees. However, pending further guidance, a small employer with a self-insured plan for any portion of the year may still be subject to reporting under the NJ Act.

Even though the ACA has not required employers with insured plans to report on actual coverage of individuals (a responsibility that falls on insurance carriers), the state still requires such employers to submit any Forms 1095-C they generate for individuals who are NJ residents.

Employer Action

All employers with employees who are New Jersey residents should evaluate whether they will be subject to these new reporting requirements beginning in 2019. In many cases, such employers will already be generating the Forms required to be filed with the state.

Employers should be aware of the February 15, 2020 reporting deadline (as it is earlier than what is required under federal law).

Further, all such employers should watch for updates on the New Jersey website, particularly if the IRS changes the current Forms for 2019 reporting, and if NJ deploys its own separate forms.

Proposed Rules Address Prescription Drug Pricing

Published: February 6, 2019

Last week, the Department of Health and Human Services ("HHS") released a proposed rule to lower prescription drug prices and out-of-pocket costs by encouraging manufacturers to pass discounts directly to patients and bring new transparency to prescription drug markets.

Briefly:

- **Nothing has changed. This is a proposed rule.**
- Even if finalized in its current form, the proposed rule **does not impact employer-sponsored plans unless** Pharmacy Benefit Managers ("PBMs") and pharmaceutical manufacturers adopt a new safe harbor (discussed below), which may provide additional transparency.

Background

Under the federal Anti-Kickback Statute ("AKS"), the federal government may impose criminal and civil penalties on whoever "knowingly and willfully offers, pays, solicits or receives remuneration to induce or reward the referral of business reimbursable under any of the federal health care programs" (e.g., Medicare, Medicaid). Generally, employer-sponsored health plans are not "federal health care programs;" therefore, they are not directly subject to the AKS.

Because the statute had a broad reach, the law was subsequently amended when HHS developed regulations to create "safe harbors." The safe harbors specify various payment and business practices that, if followed, are not subject to sanctions under the AKS, even though such practices potentially could be capable of inducing payments that could trigger penalties under this law.

How would this Proposed Rule Impact Employer-Sponsored Plans?

The proposed rule creates a new safe harbor under the federal AKS related to PBM service fees.

If followed, the safe harbor protects the pharmaceutical manufacturer's payment for certain services that a PBM furnishes to the manufacturer from anti-kickback claims. For this purpose, the term "health plan" includes employer-sponsored group health plans.

Briefly, to qualify for the safe harbor's protection as proposed:

1. The PBM and pharmaceutical manufacturer must have a **written agreement** that:
   a. Covers all of the services the PBM provides to the manufacturer in connection with the PBM's arrangements with health plans for the term of the agreement; and
   b. Specifies each of the services to be provided by the PBM to the manufacturer and the compensation for such services.

2. Compensation paid to the PBM must:
   a. Be consistent with fair market value in an arm's-length transaction;
   b. Be a fixed payment, not based on a percentage of sales; and
   c. Not be determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties, or between the manufacturer and the PBM's health plans, for which payment may be made in whole or in part under Medicare, Medicaid or other federal health care programs.

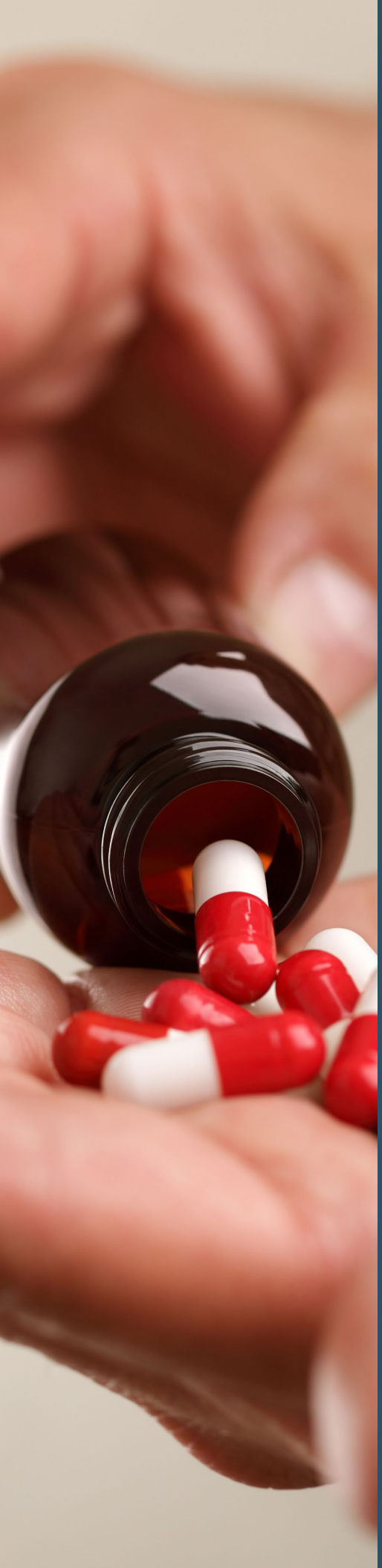
3. The PBM must disclose in writing, at least annually, to each health plan with which it contracts, and to HHS upon request, the services it rendered to each pharmaceutical manufacturer that are related to the PBM's arrangements with that health plan and associated costs for such services.

The proposed rule establishes a clear pathway for the pharmaceutical manufacturer and PBM to follow and reduce their potential exposure to federal anti-kickback claims. If they opt to use the safe harbor, then the employer-sponsored plan will receive more transparency through the new annual reporting obligation (described in (3) above) and may have favorable cost impact in a fixed fee pricing model (as described in (2) above).

However, nothing in the proposed rule requires the manufacturer and PBM to follow the safe harbor. HHS states that certain types of remuneration manufacturers may pay to PBMs either (1) would not implicate the AKS or (2) could be protected under another existing safe harbor. However, according to the proposed rule, following the safe harbor significantly reduces the risk of anti-kickback claims (which have both criminal and civil penalties).

Employer Action

This is a **proposed rule**. Nothing in here is final and at this point there are no changes affecting health plans that contract with PBMs and any government programs. There is a 60-day comment window and any final (or interim final guidance) will come at a later date and may not reflect what is currently included in the proposed rule. Employers should expect various stakeholders to voice challenges to these rules. We will continue to monitor developments in this area and will keep you posted of relevant updates.



Medicare Part D
CMS Notification Reminder

Published: February 8, 2019

Employers sponsoring a group health plan need to report information on the creditable status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services (CMS). In order to provide this information, employers must access CMS's online reporting system at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

As a reminder, notice must be provided by the following deadlines:

- Within 60 days after the **beginning** date of the plan year;
- Within 30 days after the **termination** of the prescription drug plan; and
- Within 30 days after any **change** in the creditable coverage status.

An employer with a calendar year plan (January 1 – December 31, 2019) must complete this reporting no later than March 1, 2019.

Additional guidance on completing the form, including screen shots, is available at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html

Deadlines Extended for 2018 Forms 1095-C

Published: February 11, 2019

On November 29, 2018, the IRS issued Notice 2018-94 which provides a limited extension of time for employers to provide 2018 Forms 1095-C to individuals. It also extends good-faith transition relief from certain penalties for the 2018 reporting year. The deadline to provide Forms 1094-C and 1095-C to the IRS was not extended. This is very similar to the relief extended last year for 2017 Forms 1095-C (Notice 2018-06).

Q1: What Was Extended?

2018 Forms 1095-C statements must be furnished to individuals by March 4, 2019 (rather than January 31, 2019).

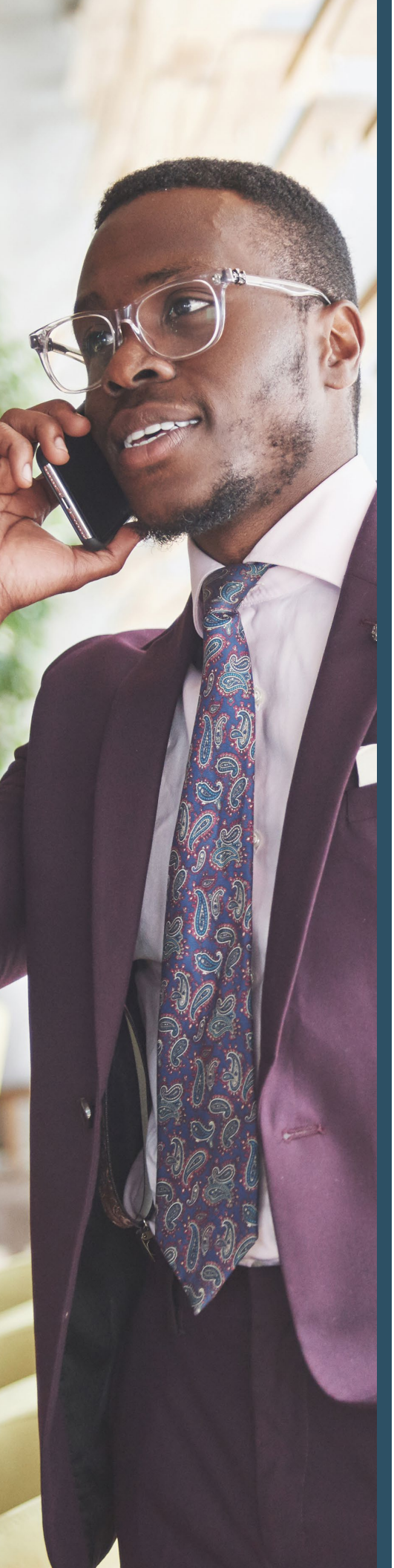
This extension of time also applies to carriers providing Forms 1095-B to individuals in insured plans.

Q2: Were The Deadlines For Reporting To The IRS Extended?

No.

The 2018 Form 1094-C and all supporting Forms 1095-C (collectively, "the return") is due to the IRS by April 1, 2019 if filing electronically (or February 28, 2019 if filing by paper). These deadlines were not extended as part of the announced relief.

As a reminder, employers that file at least 250 Forms 1095-C must file electronically. The IRS encourages all filers to submit returns electronically.



M-1 Reporting Requirements

Published: February 12, 2019

The administrator of a multiple employer welfare arrangement (MEWA) must file a Form M-1 with the Department of Labor (DOL) for every calendar year, or portion thereof, that the MEWA offers or provides medical benefits to the employees of two or more employers (including one or more self-employed individuals). The annual M-1 filing for 2018 is due no later than **March 1, 2019** (unless an extension is requested).

What is a MEWA?

Briefly, a MEWA is an arrangement that offers health and other benefits to the employees of two or more different employers (including one or more self-employed individuals).

A MEWA does not include a plan or other arrangement that is established and maintained:

- pursuant to one or more collective bargaining agreements (as determined by the Secretary),
- by a rural electric cooperative, or
- by a rural telephone cooperative association.

A plan that provides coverage to two or more trades or businesses (whether incorporated or not) within the same controlled group is considered a single employer, and not a MEWA. A determination of whether or not two employers are within the same controlled group is based on the rules contained in Internal Revenue Code § 414(c) and the applicable regulations (26 CFR § 1.414(c)-2). However, the definition of common control shall not be based on an interest of less than 25%.

Ownership interests that do not satisfy these requirements will not be viewed collectively as a single-employer plan, and thus will likely be considered a MEWA. Employers should seek the advice of legal counsel to determine whether or not their particular arrangement meets the controlled group requirements in order to avoid MEWA issues.

Who Must File the Form M-1?

The administrator of a MEWA that provides benefits for medical care to the employees of two or more employers (including self-employed individuals) must file the Form M-1 with the DOL.

There are a number of exceptions to the Form M-1 requirements. In particular, a MEWA that provides coverage consisting solely of excepted benefits (most standalone dental and vision benefits are considered excepted benefits) is not required to file a Form M-1. However, if the MEWA provides coverage that consists both of excepted benefits and other benefits for medical care that are not excepted benefits, the administrator must still file the M-1.
Also, a Form M-1 is not required when:

- The MEWA is licensed or authorized to operate as a health insurance issuer in every state in which it offers or provides coverage for medical care to employees.
- The MEWA is a group health plan (or provides coverage through a group health plan) that is not subject to ERISA, including a governmental plan, church plan, or plan maintained only for the purpose of complying with workers' compensation laws.
- The MEWA provides coverage to the employees of two or more employers that share a common interest of at least 25% at any time during the plan year (determined under Code § 414(b) or (c)).

- There is a change in control of a business (e.g., merger or acquisition) as long as the reason for the change in control was not to avoid the M-1 filing requirement and it is temporary in nature (it does not extend beyond the end of the plan year following the plan year in which the change in control occurs).
- The MEWA provides coverage to persons (excluding spouses and dependents) who are not employees or former employees of the plan sponsor (e.g., nonemployee members of the board of directors or independent contractors), and the number of these individuals does not exceed 1% of the total number of employees or former employees covered under the arrangement, determined as of the last day of the year to be reported or, in the case of a 90-day origination report, determined as of the 60th day following the origination date.

How is the Form M-1 Filed?

The Form M-1 must be filed electronically. The system may be accessed at http://www.askebsa.dol.gov/mewa/. Paper filings are no longer permitted.

When is the Annual Filing Deadline?

The Form M-1 must be filed no later than **March 1** following any calendar year for which a filing is required.

However, administrators may request an automatic 60-day extension. To request an extension, the administrator must:

- complete Parts I and II of the Form M-1 (and check Box B(3) in Part I);
- electronically sign, date, and provide the administrator's name at the end of the form; and
- electronically file this request for extension no later than the normal due date for the Form M-1 (by March 1, 2019).

When filing the completed Form M-1, a PDF copy of this request for extension must be attached to the completed Form M-1 when filed.

Is a Form M-1 Required At Other Times Besides the Annual Filing Requirement?

In addition to the annual filing requirement, administrators of both plan and non-plan MEWAs must file the Form M-1 within a certain time upon the following five registration events:

- 30 days prior to operating in any state.
- Within 30 days of knowingly operating in any additional state or states that were not indicated on a previous Form M-1 filing.
- Within 30 days of operating with regard to the employees of an additional employer (or employers, including one or more self-employed individuals) after a merger with another MEWA.
- Within 30 days of the date the number of employees receiving coverage for medical care under the MEWA is at least 50 percent greater than the number of such employees on the last day of the previous calendar year.
- Within 30 days of experiencing a material change as defined in the Form M-1 instructions.

Are there Filing Requirements other than the Form M-1 that Apply?

Possibly. MEWAs that are employee benefit welfare plans (a plan MEWA) are required to file a Form 5500 regardless of size. Part III of the Form 5500 (Form M-1 Compliance Information) requests information regarding M-1 compliance, and requests the Form M-1 Receipt Confirmation Code from the last-filed M-1.

Are there Penalties for Not Reporting?

The DOL may assess a civil penalty for failure to file a Form M-1, failure to file a completed Form M-1 and for late filings. In the event of no filing, an incomplete filing or a late filing, a penalty of up to $1,597 a day for each day that the administrator fails to comply with the requirement may apply. In addition, changes under health care reform also may impose criminal penalties on any person who knowingly submits false statements or false representations of fact in filing reports required under the rule (including Form M-1).

There is no voluntary compliance program available for delinquent Forms M-1.

Help with Completing the Form M-1

For questions on completing the Form M-1, contact the Employee Benefits Security Administration's (EBSA's) Form M-1 help desk at (**202) 693-8360**.

For inquiries regarding electronic filing capability, contact the EBSA computer help desk at **(202) 693-8600.**

For inquiries regarding the Form M-1 filing requirement, contact the Office of Health Plan Standards and Compliance Assistance at (**202) 693-8335**.

Additional Information

For the Form M-1 Online Filing System (and additional information), visit http://www.askebsa.dol.gov/mewa/.

MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation (revised August 2013) https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

IRS Helps Employers Recover Mistaken HSA Contributions

Published: February 25, 2019

The Internal Revenue Service (IRS) has released Information Letter 2018-0033 which lists seven new examples of situations where an employer can obtain a return of contributions made to an employee's health savings account (HSA).

Employers should review the examples of mistaken HSA contributions in the Information Letter (as discussed below), and implement procedures to prevent any of the mistakes from taking place. If the employer does in fact make a mistaken HSA contribution, it should contact the HSA trustee or administrator to request a return of the money, using one or more of the IRS examples as justification.

Background

Individuals have a "nonforfeitable" interest in the balance of their HSA. Under this general rule, an employer (or other third party, such as creditor) may not access an employee's HSA to obtain funds, including a return of employer contributions.

The IRS previously released Notice 2008-59, which contains three examples illustrating how the general rule operates in different situations. Two of the three examples in Notice 2008-59 relax the general rule, at least in part.

Examples in Notice 2008-59	IRS Conclusion
An employer contributes amounts to an employee's HSA that exceed the maximum annual contribution allowed by law due to an error	The employer may correct the error by contacting the HSA financial institution to obtain a return of the contribution to the employer; if the employer does not recover the money by the end of the taxable year, the contribution is treated as taxable income to the employee on Form W-2
An employer contributes to the HSA of an employee who was never eligible for HSA contributions	Same as above
An employer contributes to the HSA of an employee who was eligible for HSA contributions at the start of the year, but who ceases to be eligible for HSA contributions during the year	The employer cannot recoup any contribution from the employee's HSA

IRS Information Letter 2018-0033

The latest Information Letter contains seven new examples of situations where an employer may recover contributions made to an employee's HSA.

The IRS states, in the Information Letter, that if there is "clear documentary evidence" demonstrating that an administrative or process error occurred, then the financial institution holding the employee's HSA contributions can return them to the employer, provided that the correction puts the employer and employee in the same position that they would have been in had the error not occurred.

The Information Letter lists the following examples of "errors which may be corrected" by allowing the employer to recover contributions made to an employee's HSA.

The examples set forth below are listed in the Information Letter, while the recovery amounts are based on our analysis of what the employer's and employee's position would have been without the administrative or process error:

Examples in Information Letter 2018-0033	Recovery Amount
An amount withheld and deposited in an employee's HSA for a pay period that is greater than the amount shown on the employee's HSA salary reduction election	The employer may obtain a return of the amount contributed to the HSA that exceeds the employee's HSA salary reduction election
An amount that an employee receives as an employer contribution that the employer did not intend to contribute but was transmitted because an incorrect spreadsheet is accessed or because employees with similar names are confused with each other	The employer may obtain a return of the entire amount of the employer contribution
An amount that an employee receives as an HSA contribution because it is incorrectly entered by a payroll administrator (whether in-house or third-party), causing the incorrect amount to be withheld and contributed	The employer may obtain a return of the amount contributed to the HSA that exceeds the employee's HSA salary reduction election
An amount that an employee receives as a second HSA contribution because duplicate payroll files are transmitted	The employer may obtain a return of the second or duplicate HSA contribution
An amount that an employee receives as an HSA contribution because a change in employee payroll elections is not processed timely so that amounts withheld and contributed are greater than what the employee elected	The employer may obtain a return of the amount contributed to the HSA that exceeds the employee's payroll election (in accordance with the change in the employee's payroll election)
An amount that an employee receives because an HSA contribution is calculated incorrectly, such as a case in which an employee elects a total amount for the year that is allocated by the system over an incorrect number of pay periods	The employer may obtain a return of the amount contributed to the HSA that exceeds the employee's HSA salary reduction election (as correctly calculated)
An amount that an employee receives as an HSA contribution because the decimal position is set incorrectly, resulting in a contribution greater than intended	The employer may obtain a return of the amount contributed to the HSA that exceeds the employee's HSA salary reduction election, with the decimal point set correctly

Timing

The changes outlined in Notice 2008-59 permit the employer to recover funds so long as the recovery occurs while the applicable tax year is open. For example, if an employer contributed to the HSA of an employee who was never HSA eligible in 2018, the employer may seek to recoup its incorrect HSA contribution in 2018. If the amount is not recovered in 2018, then the employer is to treat the impermissible employer contribution as taxable income reflected on the 2018 Form W-2.

Unfortunately, Information Letter 2018-0033 did not include guidance as to the proper timing to recover mistaken or incorrect employer HSA contributions. While it may be reasonable to follow the guidance in Notice 2008-59 (which is generally to correct in the open tax year or treat as additional taxable on the Form W-2 if not recovered), further clarification on this point would be helpful.

Employer Action

Employers should review the examples of mistaken HSA contributions discussed above, and implement procedures to prevent any of the mistakes from taking place.

When a mistaken contribution is made to an employee's HSA that fits one of the examples listed in the Information Letter or in Notice 2008-59, the employer should contact the HSA trustee or administrator (usually the bank) to recover the contribution. The employer should maintain documentation to support its assertion that a mistaken contribution occurred, in case of any future IRS inquiry.

The following FAQs address some other questions that may arise.

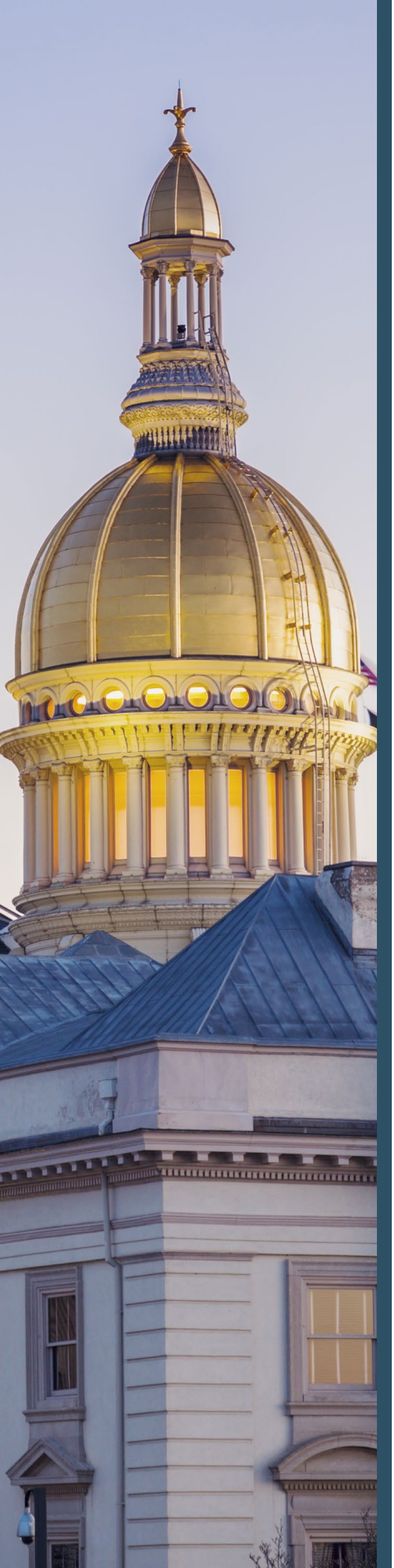
Frequently Asked Questions

Q1: Is the HSA trustee or administrator obligated to allow the employer's recovery of mistaken HSA contributions in accordance with the Information Letter and Notice 2008-59?

This issue is not addressed in the IRS guidance. Employers should review their contract with the HSA trustee or administrator in advance, to determine whether the contract permits recoupment in certain circumstances.

Q2: What if the mistaken contribution does not fit into one of the IRS examples?

IRS acknowledges in the Information Letter that the examples in the Information Letter and in Notice 2008-59 are not intended to provide an exclusive set of circumstances in which contributions made to an HSA may be returned to an employer. However, the HSA trustee or administrator may refuse the employer's request to recover contributions made to an employee's HSA unless the facts of the situation fit into one of the IRS examples.



New Jersey Small Employer Stop Loss Bill

Published: March 6, 2019

A bill has been introduced in New Jersey in both the Senate and Assembly that, if passed, would prohibit insurance carriers or other insurers subject to the insurance laws of New Jersey or any other state from offering, issuing or renewing any stop loss insurance policy of any kind to small employers. Stop loss insurance provides reimbursement for catastrophic, excess or unexpected expenses and is used by small employers to self-insure part of the health insurance coverage they provide for employees. Under New Jersey law, in connection with a group health plan, a small employer means an employer with 2-50 eligible employees on business days during the preceding calendar year. If passed, the bill would become effective three months after it is enacted.

S3270 was introduced to the Senate on February 14, 2019 and A5095 was introduced to the Assembly on February 25, 2019, but they are far from becoming law at this point. As background, when a bill is introduced into the Senate or Assembly, it must be introduced to committee. If it is approved in the committee, it goes back to the Senate/Assembly to be debated and voted on. In order for a bill to pass the Senate/Assembly, a majority of the Senate/Assembly must vote in favor of it (which requires 21 votes for the Senate and 41 votes for the Assembly). If the bill is approved by both the Senate and Assembly, it then goes to the Governor. If he signs it, it then becomes law.

The Senate bill passed the Senate House Committee on March 4 by a 3-2 vote. At this point, it will go back to the Senate for debate and vote. The Assembly bill has been referred to committee.

We are following this legislation and will continue to keep you apprised.

Proposed Changes to Out-of-Pocket Maximums and Prescription Drug Coverage

Published: March 12, 2019

On January 24, the U.S. Department of Health and Human Services ("HHS") published its Annual Notice of Benefit and Payment Parameters for 2020. This guidance is a proposed rule that addresses certain provisions of the Affordable Care Act ("ACA"). This is just a proposed rule. Any changes will be formalized in a final rule (and may be different from what is below).

Briefly, the proposed rule includes:

- Likely caps on out-of-pocket dollar limits for 2020 non-grandfathered group health plans.
- A possible change to the definition of Essential Health Benefit that, if finalized as written, may permit some employer group health plans to impose an annual and/or lifetime dollar limit on certain brand-name prescription drugs when a generic is available and medically appropriate.

Background

HHS issues its Annual Notice of Benefit and Payment Parameters on a yearly basis, first in proposed form, and then as a final rule. While the proposed rule primarily addresses the ACA insurance exchanges or marketplaces, it does include some changes that would affect employer-sponsored health plans if finalized.

Change in the Out-of-Pocket Maximum

If the proposed rule becomes final, non-grandfathered group medical plans are likely to see an increase in the out-of-pocket maximum from $7,900 for self-only coverage and $15,800 for other than self-only coverage in 2019, to $8,200 for self-only coverage and $16,400 for other than self-only coverage in 2020. (Note that different out-of-pocket limits apply to high-deductible health plans, for purposes of making contributions to a health savings account.)

HHS calculated the new dollar limits based on a proposed change in the methodology for determining the annual premium adjustment percentage. Beginning in 2020, HHS has proposed to use an alternative premium measure that captures increases in individual market premiums, in addition to increases in employer-sponsored insurance premiums, to calculate the premium adjustment percentage.

Exclusion of Brand Name Drugs from Essential Health Benefits

Because of increased prescription drug costs, HHS has proposed to allow individual and group medical plans that cover both brand name drugs and their generic equivalent to exclude the brand name drug as an "essential health benefit" ("EHB") if the generic equivalent is available and medically appropriate for the enrollee. This would become effective in 2020.

In addition, HHS proposes that if an enrollee purchases the brand name drug when the generic equivalent is available and medically appropriate, the plan would be permitted to ignore the difference in price between the brand name drug and the generic equivalent in calculating the individual's deductible and out-of-pocket maximum (or other cost-sharing). This would be true even though the individual paid the higher price for the brand name drug. Under the proposed rule, plans would still have an obligation to count the price of the generic drug towards the individual's deductible and out-of-pocket maximum (or other cost-sharing).

HHS is also considering an alternate proposal that would allow a plan to exclude the entire amount that an enrollee paid for a brand name drug (for which there is a medically appropriate generic equivalent) from the individual's deductible and out-of-pocket maximum (or other cost-sharing).

Finally, if the proposed rule becomes final, plans could impose lifetime and annual dollar limits on brand name drugs, because they would no longer be considered "essential health benefits."

Employer Action

This is a proposed rule. Nothing in this guidance is final, and at this point there are no changes affecting health plans.

Any final (or interim final) guidance will come at a later date and may not reflect what is currently included in the proposed rule.

We will continue to monitor developments in this area and will keep you posted of relevant updates.

ERISA Preempts Certain State Wage Withholding Laws

Published: March 25, 2019

A recently-released U.S. Department of Labor (DOL) letter, dated December 4, 2018, restates the DOL's long-held position that ERISA preempts state laws that require employers to obtain written consent before withholding amounts from employees' wages for contributions to an ERISA-covered plan.

Generally, most private sector employers offering health and welfare benefits are subject to ERISA regardless of size. Plans sponsored by government entities (federal and state), tribal governments and church plans are generally not subject to ERISA.

Specifically, the letter responds to the question of whether ERISA would preempt a state law if the law prohibits employers from adopting and implementing automatic enrollment arrangements under which the employer automatically enrolls eligible employees in a disability benefit plan and contributes part of the employee's wages as contributions to the plan, unless the employee affirmatively elects not to participate.

Referencing prior DOL Advisory Opinions, the Department restates its position that a state law would be preempted by ERISA to the extent the law is interpreted to limit, prohibit, or regulate an employer's adoption of automatic enrollment arrangements in connection with a disability benefit plan or other ERISA welfare benefit plan covered, or making related deductions from wages for contribution to such a plan. The letter includes two important restrictions:

- If a state criminal law prohibits deductions from employees' wages under an automatic enrollment arrangement, then employers in that state must obtain an employee's written authorization before withholding contributions from the employee's wages to pay for coverage under the ERISA plan.

- The letter does not address the types of notice and disclosure requirements that a plan fiduciary would need to adopt and implement for an automatic enrollment arrangement to be operated in a manner that is consistent with the fiduciary's prudence and loyalty obligations under ERISA.

Employer Action

- Nothing in this letter or the guidance requires an employer to do away with the employee approval of wage withholding for certain ERISA covered benefits. In fact, it is a best practice to have employees sign off on any wage withholding associated with their benefit elections as it provides documentation that the employee elected to participate in (or waive) the programs. The letter simply provides that, as it relates to an ERISA benefit plan, a state law cannot generally require employee authorization of wage withholding to pay for ERISA covered benefits, which is a helpful clarification when an employer has an automatic enrollment process.

- Not all benefits offered by an employer will benefit from ERISA's preemption power. For example, dependent care flexible spending accounts, commuter transit programs (e.g., parking and transit passes) and certain voluntary benefits not subject to ERISA. Thus, state wage withholding laws will continue to control when dealing with non-ERISA benefits.

- Benefit programs sponsored by government and church entities must comply with state payroll laws requiring them to obtain an employee's written authorization before withholding contributions from wages to pay for coverage (ERISA preemption is not available).

- If an employer is an applicable large employer, subject to the Employer Mandate, generally the employer must allow employees the opportunity to opt-out of health insurance coverage that is not of a minimum value and not affordable coverage. Employers with an automatic enrollment process will want to ensure there is a meaningful opportunity to "opt-out" of health insurance coverage.

Federal Government Eyes Paid Leave

Published: March 26, 2019

Currently, six states and the District of Columbia have implemented paid family leave laws, including New York, New Jersey and California. Recently, there have been several efforts to expand this type of leave at the federal level.

The budget proposal recently introduced by President Trump includes six weeks of paid leave for new parents. The proposed plan calls for $750 million in funding to aid in the creation of paid leave programs at the state level that are "most appropriate for their workforce and economy." While the President has discussed paid family leave several times in the past, this appears to be the first time a budget line item has been dedicated to the idea.

Additionally, both political parties have introduced competing legislation establishing federal paid leave programs. The following chart highlights some of the details from these bills

	FAMILY Act	Healthy Families Act	CRADLE Act
	Senator Kirsten Gillibrand (D-N.Y.)	**Senator Patty Murray (D-Wash.) and Representative Rosa DeLauro (D-Conn.)**	**Joni Ernst (R-Iowa) and Mike Lee (R-Utah)**
Paid Sick Leave	Yes	Paid if Employer has more than 15 employees. Unpaid for smaller groups	No
Paid Parental Leave	Yes	See above	Yes
Paid Family Leave	Yes	See above	No
Sick leave for employee only or also for sick loved ones?	Yes	See above	No
Length of Leave	12 weeks	7 days	Up to three months
Accrual or immediate?	Unknown	Accrued at 1 hour for every 30 hours worked.	Unknown
Who pays?	Employer and Employee	Employer	Federal Government (parent must agree to post-pone Social Security benefits)

These proposed plans are very much in their infancy. However, there appears to be both support from the President and bipartisan interest in a paid leave benefit, opening the door for possible agreement and future legislation.

Employers should be aware of the federal interest in a paid leave program and identify whether employees work in states that are already subject to state paid leave requirements.

We will continue to keep you apprised of any developments.

New Jersey to Require Pre-Tax Commuter Benefits

Published: March 27, 2019

On March 1, 2019, New Jersey established a transit benefit ordinance that requires employers to offer employees pre-tax commuter transit benefits, consistent with certain "qualified transportation fringe" benefits, as defined in Section 132(f) of the Internal Revenue Code.

Background

Qualified transportation fringe benefits under Section 132(f) of the Internal Revenue Code allow an employer to provide commuter and transit benefits to their employees that are tax-free up to a certain limit. This employer-provided voluntary benefit program allows employees to effectively reduce their monthly commuting or transit costs. In 2019, the monthly limit is $265 for any commuter benefit or transit pass. While such benefits provide a tax benefit to employees, under the 2017 Tax Cuts and Jobs Act, employers are no longer allowed a federal income tax deduction for qualified transportation fringe benefits. The Act also requires tax-exempt employers to pay unrelated business income taxes on such benefits.

New Jersey Requirements

Covered employers in New Jersey will be required to offer a "pre-tax transportation fringe benefit" to their employees. It appears that "covered employers" means employers with at least 20 employees, regardless of whether they all work in the State of New Jersey; however, clarification from the regulators on this would be helpful.

An employee under the new law is identified as anyone hired or employed by the employer and who reports to the employer's work location, and mirrors the definition used in the unemployment compensation law. Certain temporary or limited exceptions exist for employees covered by a collective bargaining agreement and those employed by the federal government.

Some of the details regarding implementation of the program are still outstanding and the Commission of Labor and Workforce Development will adopt rules and regulations concerning the administration and enforcement of the benefit. Civil penalties will apply for non-compliance with this new law.

Employer Action

While the ordinance takes effect immediately, it will not be enforced until final rules and regulations are released. The earliest enforcement is anticipated to be March 1, 2020, but is subject to change. Employers should determine whether their current employee demographic would require these benefits to be offered to their employees. Employers currently offering transportation fringe benefits to employees should review their current program to ensure compliance with the final rules and regulations in New Jersey once those are released.

Reminder

San Francisco HCSO & FCO Reporting Due April 30

Published: March 29, 2019

As a reminder, covered employers under the San Francisco Health Care Security Ordinance (HCSO) and/or the Fair Chance Ordinance (FCO) need to complete the 2018 Employer Annual Reporting Form by **Monday, April 30, 2019**. The form can be submitted electronically via the website below. Covered employers may have received information from the Office of Labor Standards Enforcement (OLSE) regarding the annual reporting requirement in January.

The HCSO requires San Francisco's OLSE to collect information on an annual basis from covered employers regarding their health care expenditures. To avoid penalties, covered employers must complete the Employer Annual Reporting Form to report these expenditures.

Please note that the penalty for failing to timely submit the Employer Annual Reporting Form is $500 per quarter.

If you were not covered by the HCSO and/or the FCO in any quarter of calendar year 2018, you do not need to submit the form, and no further action is required.

To determine whether you are required to submit the form, fill out the short survey on the first page of the Form (https://etaxstatement.sfgov.org/OLSE/). Employers who were not covered by the HCSO or the FCO in 2018 will be directed to a page indicating that they do not need to submit. Covered employers will be directed to the appropriate online form.

In addition, if you haven't already done so, make sure to post the updated 2019 official HCSO Poster in a conspicuous place at any workplace or job site where covered employees work. The notice is available in 6 languages at https://sfgov.org/olse/sites/default/files/Document/HCSO%20Files/2019%20HCSO%20Poster%20Final.pdf.

For more information, visit the HCSO website at http://www.sfgov.org/olse/hcso.

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

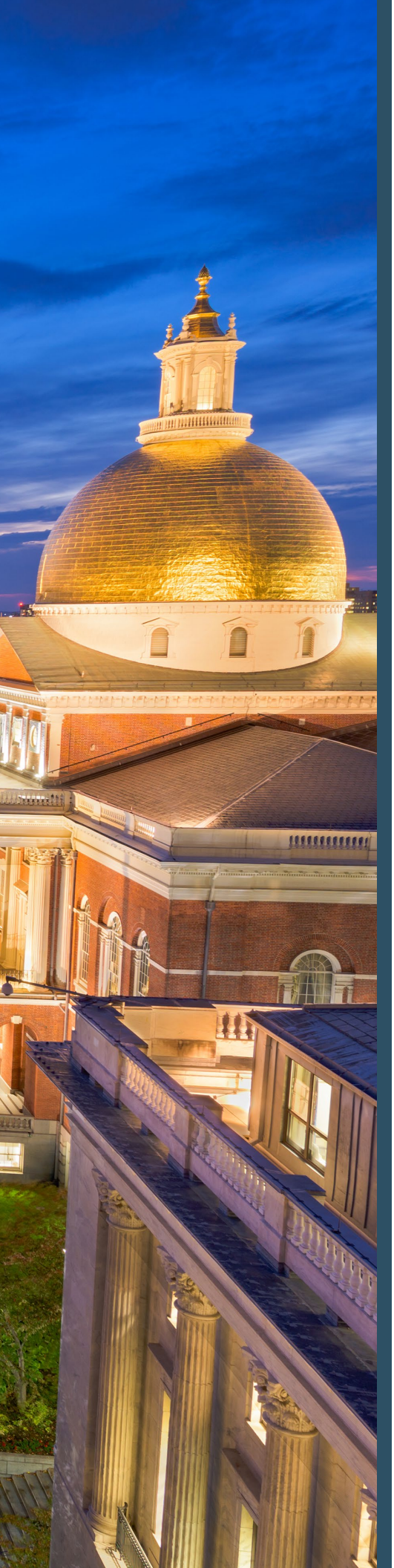
In 2018, a Texas Court ruled in favor of 20 Republican state attorneys general ("AGs") to invalidate the Affordable Care Act ("ACA"). Sixteen Democratic AGs and now the House of Representatives (as of January 2019) are joined in defending the ACA and appealing the Texas court's decision. The case is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

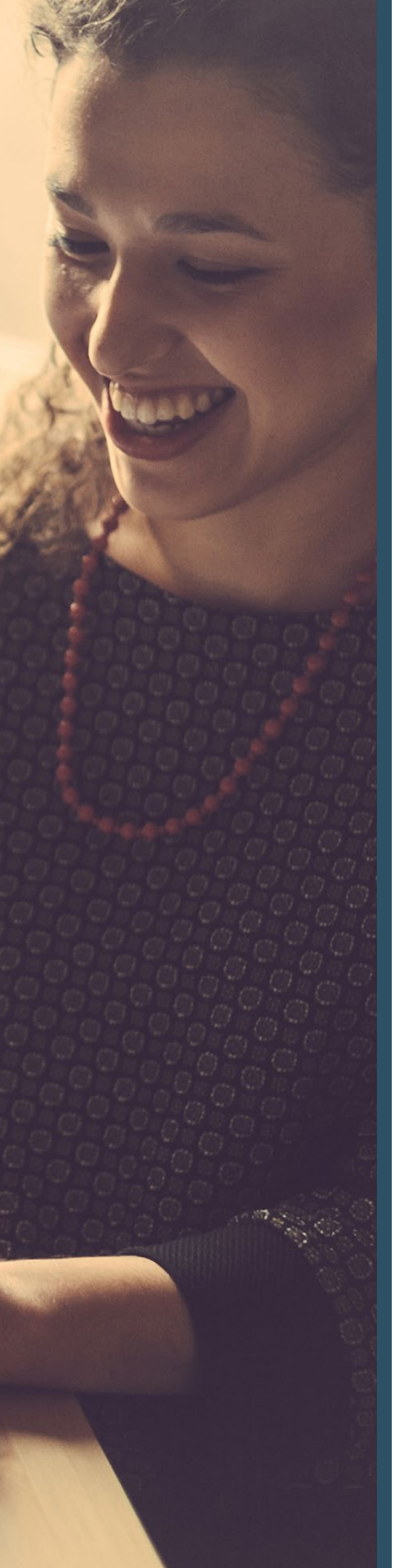
For Exemption Information: https://www.mass.gov/info-details/exemptions-from-paid-family-and-medical-leave-for-private-plans

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.

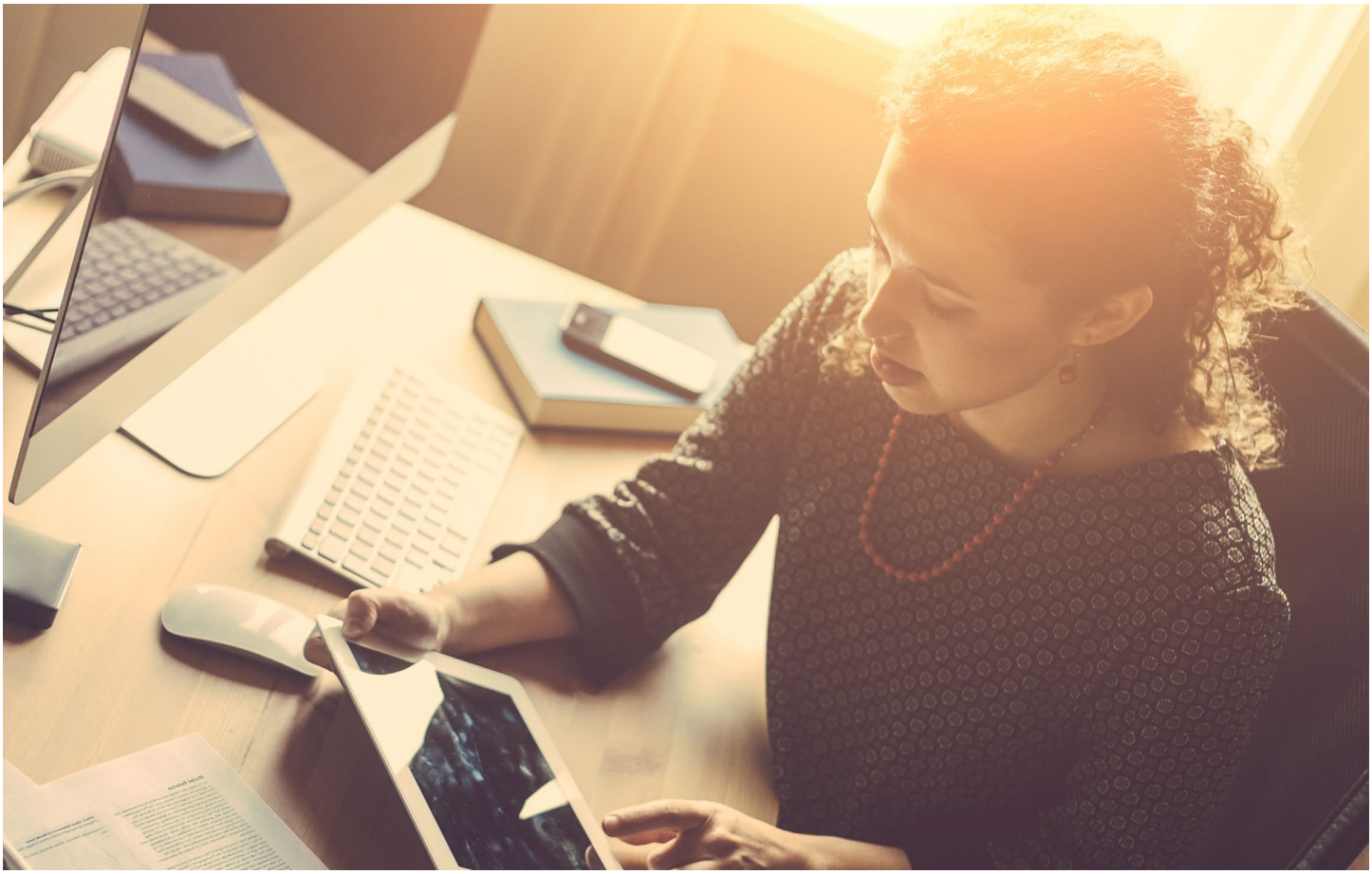
Regardless of whether you received a notification or not, employers with self-funded plans should ask their TPAs whether they engage in cross-plan offsetting.

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.

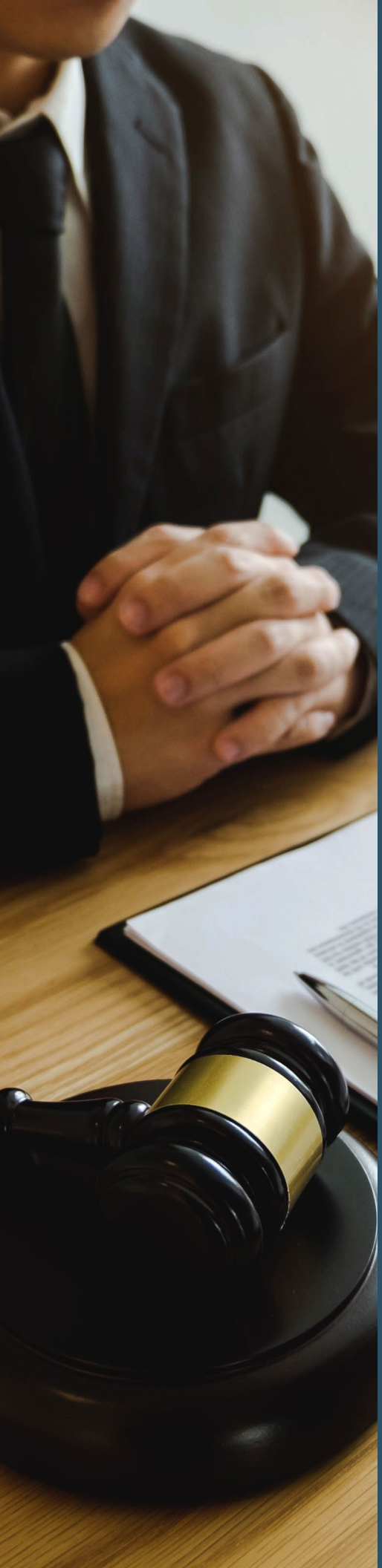
Employer Action

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

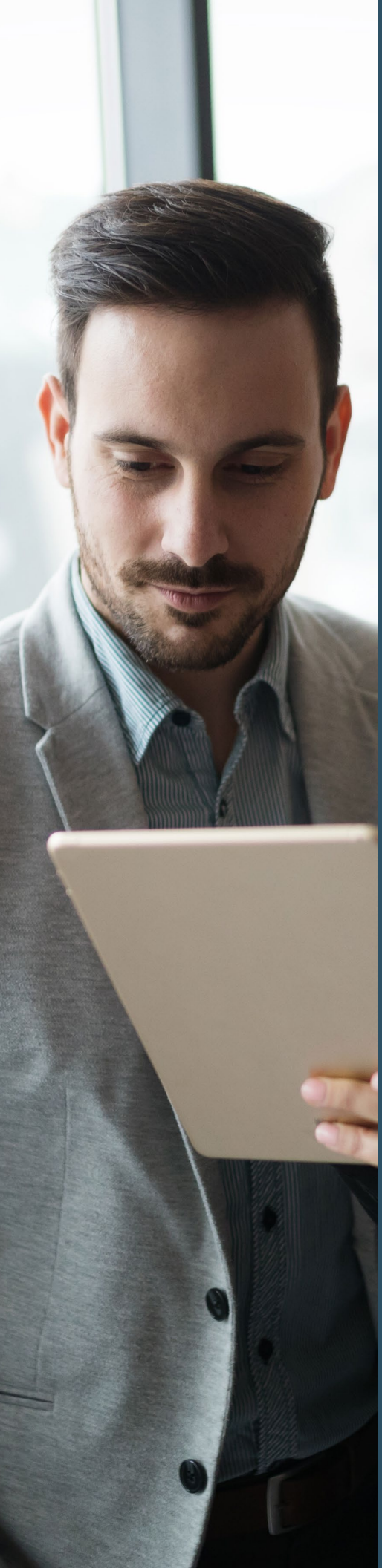
Monitoring Service Providers

- 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.

Excepted Benefit HRAs

Highlights from the Final Rule

Published: July 1, 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 the new Excepted Benefit HRA ("EB HRAs"). Individual Coverage 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 EB HRAs. An EB HRA is generally available when an employer offers a traditional group health plan, subject to certain conditions, including a $1,800 maximum annual benefit.

Excepted Benefit HRA

The regulations create an EB HRA. This type of HRA is different from an HRA integrated with a group health plan or an individual coverage HRA and is subject to more restrictive conditions.
To be considered an EB HRA (or other account-based plan), the arrangement must meet the following conditions:

- The annual EB HRA contribution cannot exceed $1,800. The $1,800 will have a cost-of- living adjustment annually beginning with the 2021 plan year.

- The EB HRA must be offered with a traditional group health plan, although the employee is not required to enroll in the traditional group health plan to access the HRA. This is a significant difference from previous rules that only permitted employers to offer integrated HRAs, which require coverage in the group health plan coverage.

- The EB HRA cannot reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA premiums), or Medicare premiums.

- The EB HRA must be made available under the same terms to similarly situated individuals regardless of any health factor.

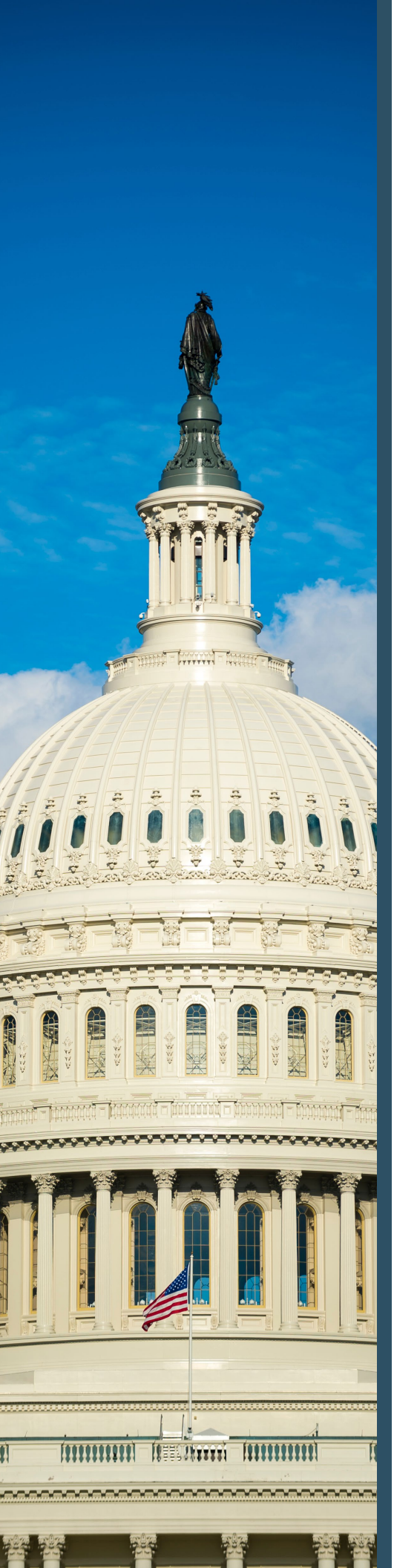
It is important to note the following:

- If an employer offers an EB HRA, the employer may not offer a QSEHRA or an Individual Coverage HRA to the same person.

- An EB HRA may be disqualifying coverage for purposes of HSA eligibility if it reimburses medical expenses otherwise covered by a qualified high deductible health plan (QHDHP) prior to satisfaction of the required deductible. Thus, this is not likely a good option if offering a QHDHP and health savings account (HSA).

Employer Action

Employers may want to look at whether offering an EB HRA is an option for their employee benefit plan strategy in 2020 or beyond. Employers interested in adding an EB HRA to their benefit offerings should review the final rule and supporting guidance and work with their benefits consultant and third-party administrators to understand the various requirements.



New Executive Order Addresses Healthcare Issues

Published: July 5, 2019

On June 24, 2019, President Trump issued an Executive Order ("EO") directing the relevant federal agencies to issue regulations or other guidance to make available more meaningful information related to the price and quality of healthcare.

This summary highlights aspects of the EO that may be relevant to employer-sponsored group health plans and their covered participants.

- By October 22, 2019, the Treasury shall issue guidance to expand the ability of patients to select a qualified high-deductible health plan ("QHDHP") that can be used alongside a health savings account ("HSA"), and that cover low-cost preventive care, before the deductible, for medical care that helps maintain health status for individuals with chronic conditions. This may provide first dollar coverage of more items and services for individuals with a QHDHP, particularly as it relates to individuals with chronic conditions (e.g., diabetes).

- By December 21, 2019, the Treasury shall propose:
  - Regulations to treat expenses related to certain types of arrangements, potentially including direct primary care arrangements and healthcare sharing ministries, as eligible medical expenses under section 213(d). This has the potential to make the monthly fees associated with certain programs reimbursable through a health FSA, HRA, or HSA.
  - Guidance to increase the Health FSA carry over without penalty. This could increase the dollar amount available for a health FSA carryover (currently capped at $500).

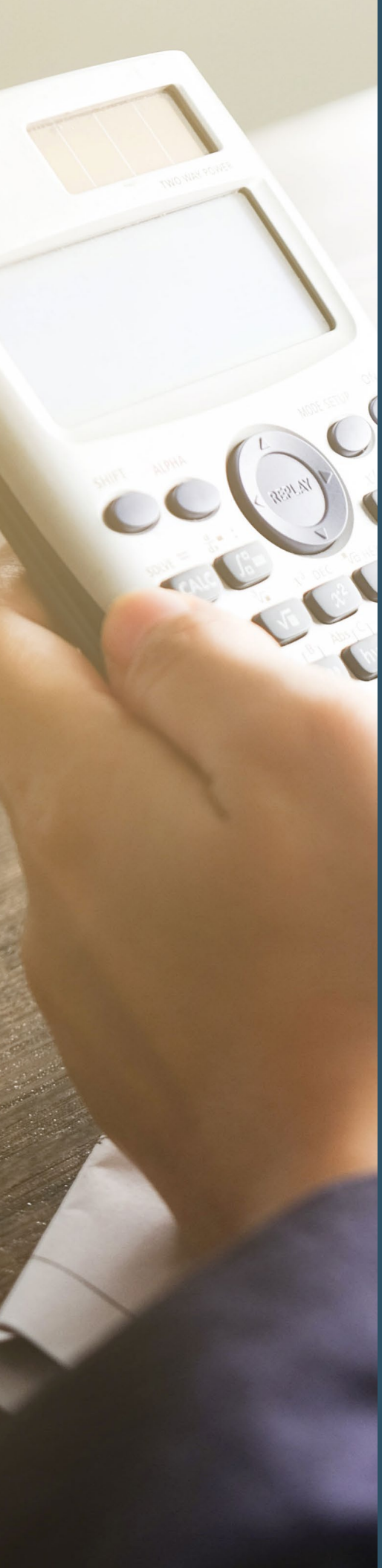
- By August 23, 2019, the Department of Health and Human Services ("HHS") shall issue regulations requiring hospitals to publicly post standard charge information, including charges and information based on negotiated rates and for common or shoppable items and services, in an easy-to-understand, consumer-friendly, and machine-readable format. Currently we have varying state laws and federal rules that took effect in January under the ACA that required hospitals to post online their "list prices," but hospitals set them themselves and they have little relation to actual costs or what insurers actually pay.

- By December 21, 2019, HHS shall submit a report to the President on additional steps the Administration may take to address issues on surprise medical billing.

- By September 22, 2019, direct the relevant agencies to solicit comments on a proposal to require healthcare providers, health insurance issuers, and self-insured group health plans to provide or facilitate access to information about expected out-of-pocket costs for items or services to patients before they receive care.

Next Steps

The EO provides the relevant agencies with their marching orders to develop new regulations and other guidance on these issues. In the next 3-6 months, it is likely we will see new proposed rules that may directly impact employer health plans. We will continue to keep you apprised.



IRS Expands Preventive Care for QDHDPs

Published: August 6, 2019

On June 24, 2019, the President issued an Executive Order directing the Department of the Treasury and the IRS to issue guidance that expands the ability of HSA-qualifying high-deductible health plans (QHDHPs) to cover low-cost preventive care that helps maintain health status for individuals with chronic conditions before the statutory minimum deductible for QHDHPs has been met. In response, on July 17, 2019, the Treasury Department and IRS issued Notice 2019-45 expanding the list of preventive care benefits.

Briefly, the following services and items are treated as preventive care when:

- prescribed to treat an individual diagnosed with the associated chronic condition (as specified in the IRS guidance), and
- prescribed for the purpose of preventing the exacerbation of the chronic condition or the development of a secondary condition.

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

Preventive Care for Specified Conditions	For Individuals Diagnosed with
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

Services and items not listed here that are for secondary conditions or complications that occur notwithstanding the preventive care are not treated as preventive care for this purpose.

Any items or services that constitute preventive care under earlier guidance, continue to be treated as preventive care. Further, nothing in Notice 2019-45 affects the definition of preventive care under the ACA and the services and items included on this list are not treated as ACA mandated preventive care.

The IRS will review the list of preventive care services and items every 5-10 years to determine whether additional items or services should be added or removed.

This guidance is effective July 17, 2019.

Why is this Helpful?

In order to preserve HSA eligibility, individuals must satisfy the statutory minimum deductible before the QHDHP can pay for non-preventive medical services or items. While the QHDHP is permitted to cover preventive care items and services before satisfaction of the required deductible, the list of permitted preventive care is narrow and only includes preventive services and items:

- as required to be covered by non-grandfathered plans under the ACA; and

- as described in IRS Notice 2004-23, which includes:
  - periodic health evaluations, such as annual physicals (and the tests and diagnostic procedures ordered in conjunction with such evaluations);
  - routine prenatal and well-child care;
  - immunizations for adults and children;
  - tobacco cessation and obesity weight-loss programs; and
  - screening devices.

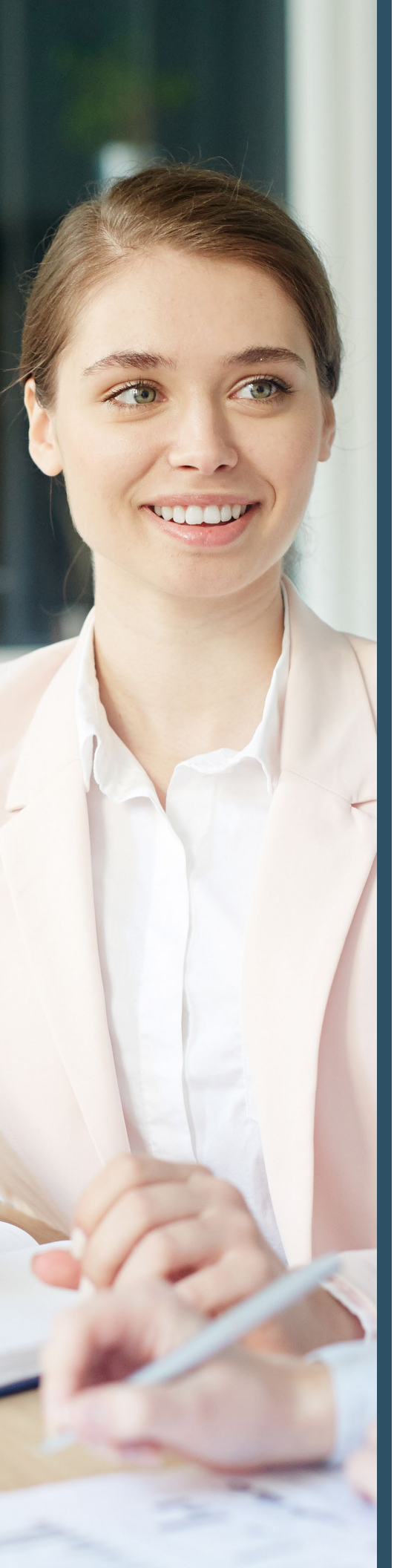
Importantly, under this definition, preventive care does not include any service or benefit intended to treat an existing illness, injury, or condition. Thus, many individuals with certain chronic conditions must satisfy the minimum deductible before the plan would pay for services and items associated with their condition.

This new guidance allows individuals diagnosed with certain chronic conditions (as described in the IRS list) to have certain services and items treated as preventive care by the QHDHP when prescribed for the purpose of preventing the exacerbation of the chronic condition or the development of a secondary condition.

Employer Action

- **Fully insured QHDHPs.** The insurance carrier will determine when to expand the definition of preventive care as permitted under this guidance. Carriers may wait until the next policy year to make this change or may make the change mid-year.

- **Self-funded QHDHPs.** Plans may be amended to adopt this expanded definition of preventive care for individuals with chronic conditions mid-year or wait until the next plan year. Any change is subject to approval by the TPA and stop loss carrier.



IRS Announces 2020 ACA Affordability Indexed Amount

Published: August 8, 2019

The IRS recently announced in Revenue Procedure 2019-29 that the Affordable Care Act (ACA) affordability indexed amount under the Employer Shared Responsibility Payment (ESRP) requirements will be 9.78% for plan years that begin in 2020. This is a decrease from the 2019 percentage amount (9.86%).

Background

Rev. Proc. 2019-29 establishes the indexed "required contribution percentage" used to determine whether an individual is eligible for "affordable" employer-sponsored health coverage under Section 36B (related to qualification for premium tax credits when buying ACA Marketplace coverage). However, the IRS explained in IRS Notice 2015-87 that a percentage change under Section 36B will correspond to a similar change for affordability under section 4980H ESRP requirements.

Determining Affordability in 2020

An employer will not be subject to a penalty with respect to an ACA full-time employee (FTE) if that employee's required contribution for 2020 for the employer's lowest cost self-only coverage complies with one of the following safe harbors.

1. The W-2 safe harbor.

   The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.78% of the employee's W-2 wages (as reported on Box 1 of Form W-2). Application is determined after the end of the calendar year and on an employee-by-employee basis. Box 1 reflects compensation subject for federal income taxes, which would exclude amounts such as employee contributions to a 401(k) or 403(b) plan, and towards other benefits through a cafeteria plan.

2. Rate of pay safe harbor.

   The employee's monthly contribution amount for the self-only premium of the employer's lowest cost coverage that provides minimum value is affordable if it is equal to or lower than 9.78% of the employee's computed monthly wages. For hourly employees, monthly wages are equal to 130 hours multiplied by their rate of pay. For salaried employees, monthly wages are equal to their monthly salary.

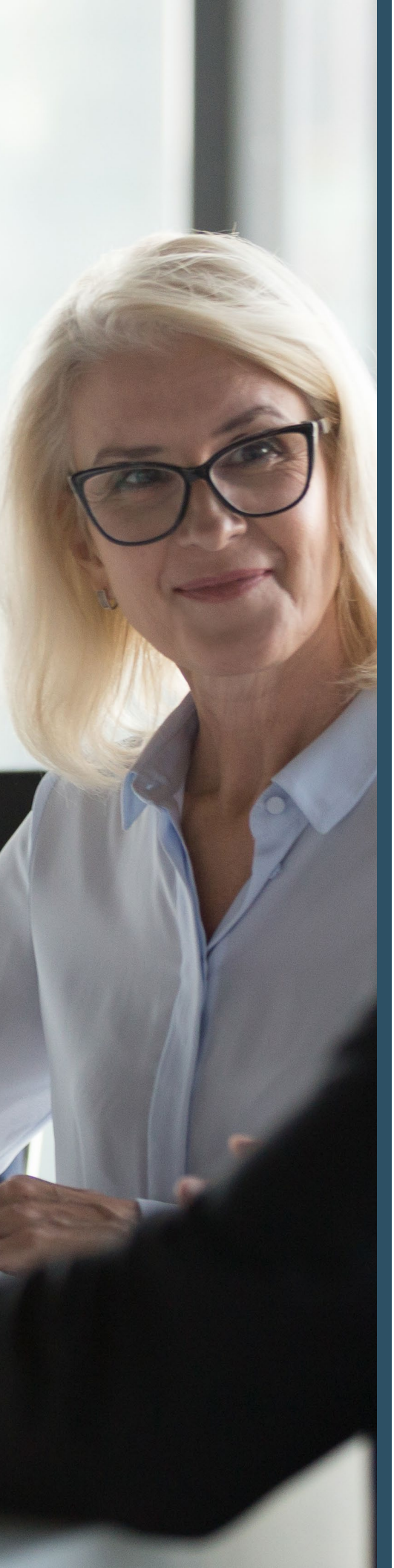
3. Federal Poverty Level (FPL) safe harbor.

   Coverage is affordable if it does not exceed 9.78% of the FPL.

   For a 2020 calendar year plan, coverage is affordable under the FPL safe harbor if the employee monthly cost for self-only coverage in the lowest cost plan that provides minimum value is not more than $101.79 (48 contiguous states), $127.14 (Alaska), or $117.19 (Hawaii).

Employer Action

Employers budgeting and preparing for the 2020 plan year should review these affordability safe harbors when analyzing employee contribution amounts for the coming year.



Anti-Assignment Clause Upheld Against Out-Of-Network Provider

Published: September 6, 2019

Another recent court case highlights how self-insured group health plans should ensure their plan documents contain strong language that prohibits third parties, particularly out-of-network health providers, from being assigned rights to pursue claims against such plans on behalf of a member. Such anti-assignment clauses can reduce some litigation risks.

Background

Self-insured group health plans frequently provide members with coverage when using out-of-network medical providers. Generally, claims for such providers' services are susceptible to denial and "offset." When a plan denies a claim, out-of-network providers may be left trying to collect the balance of billed charges from members, who often do not have the resources to pay. Thus, out-of-network providers routinely require patients to sign assignment-of-benefit forms, and/or other related forms, such as authorized-representative-designation forms, and forms granting power of attorney. With such forms, providers take the position that they stand in the shoes of the member, can demand payment, and can directly sue the plans when they refuse to pay alleged amounts due.

Group health plan sponsors and fiduciaries generally desire to limit the risk of such actions by out-of-network providers, and well-drafted health plan documents typically include strong anti-assignment language. Historically, numerous courts, including the First, Second, Third, Fifth, Ninth, Tenth, and Eleventh Circuits have consistently upheld anti-assignment clauses whereby providers are generally denied standing to bring legal action against plans. However, on occasion, courts have held that plans have waived such clauses through actions involving providers in the claims process.

Anti-Assignment Clause Case

In The Medical Society of the State of New York et al v. UnitedHealth Group Inc. et al, various out-of-network surgeons, surgical practices, and associations of which they were members sued United Health Group ("United") in the U.S. District Court for the Southern District of New York for refusing to pay for certain services, primarily facility fees for office-based surgeries. Nineteen United plans were involved, and each plan had an anti-assignment clause, but did give the

plans discretion to pay out-of-network providers directly for services. While various plans had slight variations on anti-assignment language, six of them included the following language:

> You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

While United often did pay these providers directly, it also would: (a) provide providers with denial-of-claim explanations, (b) remain silent when providers asked about anti-assignment provisions, (c) allow providers to proceed in the internal claims appeal process when an authorized representative, and (d) seek repayment from providers for overpayments, or effect offsets. The plaintiffs argued that these actions resulted in a waiver of the anti-assignment clause. However, the court rejected those arguments and concluded that "no reasonable jury could find ... that United clearly manifested an intention to relinquish its right to enforce the anti-assignment clauses." Thus, the court upheld the clauses, and United was granted partial summary judgment.

The plaintiffs further argued that they nonetheless had standing to sue as the members' authorized representative or attorney-in fact, and United's appeal notification letters that were sent to providers indicated that a patient's authorized representative could file an appeal on the patient's behalf. However, the court observed that the plaintiffs did not bring the suit in their roles as authorized representatives, and were seeking damages on its own behalf, which could only be done through a valid assignment.

Employer Action

While this case is related to United and fully-insured plans, the same concepts apply to self-insured group health plans. Plan Sponsors and/or fiduciaries of such plans should consider the following:

- Review both the formal health plan document and the Summary Plan Description (SPD) with respect to an anti-assignment clause. Consider confirming, where possible, that the clause seems consistent with clauses that have been upheld in the plan's jurisdiction, and if there is no clause, or it appears the clause is inadequate, consider enhancing the provisions in these documents.

- Use caution when engaging in a plan's appeals process with a provider to avoid giving the provider an argument that the plan has waived its right to enforce an anti-assignment clause.

- Watch for further developments on providers using authorized-representative-designation forms, and/or forms granting power of attorney in order to assert standing in seeking recovery of amounts they are allegedly owed.

California Relaxes Registration Requirements for Opposite-Sex Domestic Partners

Published: September 10, 2019

Effective January 1, 2020, California eliminates the requirement that at least one member of an opposite-sex couple be at least age 62 and eligible for Social Security benefits in order for the couple to register as domestic partners with the state of California. For employers who sponsor fully-insured benefit plans, this may result in more employees enrolling a registered domestic partner in an employer-sponsored health plan.

Background

Under California law, domestic partners who are registered with the state's domestic partner registry are generally afforded the same rights, protections, and benefits as are granted to legal spouses.

If an insured group health plan offers coverage to legal spouses of employees residing in California, the plan is required to also offer coverage to the registered domestic partners of employees in California. Self-insured plans are not required to treat registered domestic partners the same as legal spouses in California for plan eligibility purposes. However, an employer with a self-insured plan may voluntarily choose to extend coverage to domestic partners; either requiring a couple be registered to be eligible, or crafting its own domestic partner eligibility criteria.

Under current law, in order to be registered domestic partners, a couple must file a Declaration of Domestic Partnership with the California Secretary of State, which attests that the couple meets certain criteria at the time of filing. One requirement is that one or both members of an opposite-sex couple must be (1) eligible for Social Security benefits, and (2) at least age 62.

California SB 30

California Senate Bill 30 was signed into law by Governor Newsom on July 30, 2019. This new law eliminates the additional requirement for opposite-sex couples that one or both members be eligible for Social Security benefits and age 62 or older in order to register as domestic partners. This change is effective January 1, 2020. Beginning January 1, 2020, the domestic partner definition outlined in Section 297 of the California Family Code will read:

a. Domestic partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring.

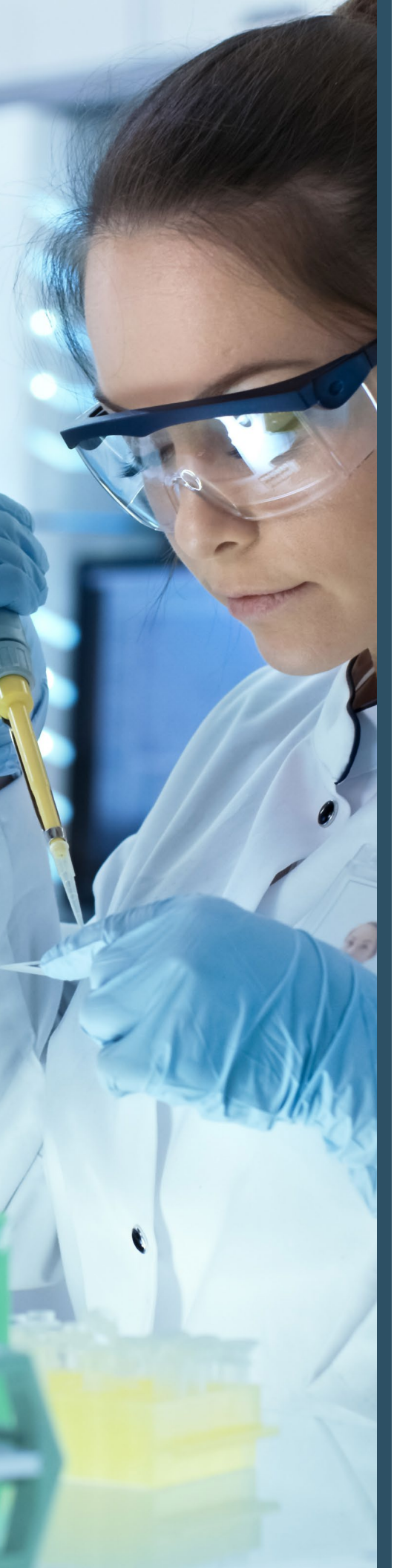
b. A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
   1. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
   2. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
   3. Both persons are at least 18 years of age, except as provided in Section 297.1.
   4. Both persons are capable of consenting to the domestic partnership.

After January 1, 2020, same-sex and opposite-sex partners will be subject to uniform rules for registering as domestic partners. This could result in an increase in the number of employees who have registered domestic partners, and therefore an increase in the number of employees looking to enroll registered domestic partners in any insured group health plan sponsored by their employer.

Employer Action

Employers with California employees should review the language in their plan documents, summary plan descriptions, employee handbooks, open enrollment materials, and other communications to see if there is a definition of domestic partner that will need to be updated. No change to the term "registered domestic partner" is necessary, but a list of the specific criteria required to register as a domestic partner in California will need to be updated, effective January 1, 2020.

In addition, an employer with a self-insured plan that has voluntarily extended coverage to domestic partners, and whose crafted definition of eligible domestic partner includes a requirement that one or both members of an opposite-sex couple be at least age 62 and/or eligible for Social Security benefits (to mirror the current California requirements), may want to consider amending that criteria to reflect the upcoming change in the California definition of domestic partner.



IRS Ruling on Genetic Testing Services as Medical Care

Published: September 12, 2019

In a private letter ruling ("PLR") released August 16, 2019, the IRS ruled that a taxpayer can allocate the cost of a DNA collection kit and related health services between non-medical ancestry services and health services that are medical care for tax purposes. Thus, a portion of the cost could be reimbursed by a health flexible spending account (FSA) or other account-based health plan.

Background

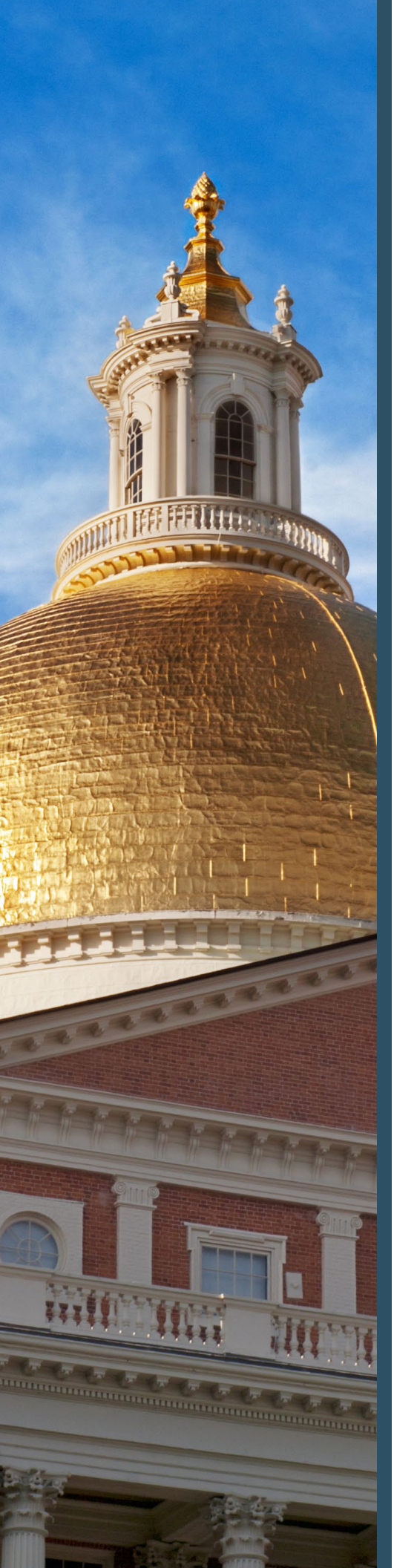
The Internal Revenue Code (IRC) generally provides tax advantages for health related expenses that provide for "medical care," which is defined in IRC § 213(d)(1)(A). This includes allowing for pre-tax reimbursement for the "diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body," and includes diagnostic services (as set forth in IRS regulations), for employees who participate in an employer-sponsored health flexible spending account (FSA), health reimbursement arrangement (HRA), and health savings account (HSA). However, no such tax advantages apply to expenditures that are merely beneficial to the general health of an individual.

In PLR 201933005, the taxpayer sought to use a health FSA to purchase genetic testing services that include reports on an individual's ancestry and health. The taxpayer conceded that the ancestry portion was not for medical care. However, as part of the services, a DNA sample was tested through a process called genotyping and further analysis of the genetic information was done resulting in reports providing lab results and general information. In the PLR, the IRS cited the IRC, IRS regulations and prior guidance relating to allocation of certain expenses as between medical care and non-medical items and services and determined that the genotyping, but not the reports providing general information, was medical care. The IRS concluded the taxpayer must allocate the price of the DNA collection kit between the ancestry services and the health services using a percentage. With respect to the health services portion, the IRS provided that the taxpayer may use a reasonable method to value and allocate the cost between services that are medical care, such as the lab testing, and non-medical, such as the general information reports.

It is important to note that a PLR issued by the IRS may not be cited or used as precedent, as it is directed specifically to the taxpayer who has requested it. Nonetheless, such a ruling does provide some insight as to the IRS's thinking on certain tax issues.

Next steps

Employers with account-based plans, such as health FSAs, HRAs and HSAs, may want to review their plans regarding their past practices in allowing reimbursement for DNA collection kits that include genetic testing services. To the extent such plans expressly exclude covering such kits or services, no further action is required. However, to the extent such plans generally allow reimbursement for any expenses that provide "medical care," sponsors may want to evaluate whether to provide an express exclusion, or determine how to go about evaluating whether just a portion of the cost of such kits or services should be reimbursed.



Upcoming Deadline for Massachusetts PFML

Published: September 16, 2019

The Massachusetts Department of Family and Medical Leave ("DFML") has finalized regulations regarding Massachusetts Paid Family and Medical Leave ("PFML"). The final regulations were effective July 1, 2019 and did not substantially differ from the proposed regulations previously issued by the DFML. Much of the below information has already been provided in our earlier article (Click Here) and this article shall briefly serve as a reminder of the upcoming October 1 withholding date.

Background

In 2018, Massachusetts enacted legislation to create a statewide 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 withholding contributions on October 1, 2019 (they were previously scheduled to begin on July 1, 2019).

Employers may opt out to provide an approved private plan to employees. These arrangements must be approved by the DFML. If the employer secures approval on or before December 20, 2019 (previously July 1, 2019), the employer will not be required to remit contributions for the full period that begins with the October 1 start date.

Important Items to Remember/Note

- Generally, the DFML follows the same eligibility criteria as the unemployment insurance program in Massachusetts. Therefore, if an employer submits its Massachusetts W-2 employees for unemployment in Massachusetts, the employer would be subject to the PFML program.

- Employers that participate in the state program must begin withholding PFML contributions for the October 1 to December 31 quarter through MassTaxConnect by January 31, 2020 (for MassTaxConnect: https://mtc.dor.state.ma.us/mtc/).

- The total contributions for an employee has been adjusted from 0.63% to 0.75% of qualifying earnings, capped at the Social Security maximum, currently $132,900.

- If an employer has at least 25 covered individuals (which includes employees and 1099 contractors in MA), both the employer and the employee share in the cost of medical leave benefits. If an employer has fewer than 25 covered individuals in Massachusetts, the employer is not required toward the medical leave or family portions of the benefit. The final regulations include a new contributions provision allowing an employer to deduct differing percentages from the wages or qualifying payments of different groups of covered individuals, but the employer may not deduct more than the maximum percentages allowed by the PFML law. The DFML will also refund contributions to an employer that overpays its contributions.

- If an employer chooses to provide benefits through an approved private plan option, it may do so through an insurance policy or self-insurance. If the employer's plan provides for insurance, the forms of the policy must be issued by a Massachusetts licensed insurance company (at this time, the carriers have not yet responded with new products in the marketplace). If an employer's plan is in the form of self-insurance, the employer must secure a surety bond running to the state in an amount based on the number of covered individuals and the surety company issuing the bond must be authorized to transact business in Massachusetts.

- An employer already providing a paid leave benefit to its workforce may be eligible to receive an exemption from the medical leave contribution, family leave contribution, or both through its MassTaxConnect account. The deadline to file for a private plan exemption for first quarter contributions is December 20, 2019. A self-insured employer must complete the state approved bond form and submit it to the DFML in order to complete the exemption application. The DFML may assess a penalty, including retroactive contributions to the Public Trust Fund, if an employer offers a private plan that has not received DFML approval or fails to renew an approved private plan prior to January 1, 2021.

- Employers should already have posted the mandatory PFML workplace poster (which can be found at https://www.mass.gov/files/documents/2019/06/14/20190614_DFML%20Notice_English.pdf.

- Employers must notify each of their Massachusetts W-2 employees in writing about available PFML benefits on or before September 30, 2019 (and issue this notice to each employee within 30 days of their first day of employment). If more than 50% of an employer's workforce is made up of Massachusetts 1099-MISC contractors, the employer is required to inform them of PFML benefits and protections the same as Massachusetts W-2 employees.

- Employers must file quarterly reports through MassTaxConnect beginning in January 2020. Reporting and documentation guidelines will be announced prior to October 1, 2019.

Additional Guidance

- The definition of "employment" for PFML includes the statutory exclusions contained in Massachusetts unemployment law (i.e., service performed by a student in the employ of a school, college or university, if such service is performed while regularly attending classes at such institution, is not covered by PFML).

- An employer may require intermittent leave to be taken in increments not smaller than a designated minimum time period; provided, however, that an employer's designated minimum time period may not be greater than four consecutive hours.

- Where the approved claim involves leave on an intermittent or reduced leave schedule, the wait period is seven consecutive calendar days, not the aggregate accumulation of seven days of leave.

- The DFML may contact an employee's health care provider to verify or supplement information necessary to support a leave certification.

- An employer is not required to restore an employee who was hired for a specific term or only to perform work on a discrete project, if the employment term or project is over and the employer would not otherwise have continued to employ the employee.

Employer Action

Employers with employees in Massachusetts should work with labor counsel and payroll processors to finalize their leave policies and procedures to make sure they are compliant with the Act by October 1, 2019. In addition, employers should monitor the state's PFML website for additional guidance and regulations

Medicare Part D Notification Requirements

Published: September 19, 2019

Employers sponsoring a group health plan with prescription drug benefits are required to notify their Medicare-eligible participants and beneficiaries as to whether the drug coverage provided under the plan is “creditable” or “non-creditable.” This notification must be provided **prior to October 15th each year**. Also, following the plan’s annual renewal, the employer must notify the Centers for Medicare & Medicaid Services (“CMS”) of the creditable status of the drug plan.

This information serves to summarize these requirements in more detail.

What are the Notification Requirements About?

Medicare Part D, the Medicare prescription drug program, imposes a higher premium on beneficiaries who delay enrollment in Part D after initial eligibility unless they have employer-provided coverage that is creditable (meaning equal to or better than coverage provided under Part D).

Employers that provide prescription drug benefits are required to notify Medicare-eligible individuals annually as to whether the employer-provided benefit is creditable or non-creditable so that these individuals can decide whether or not to delay Part D enrollment.

Also, the employer must annually notify CMS as to whether or not the employer plan is creditable.

Participant Notice

In order to assist employers in their compliance obligations, CMS has issued participant disclosure model notices for both creditable and non-creditable coverage, which can be found at:

http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html
(notices last updated by CMS for use on or after April 1, 2011).

These model notices, when appropriately modified, will serve as a proper notice for purposes of this requirement. Spanish notices are also provided at the above link.

To Whom Should the Participant Notice Be Sent?

Notice should be sent to all Part D-eligible participants. This includes active employees, COBRA qualified beneficiaries, retirees, spouses, and other dependents of the employee covered by the plan. In many cases, the employer will not know whether an individual is Medicare eligible or not. Therefore, employers may wish to provide the notice to all plan participants (including COBRA qualified beneficiaries) to ensure compliance with the notification requirements.

When Should the Participant Notice Be Sent?

Participant disclosure notices should be sent at the following times:

- Prior to October 15th each year (or next working day);[2]
- Prior to an individual's Initial Enrollment Period for Part D;
- Prior to the effective date of coverage for any Medicare eligible individual under the plan;
- Whenever prescription drug coverage ends or changes so that it is no longer creditable or it becomes creditable; and
- Upon a beneficiary's request.

If the disclosure notice is provided to all plan participants annually, prior to the ACEP each year (October 15th or next working day for 2011 and subsequent years), CMS will consider the first two bullet points satisfied. Many employers provide the notice either during or immediately following the annual group plan enrollment period.

In order to satisfy the third bullet point, employers should provide the participant notice to new hires and newly eligible individuals under the group health plan.

How Should the Participant Notice Be Sent?

Entities have flexibility in the form and manner they provide notices to participants.

The employer may provide a single disclosure notice to a participant and his or her family members covered under the plan. However, the employer is required to provide a separate disclosure notice if it is known that a spouse or dependent resides at an address different from the address where the participant's materials were provided.

Mail

Mail is the recommended method of delivery, and the method CMS initially had in mind when issuing its guidance.

Electronic Delivery

The employer may provide the notice electronically to plan participants who have the ability to access the employer's electronic information system on a daily basis as part of their work duties (consistent with the DOL electronic delivery requirements 29 CFR § 2520.104b-4(c)(1)).

If this electronic method of disclosure is chosen, the plan sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare eligible dependents covered under the group health plan.

In addition to having the disclosure notice sent electronically, the notice must be posted on the entity's website, if applicable, with a link to the creditable coverage disclosure notice.

Sending notices electronically will not always work for COBRA qualified beneficiaries who may not have access to the employer's electronic information system on a daily basis. Mail is generally the recommended method of delivery in such instances.

Open Enrollment Materials

If an employer chooses to incorporate the Part D disclosure with other plan participant information, the disclosure must be prominent and conspicuous. This means that the disclosure portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded or offset on the first page of the provided information.

CMS provides sample language for referencing the creditable or non-creditable coverage status of the plan per the requirements:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Personalized Notices

A personalized notice is only provided upon request of the beneficiary. If an individual requests a copy of a disclosure notice, CMS recommends that entities provide a personalized notice reflecting the individual's information.

For more information on the participant disclosure requirement, visit: http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/Updated_Guidance_09_18_09.pdf

CMS Notification

When and How Should Notification Be Given to CMS?

Employers will also need to electronically notify CMS as to the creditable status of the group health plan prescription drug coverage. This notice must be provided by the following deadlines:

- Within 60 days after the beginning date of the plan year (February 29, 2020 for a 2020 calendar-year plan);
- Within 30 days after the termination of the prescription drug plan; and

- Within 30 days after any change in the creditable coverage status.

Notice must be submitted electronically by completion of a form found at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html

Additional guidance on completing the form including screen shots is available at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/2009-06-29_CCDisclosure2CMSUpdatedGuidance.pdf

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/CredCovDisclosureCMSInstructionsScreenShots110410.pdf

How is Creditable Coverage Determined?

Most insurance carriers and TPAs will disclose whether or not the prescription drug coverage under the plan is creditable for purposes of Medicare Part D.

CMS's guidance provides two ways to make this determination, actuarially or through a simplified determination.

Actuarial Determination

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general, this is determined by measuring whether the expected amount of paid claims under the employer's drug program is at least as much as what is expected under the standard Part D program. This can be determined through an actuarial equivalency test, which generally requires the hiring of an actuary to perform.

Simplified Determination

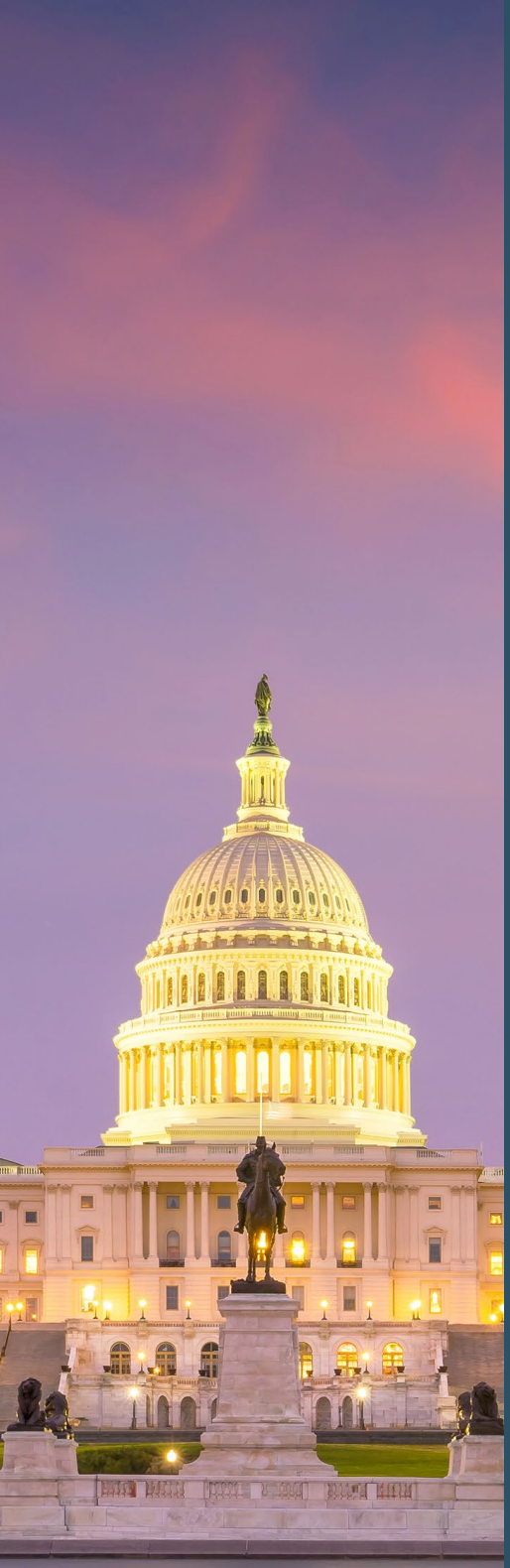
Most entities will be permitted to use the simplified determination of creditable coverage status to annually determine whether coverage is creditable or not.

A prescription drug plan is deemed to be creditable if:

- It provides coverage for brand and generic prescriptions;
- It provides reasonable access to retail providers;
- The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
- It satisfies at least one of the following:
  - The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000;
  - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual; or
  - For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000, and has no less than a $1,000,000 lifetime combined benefit maximum.

An integrated plan is any plan of benefits where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

- a combined plan year deductible for all benefits under the plan,
- a combined annual benefit maximum for all benefits under the plan, and/or
- a combined lifetime benefit maximum for all benefits under the plan.



D.C. Implements Individual Taxpayer Health Insurance Responsibility Requirement

Published: October 4, 2019

For tax years ending on or after December 31, 2019, all residents in the District of Columbia (D.C.) must maintain minimal essential health care coverage, qualify for a coverage exemption, or pay a tax penalty. In October 2018, D.C. passed the Individual Taxpayer Health Insurance Responsibility Requirement Amendment Act of 2018 (D.C. Law 22-168), which imposes an individual mandate modeled after the federal individual shared responsibility requirement that was in effect under the Affordable Care Act prior to 2019.

Employers with at least 50 employees, including at least one employee who was a D.C. resident during the applicable calendar year, and other applicable entities including governmental agencies, insurance companies and third-party service providers that provide minimum essential health coverage to D.C. residents are required to comply with filing requirements established by the D.C. Office of Tax Revenue (OTR). Employees are considered D.C. residents for reporting purposes if the employer paid payroll taxes to the District on behalf of the employee for any period during the applicable calendar year.

Plan sponsors and other applicable entities are required to file information with OTR regarding health coverage and issue an annual statement of health coverage to covered individuals. Compliance with the federal IRS requirement to furnish an annual statement of health coverage to employees or covered individuals (i.e., Forms 1095-B and 1095-C) will also satisfy D.C.'s OTR annual statement requirement. For the 2019 tax year, filings are due by June 30, 2020. For tax years beginning after December 31, 2019, the deadline is 30 days after the IRS deadline for submitting 1095-B or 1095-C forms, including any extensions granted by the IRS.

To satisfy the OTR filing requirement, applicable entities should file the same information returns as they file with the IRS including:

- Form 1094-B, Transmittal of Health Coverage Information Returns
- Form 1095-B, Health Coverage
- Form 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns
- Form 1095-C, Employer-Provided Health Insurance Offer and Coverage

All information returns must be filed electronically with OTR by uploading files through MyTax.DC.gov using OTR's prescribed layouts and file formats. All files must be a delimited file with an extension of .txt (.zip files are acceptable). Filing paper information returns is not permitted. An employer may contract with a third-party service provider to file the information returns on its behalf.

Unlike the IRS's ACA Information Returns System (AIR), the MyTax.DC.gov platform does not provide a filing confirmation that acknowledges a successful filing. Instead, OTR will notify filers if filing errors exist. Filers wishing to submit an amendment or correction to a previously filed return may upload one corrected filing per business day until December 31 of the filing year. OTR will not accept corrected filings after the end of the filing year.

Employer Action

Employers with D.C. employees should register with MyTax.DC.gov and complete the sign-up process before the deadline for filing the required information returns. For tax year ending December 31, 2019, the deadline is June 30, 2020. If you have questions about how to register with OTR or how to file returns, please contact OTR's Customer Service Center at e-services.otr@dc.gov or (202) 759-1946. Employers that have questions about whether they are required to file returns may contact the Office of General Counsel at (202) 442-6500.

For more information, see the D.C. OTR website at:
https://otr.cfo.dc.gov/.

New Jersey Updates 2019 Individual Mandate Employer Reporting

Published: October 7, 2019

The State of New Jersey has posted information related to employer reporting under New Jersey's individual health insurance mandate that went into effect January 1, 2019.

Background

The New Jersey Health Insurance Market Preservation Act (the "NJ Act") requires most New Jersey residents to maintain health insurance, starting January 1, 2019. Failure to maintain health insurance, absent an exception, will result in an individual penalty imposed by the State when a person files his or her 2019 New Jersey Income Tax Return. This state mandate essentially replaces the federal individual mandate imposed under the Affordable Care Act (ACA), which was effectively eliminated starting in 2019 under the Tax Cuts and Jobs Act.

As with the ACA, the NJ Act requires certain employers and insurance carriers to report covered participants to the state to confirm that such individuals had actual health coverage in the calendar year.

What's New?

Recently the State of New Jersey updated its "Information for Employers" website with respect to the New Jersey Health Insurance Mandate. Notably, employers must provide the same Forms 1094-C and 1095-C to the State of New Jersey as they provide to employees and other individuals otherwise covered under an employer sponsored plan to the Internal Revenue Service (IRS) under the ACA. The Forms are to be sent to the New Jersey Division of Taxation by March 31, 2020. Previously, this deadline was set at February 15, 2020, a deadline that preceded the general deadline by which Forms need to be filed with the IRS under ACA. Now, forms will be due to the State on the same day as the IRS deadline.

Employer reporting under the NJ Act applies to all employers that withhold and remit New Jersey Gross Income Tax for New Jersey residents, including employers located outside of the state. The State also provides the following guidance for companies:

Fully Insured Plans

Single-Company, Applicable Large Employers (ALEs)
ALEs are generally companies that employed an average of at least 50 full-time-equivalent employees on business days during the preceding calendar year. The insurer files a Form 1095-B for each covered member of the plan. The Employer files a Form 1095-C (Parts I & II) for each person who was a full-time employee of the employer for at least one month of the calendar year.

Single-Company, Not an Applicable Large Employer (Non-ALEs)
Non-ALEs generally are companies that employed an average of fewer than 50 full-time-equivalent employees on business days during the preceding calendar year. The insurer files the Form 1095-B for each covered member on the plan. Employer does not file a Form 1095-C.

Fully Insured Employer Participating in a Multiemployer Plan
Plan Sponsor files a Form 1095-B for enrolled individuals. ALEs also file Form 1095-C (Parts I & II) for each person who was a full-time employee for at least one month of the calendar year.

Self-Insured Plans

Single Company, ALEs
Employer files a Form 1095-C for each person who was a full-time employee for at least one month of the year and for any employee who was enrolled in the self-insured plan. ALEs that offer coverage to non-employees (such as COBRA members or retired employees) must use Forms 1094-B and 1095-B for these non-employees or may file a 1095-C using Code 1G in Part II to report for these non-employees.

Single Company, Non-ALE
Non-ALEs must file a 1095-B for each covered employee.

Self-Insured Employer participating in a Multiemployer plan
Plan Sponsor files a Form 1095-B for each covered employee. ALEs must also file Parts I & II of 1095-C for each covered employee.

Reporting System

Insurers or employers are able to provide confidential or sensitive data to the State of New Jersey using the Division of Revenue and Enterprise Services' (DORES) MFT SecureTransport service. Employers that have MFT SecureTransport service user credentials can now use them to submit the required forms. If you do not have an account or need technical specifications, employers are encouraged to contact e-GovServices@treas.nj.gov to request assistance. The System also encourages employers to participate in the testing period, which initially will run through October 31, 2019. To join the testing program, send an e-mail to the above e-mail address stating "Please tell me how to join New Jersey's Health Mandate filing testing program."

Employer Action

- All employers with employees who are New Jersey residents should evaluate whether they will be subject to these new reporting requirements beginning in 2019. In many cases, such employers will already be generating the Forms required to be filed with the state.
- Employers should be aware of the new March 31, 2020 reporting deadline.
- Employers should join the testing program with the MFT Secure Transport service, if interested.
- Employers should watch for updates on the New Jersey website, particularly if the IRS changes the current Forms for 2019 reporting, and if NJ deploys its own separate forms.

MLR Rebate Checks Recently Issued to Fully Insured Plans

Published: October 10, 2019

As a reminder, insurance carriers are required to satisfy certain medical loss ratio ("MLR") thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan, it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to employers in the form of a premium credit or check.

If a rebate is available, carriers were required to distribute MLR checks to employers by September 30, 2019.

Importantly, employers must distribute any amounts attributed to employee contributions to employees and handle the tax consequences (if any).

This does not apply to self-funded plans.

The rules around rebates are complex and require careful review with ERISA counsel. Among other things, an employer receiving a rebate as a policy holder will need to determine:

- who receives a rebate (e.g., current participants v. former participants);
- the form of the rebate (e.g., premium reduction v. cash distribution);
- the tax impacts of any such rebate (on both the employer and participants receiving the rebate); and
- what, if any, communication to provide participants regarding the rebate.

The following questions and answers summarize information regarding what employer action may be necessary.

What Will the Rebate Amount Be?

Carriers determine MLR on a state basis by market segment (individual, small group, or large group). Carriers do not disaggregate by type of plan within these markets (e.g., PPO v. HMO v. HDHP) or by policyholder so the carrier will have to let you know the amount.

A carrier is not required to provide a rebate to an enrollee if the total rebate owed is less than $20 per subscriber ($5.00 when a carrier pays the rebate directly to each subscriber). This rule regarding de minimis amounts only applies to the carrier, not to employers refunding amounts to participants.

Will there be any Communication?

Yes.
For each MLR reporting year, at the time any rebate of premium is provided, a carrier must provide the policyholder and each current enrollee who was also enrolled in the MLR reporting year in a form prescribed by HHS.

Employers do not have to notify employees, but they may want to address the notices being distributed by the carriers. Language similar to the following provides a starting point for such a notice:

> Employees should have received a notice of rebate from [carrier]. In short, [Employer] received a rebate check in the amount of $_____. Amounts attributable to participant contributions will be used to [reduce premium amounts] for [currently enrolled employees] in accordance with legal requirements. These amounts will be reflected in the [October ___] paychecks.

What will the Form of Rebate to the Employer Be?

Carriers may issue rebates in the form of either a premium credit (i.e., reduction in a premium owed), a lump-sum payment, a lump-sum reimbursement to the account used to pay the premium if an enrollee paid the premium using a credit card or direct debit, or a "premium holiday," if this is permissible under state law.

When will Rebates be Issued?

Rebates must be paid by **September 30** each year. A carrier that fails to timely pay any rebate must additionally pay the enrollee interest at the current Federal Reserve Board lending rate or 10% annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due.

Do Employers Have to Give Some or All of the Rebate to Participants?

Yes, unless they paid 100% for all tiers of coverage.

Carriers will generally send rebate checks to employers and employers must mete out any amounts attributed to employee contributions to employees and handle the tax consequences.

There is no one formula for employers to use, but guidance has been provided to aid employers.

ERISA-covered group health plans

To the extent that rebates are attributable to participant contributions, they constitute plan assets. Plan assets must be handled in accordance with the fiduciary responsibility provisions of Title I of ERISA.

If the employer is the policyholder, determining the plan's portion, if any, may depend on provisions in the plan or the policy or on the manner in which the plan sponsor and the plan participants have shared in the cost of the policy. If the plan or its trust is the policyholder, in the absence of specific plan or policy language to the contrary, the entire rebate would constitute plan assets, and the policyholder would be required to comply with ERISA's fiduciary provisions in the handling of rebates that it receives.

The HHS regulations and related DOL guidance for ERISA plans leave to the policyholder the decision as to how to use the portion of a rebate that constitutes plan assets, subject to ERISA's general standards of fiduciary conduct. The DOL notes that, in choosing an allocation method, "the plan fiduciary may properly weigh the costs to the plan and

the ultimate plan benefit as well as the competing interests of participants or classes of participants provided such method is reasonable, fair and objective." An allocation does not necessarily have to exactly reflect the premium activity of policy subscribers. A plan fiduciary may instead weigh the costs to the plan and the competing interests of participants or classes of participants when fashioning an allocation method, provided the method ultimately proves reasonable, fair, and objective. If the fiduciary finds that the cost of passing through the rebate to former participants would exhaust most of those rebates, the proceeds can likely be allocated to current participants.

Guidance does not address how to handle an MLR rebate where the amount is inconsequential (e.g., a dollar per participant). Taking a cue from DOL Field Assistance Bulletin No. 2006-01, a fiduciary may be able to conclude, after analyzing the relative costs, that no allocation is necessary, when the administrative costs of making correction far exceed the amount of the allocation.

If a plan provides benefits under multiple policies, the fiduciary is instructed to allocate or apply the plan's portion of a rebate for the benefit of participants and beneficiaries who are covered by the policy to which the rebate relates provided doing so would be prudent and solely in the interests of the plan according to the above analysis. But, according to the DOL, "the use of a rebate generated by one plan to benefit the participants of another plan would be a breach of the duty of loyalty to a plan's participants."

Plans that are neither covered by ERISA nor are governmental plans (e.g., church plans)

With respect to policyholders that have a group health plan but not a governmental plan or a plan subject to ERISA, carriers must obtain written assurance from the policyholder that rebates will be used for the benefit of current subscribers or otherwise must pay the rebates directly to subscribers.

The final rule issued on February 27, 2015 provides that subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates within three (3) months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do.

When Do Rebates Need to Be Made to Participants?

As soon as possible following receipt and, in all cases, within 3 months of receipt.

What is the Form of Rebate to Participants?

There is no one way to determine this, but guidance has been provided to aid employers.

Reductions in future premiums for current participants is probably the best method.

If proceeds are to be paid to participants in cash, the DOL is likely to require that payments go to those who participated in the plan at the time the proceeds were "generated," which may include former employees. An option that may be easier to administer is to keep the proceeds in the plan and provide a "premium holiday" (suspension of required premiums) or a reduction in the amount of employee-paid premiums.

The interim final regulations for non-ERISA governmental plans require that rebates be used to reduce premiums for all health plan options for subscribers covered when the rebate is received, to reduce premiums for current subscribers to the option receiving the rebate, or as a cash refund to current subscribers in the option receiving the rebate. In each case, the regulations allow the rebate to be allocated evenly or in proportion to actual contributions to premiums. Note that the rebate is to be used to reduce premiums for (or pay refunds to) employees enrolled during the year in which the rebate is actually paid (rather than the MLR reporting year on which the rebate was calculated).

To recap, here are some options to consider:

- **Reduce future premiums for current plan participants.** This is administratively easy with limited tax issues with respect to participants.
- **Cash payments to current participants.** This is administratively burdensome and results in tax consequences to participants.
- **Cash payments to former participants.** This is administratively burdensome and results in tax consequences to former participants.

The employer could also consider, with counsel, whether providing benefit enhancements or payment of reasonable plan expenses would be considered permissible.

What are the Federal Tax Implications to Employees?

Pre-Tax Premium Payments

When employees pay their portion of the premiums for employer-sponsored health coverage on a pre-tax basis under a cafeteria plan, MLR rebates will be subject to federal income tax and wages. Briefly:

- For rebates that are distributed as a reduction in premium (thus reducing an individual's pre-tax premium payment during the year), there is a corresponding increase to the employee's taxable salary that is also wages taxable for employment tax purposes.

- Rebates that are distributed as cash will result in an increase in taxable income that is also wages subject to employment taxes.

The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

After-Tax Premium Payments

When employees pay their portion of the premiums on an after-tax basis, MLR rebates generally are not subject to federal income tax or employment taxes. This applies when the rebate is provided as a reduction in premiums or as a cash. The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

What are the Tax Implications to Employers?

Employers should review the tax implications of a rebate with tax advisors. Generally, amounts used for benefits (e.g., to pay premiums with respect to insured plans) should not be taxable.

When Employees Pay Premiums on a Pre-Tax Basis, Does Reducing a Participant's Premiums Mid-Year Allow Them to Make Election Changes?

Probably not.

If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

If the plan incorporates the permitted election change rules, the relevant issue is whether this change in cost is permitted under the regulations.

- If there is an insignificant decrease, there can be an automatic adjustment.

- If there is a significant decrease, employees may make a corresponding change including commencing participation in the cafeteria plan for the first time for the option with a decrease in cost.

Generally, MLR rebates are expected to be fairly low dollar amounts and may not rise to the level of a significant change. Employers should consider either taking the position that the cost change is insignificant or that the cost change is significant and the "corresponding change" is to simply allow the reduction or increase. The cafeteria plan document should be consistent with the employer's position.

California Enacts A "Two Notice" Requirement for FSAs

Published: October 17, 2019

On August 30, 2019, California Governor Gavin Newsom signed into law Assembly Bill 1554, which applies to employers with employees working in California who participate in a flexible spending arrangement (FSA), including a health FSA, dependent care FSA, or adoption assistance FSA.

The new state law requires employers to notify California employees who participate in an FSA of any deadline to withdraw funds before the end of the plan year. The notice must be made in two different forms (one of which may be electronic), including by electronic mail, telephone, text message, postal mail, or in-person.

The language of the new state law does not clearly indicate what the notification deadline is. According to the legislative history, California intended the two notices to be provided before the end of the FSA plan year, but the statutory language could be interpreted to require their delivery before an employee stops participating in the FSA during the year (for example, because of termination of employment). Cautious employers should follow the latter approach, which means delivering the two notices to participants shortly after the FSA plan year begins or, in the case of mid-year enrollments, shortly after they begin participating in the FSA.

The new state law is effective on January 1, 2020. Employers that fail to comply with the new state law could be required to indemnify employees for losses caused by the employer's "want of ordinary care" under California employment law.

The new state law does not address the issue of federal ERISA preemption, which generally overrides state laws that relate to an ERISA plan. Whether this new state law is preempted by ERISA with respect to health FSAs offered by private sector employers is not clear; further guidance would be helpful. However, dependent care FSAs, adoption assistance FSAs, and health FSAs that are governmental plans or church plans are not ERISA plans, and would be subject to the new state law.

The California Department of Industrial Relations has not indicated whether it will provide guidance to employers on the specific requirements of the new state law or on the ERISA preemption issue.

As a best practice, employers with employees working in California should comply with the notice requirements and maintain applicable records.

Proposed Rules Clarify Individual Coverage HRAs

Published: October 18, 2019

On September 30, 2019, the IRS published proposed regulations to clarify the application of the employer mandate under the Affordable Care Act ("ACA") and certain nondiscrimination rules under the Internal Revenue Code ("Code") Section 105(h) to health reimbursement arrangements ("HRAs") integrated with individual health insurance coverage (individual coverage HRAs, or "ICHRAs"). Notably, the proposed regulations provide information on how to determine when an individual policy is "affordable" and of a "minimum value" and provide some relief under the Code Sec. 105(h) rules.

Background

Beginning with the 2020 plan year, employers are permitted to offer an ICHRA. 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.

The rules that created this new HRA did not address how it would interact with the employer mandate and nondiscrimination provisions.

Employer Mandate

The employer mandate penalties apply to applicable large employers ("ALEs") who fail to offer minimum essential coverage to at least 95% of their ACA full-time employee population (the "A" Penalty) or who do so, but that coverage is not affordable or not of a minimum value (the "B" Penalty).

This section describes highlights from the proposed regulation on this topic.

Minimum Essential Coverage

An offer of an ICHRA counts as an offer of minimum essential coverage for "A" Penalty purposes.

Affordability

- Safe Harbor. There are currently three affordability safe harbors (federal poverty line, W-2 and rate of pay). The proposed rule confirms use of one of these safe harbors to determine affordability of an ICHRA is permitted. Additionally, the proposed regulations provide a new safe harbor for ICHRAs – an ALE may base affordability on the lowest cost silver plan for self-only coverage offered through the Exchange where the employee's primary site of employment or residence is located.

- Date to determine lowest cost silver plan. ALEs use the monthly premium for January of the prior calendar year (or for January of the current calendar year for a non-calendar-year plan) to determine the lowest cost silver plan.

- Classes of employees. An ALE may choose to apply the safe harbors for any class of employees, provided the ALE does so on a uniform and consistent basis for all employees in the class.

- Primary site. An employee's primary site of employment generally is the location at which the employer reasonably expects the employee to perform services on the first day of the plan year (or on the first day the ICHRA may take effect, for an employee who is not eligible for the ICHRA on the first day of the plan year). Special rules address what happens when an employee's worksite changes.

- Remote work. In the case of an employee who regularly works from home or at another worksite that is not on the employer's premises but who may be required by his or her employer to work at, or report to, a particular worksite, such as a teleworker with an assigned office space, the worksite to which the employee would report to provide services if requested is considered the primary site of employment. For other employees who work remotely, the employee's residence is the primary site of employment.

- Age. The lowest cost silver plan for an employee is the lowest cost silver plan for the lowest age band in the applicable rating area. The employee's age is based on the employee's age as of the first day of the plan year (or, if the employee becomes eligible for the ICHRA after the first day of the plan year, the first date the ICHRA can become effective for that employee).

- Wellness incentives. If there is a wellness incentive, the premium is determined without regard to that incentive unless the incentive relates exclusively to tobacco use, in which case the incentive is treated as earned.

- Data availability. Lowest cost silver plan data will be made available by HHS for employers in all states that use the federal Exchange. CMS has released a tool. Regarding state exchanges, HHS has begun discussing the information it plans to make available.

Minimum Value

An ICHRA that is affordable is deemed to provide minimum value.

Code Section 105(h) Nondiscrimination

For self-funded health plans, including HRAs, any maximum limit attributable to employer contributions must be uniform for all participants and for all dependents of employees who are participants and may not be modified by reason of a participant's age or years of service.

The proposed rules indicate that:

- An ICHRA does not fail Code Sec. 105(h) nondiscrimination testing solely due to the variation based on age.

- The maximum amount available under an ICHRA may vary within a class of employees or between classes without violating the uniform employer contribution requirement if (a) within each class, the maximum dollar amount only varies in accordance with the "same terms" requirement under the ICHRA rules, and (b) with respect to differences in the maximum dollar amount for different classes.

Note that satisfying the terms of the safe harbors under the proposed regulations does not automatically satisfy the prohibition on nondiscriminatory operation. Thus, for example, if a disproportionate number of HCIs qualify for and utilize the maximum HRA amount allowed under the same terms requirement based on age in comparison to the number of non-HCIs who qualify for and use lower HRA amounts based on age, the ICHRA may still be found to be discriminatory, with the result that excess reimbursements of the HCIs will be included in their income.

An ICHRA that only reimburses insurance premiums is treated as an insured plan and is not subject to the Code § 105(h) rules.

Code Section 125

An employer generally may not provide an Exchange plan as a benefit under its cafeteria plan. However, for an employee who purchases off-Exchange individual health insurance coverage, the employer may permit the employee to pay the balance of the premium for the coverage through its cafeteria plan.

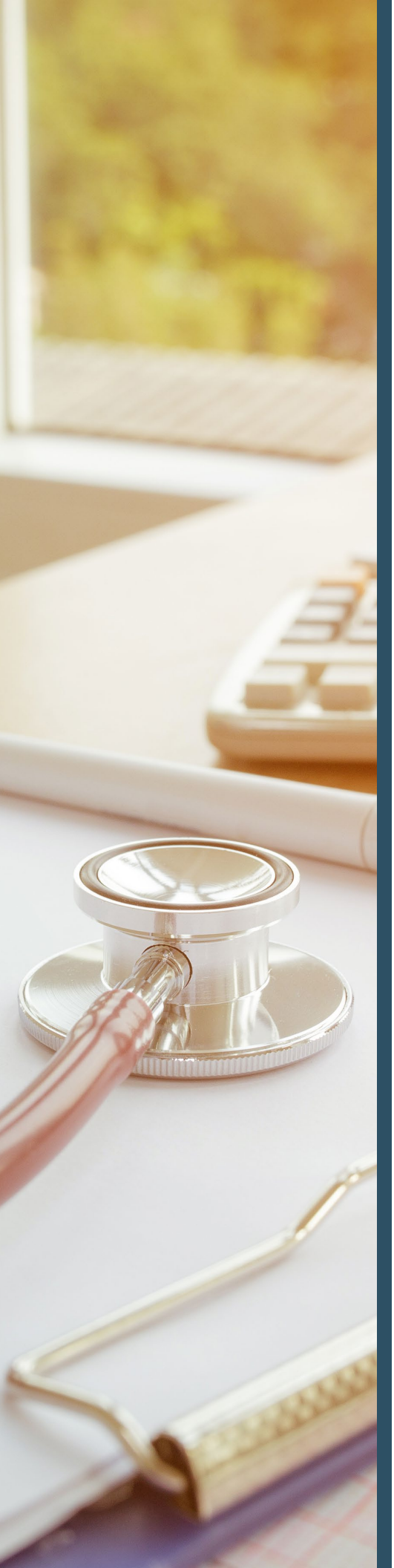
Effective Date

- The proposed regulations related to the employer mandate apply beginning January 1, 2020.

- The proposed regulations under Code Section 105(h) apply beginning with the 2020 plan year.

- Employers may rely on the proposed regulations until the plan year beginning after six months following the publication of any final regulations.

For the regulations, visit: https://www.govinfo.gov/content/pkg/FR-2019-09-30/pdf/2019-20034.pdf



IRS Announces 2020 Health Insurer Fee

How it Will Impact the Insurance Marketplace

Published: November 6, 2019

The IRS recently released Notice 2019-50, which outlines the health insurer fee for the 2020 tax year.

Background

To help fund the creation and ongoing operation of the federal and state marketplace exchanges, the Affordable Care Act (ACA) requires that all insurers offering fully-insured health insurance programs pay an annual tax. The tax is not applicable to self-funded group health plans sponsored by an employer, but does apply to a self-funded Multiple Employer Welfare Arrangement (MEWA).

The amount of this tax, often called the health insurance tax (HIT) or fee (HIF), paid by insurers, is calculated based on each insurer's proportionate share of the marketplace. Congress suspended this tax for 2019 due to concerns with the impact the tax was having on premiums, but without any legislative action the tax will resume next year. Although the tax was initially $8 billion (referred to as the applicable amount) in its first year (2014), the amount has increased each year, with the IRS expecting to collect a little over $15 billion dollars cumulatively from all carriers in 2020.

Impact on Plan Sponsors

The health insurance tax will impact all insurers offering medical, dental and vision insurance (called "covered entities"), through both off-exchange and on-exchange individual markets, the small and large group marketplace, and programs like Medicare Advantage and Medicare Part D. And although plan sponsors do not need to take any action pursuant to Notice 2019-50, they will not escape being impacted by the fee. Most carriers have indicated that they will set their premium levels for 2020 to incorporate these additional fees. If the IRS implements the tax as planned, the fee is expected to add an estimated 3-4% on medical plan renewals, with the biggest impact on Medicare Advantage and Part D premiums.

Reminder:
Massachusetts HIRD Reporting Due December 15

Published: November 7, 2019

As a reminder, Massachusetts employers must file the annual Health Insurance Responsibility Disclosure HIRD) form through the MassTaxConnect (MTC) web portal (https://mtc.dor.state.ma.us/mtc/_/). The HIRD reporting will be available to be filed starting November 15th and must be completed by December 15th. Please note, this is a change from the previously announced November 30th deadline.

The HIRD form collects employer-level information about employer-sponsored health insurance (ESI) offerings. The HIRD form assists MassHealth in identifying members with access to qualifying ESI who may be eligible for the MassHealth Premium Assistance Program.

Massachusetts law requires every employer with six or more employees in Massachusetts to annually submit a HIRD form. If you are an employer who currently has (or had) six or more employees in any month during the past 12 months preceding the due date of this form (December 15 of the reporting year), you are required to complete the HIRD form. An individual is considered to be your employee if you as the employer included such individual in your quarterly wage report to the Department of Unemployment Assistance (DUA) during the past 12 months. You are required to complete the HIRD form if you reported six or more employees (includes all employment categories) in any DUA wage report during the past 12 months.

For more information about the Premium Assistance Program and additional employer resources, visit the MassHealth Premium Assistance web page: https://www.mass.gov/service-details/other-health-insurance-and-masshealth-premium-assistance.

2020 Cost of Living Adjustments

Published: November 12, 2019

The IRS recently released cost of living adjustments for 2020 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

For plan years beginning in 2020, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements increases to $2,750.

The Affordable Care Act (ACA) amended Code Section 125 to place a $2,500 limitation on voluntary employee salary reductions for contributions to health flexible spending arrangements, subject to inflation for plan years beginning after December 31, 2013.

Qualified Transportation Fringe Benefits

For calendar year 2020, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Code Section 132(f)(2)(B)) increases to $270.

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Beginning with the 2018 calendar year, employers can no longer deduct qualified transportation fringe benefits; employees may still pay for these benefits on a tax-favored basis.

Highly Compensated

The compensation threshold for a highly compensated individual or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) increases to $130,000 for 2020.

Under the cafeteria plan rules, the term highly compensated means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B). Prop. Treas. Reg. 1.125-7(a)(9).

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2020 increases to $185,000.

For purposes of cafeteria plan nondiscrimination testing, a key employee is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year. Prop. Treas. Reg. 1.125-7(a)(10).

Non-Grandfathered Plan Out-Of-Pocket Cost-Sharing Limits

The 2020 maximum annual out-of-pocket limits for all non-grandfathered (NGF) group health plans are $8,150 for self-only coverage and $16,300 for family coverage.

These limits generally apply with respect to any essential health benefits (EHBs) offered under the group health plan. Federal guidance established that starting in the 2016 plan year, the self-only annual out-of-pocket limit applies to each individual, regardless of whether the individual is enrolled in other than self-only coverage, including in a family HDHP.

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2020, to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) under Code Section 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed $5,250 ($10,600 for family coverage).

Health Savings Accounts

As announced in May 2019, the inflation adjustments for health savings accounts (HSAs) for 2020 were provided by the IRS in Rev. Proc. 2019-25.

Annual contribution limitation.

For calendar year 2020, the limitation on HSA contributions for an individual with self-only coverage under a high deductible health plan is $3,550. For calendar year 2020, the limitation on HSA contributions for an individual with family coverage under a qualifying high deductible health plan is $7,100.

Qualifying high deductible health plan.

For calendar year 2020, a "qualifying high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $6,900 for self-only coverage or $13,800 for family coverage.

Non-calendar year plans: In cases where the qualifying high deductible health plan renewal date is after the beginning of the calendar year, any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date. See IRS Notice 2004-50, 2004-33 I.R.B. 196, Q/A-86 (Aug.16, 2004).

Catch-up contribution.

Individuals who are age 55 or older and covered by a qualifying high deductible health plan may make additional catch-up HSA contributions each year until they enroll in Medicare. The additional contribution, as outlined in Code 223(b)(3)(B), is $1,000 for 2009 and thereafter.

CMS Reporting to Include Prescription Drug Information

Published: December 4, 2019

For quarters beginning on and after January 1, 2020, the Centers for Medicare and Medicaid Services (CMS) will require Responsible Reporting Entities (RREs) to include information on prescription drugs in their Section 111 quarterly reporting. Prior to 2020, reporting on prescription drugs was voluntary.

Self-funded group health plans that separately contract with a pharmacy vendor (i.e., a pharmacy benefit manager (PBM)) should be aware that it may be the PBM (and not the medical third-party administrator (TPA)) who is the RRE for prescription drug coverage. PBMs may be reaching out for additional information from employers/plan sponsors in order to meet these reporting requirements.

Employers sponsoring fully insured plans or self-funded plans where prescription drug benefits are provided as part of a medical, hospital, and pharmacy benefit contract through a TPA will likely experience little to no impact as a result of this change.

Background

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 created reporting requirements for group health plans to CMS. These requirements were effective January 1, 2009. In most cases, the insurance carrier and TPA are the RREs. An employer may be the RRE when it both sponsors and administers the group health plan (not common). This reporting requirement was implemented in order to better facilitate Medicare Secondary Payer requirements, identifying instances where the group health plan should have paid primary to Medicare.

What's New

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) imposes additional reporting requirements related to prescription drug benefits on RREs, effective January 2020. Specifically, the law requires reporting for Medicare beneficiaries who have prescription drug coverage (other than or in addition to Medicare Part D) which is primary to Medicare. This includes prescription drug coverage for someone who may be Medicare-eligible and currently is employed or is the spouse or family member of a worker who is covered by a prescription drug plan.

Which entity is considered to be the RRE for the purpose of reporting primary prescription drug coverage will depend on how the employer/plan sponsor structures its contracts for medical, hospital, and prescription drug coverage. It should not be assumed that the RRE will be the entity that has direct responsibility of processing and paying the prescription drug claims.

In general, the RRE will be the entity that has the direct relationship with the employer/plan sponsor regarding the prescription drug coverage. The following entities are most likely to be RREs for the purpose of reporting primary prescription drug coverage to CMS:

- Carrier. If the group health plan is fully insured, the insurance carrier is the RRE.

- TPA. If the group health plan is self-funded and the employer/plan sponsor directly contracts with a TPA to provide medical, hospital, and pharmacy benefits, the TPA is the RRE. This is the case even if the TPA separately contracts with a PBM for pharmacy benefits.

- PBM. If the group health plan is self-funded and the employer/plan sponsor directly contracts with the TPA to provide medical and hospital benefits and the employer/plan sponsor independently contracts with a separate third party (such as a PBM) to administer prescription drug coverage, the PBM is the RRE for purposes of the prescription drug reporting. The TPA remains the RRE as it pertains to reporting on medical and hospital benefits.

Employer Action

In most instances, employers sponsoring health plans are not considered RREs and therefore not responsible for compliance with the Section 111 reporting to CMS, including the new requirement related to prescription drugs.

However, particularly as it relates to group health plans with a carved-out pharmacy benefit, the PBM may be undertaking new reporting responsibilities and may be requesting additional information from an employer/plan sponsor. CMS strongly encourages employers to cooperate with RREs so they can fulfill their reporting responsibilities.

Deadline Extended for 2019 Forms 1095-C

Published: December 9, 2019

On December 2, 2019, the IRS issued Notice 2019-63, which provides:

- An extension of time, until **March 2, 2020**, for employers to provide Forms 1095-C to their full-time employees and other individuals; and
- An extension of relief from penalties for the 2019 reporting year for employers and other entities that make good-faith efforts to comply with the reporting requirements.

Notice 2019-63 does not, however, extend the deadline to provide completed Forms 1094-C and 1095-C (and Forms 1094-B and 1095-B) to the IRS (as described in Q/A-2 below). Nor does it provide any relief from providing Forms 1095-C to full-time employees ("FTEs"). This means that all Applicable Large Employers ("ALEs") must continue to provide Form 1095-C to any employee that was full time for any month of 2019.

However, the Notice provides an alternative furnishing method for Form 1095-B (and in some cases Form 1095-C), with relief from the 2019 Section 6055 reporting penalty, for:

- Insurance carriers that are otherwise required to furnish Form 1095-B to covered individuals for calendar year 2019;
- Employers with self-funded health plans that are otherwise required to furnish Form 1095-B to covered individuals for calendar year 2019; and
- Employers with self-funded health plans that are otherwise required to furnish Form 1095-C to covered individuals who were not full-time employees in any month of calendar year 2019.

Briefly, the alternative furnishing method allows carriers (and in some cases employers) to avoid 2019 Section 6055 penalties associated with a failure to furnish the applicable form to covered individuals by posting information to a website and timely providing the completed applicable Form upon request.

The following FAQs provide additional details.

Q1: What Was Extended?

2019 Forms 1095-C must be furnished to FTEs and other individuals by **Monday, March 2, 2020** (rather than by January 31, 2020).

This extension of time also applies to insurance carriers providing 2019 Forms 1095-B to individuals covered under an insured plan, and to employers providing 2019 Forms 1095-B to individuals covered under a self-funded health plan (but see Q/A-3).

The Notice states that the new deadline of March 2, 2020, will not be further extended by the IRS.

Q2: Were The Deadlines For Reporting To The IRS Extended?

No, the 2019 Form 1094-C and all supporting Forms 1095-C (and the 2019 Form 1094-B and all supporting Forms 1095-B) must be filed with the IRS by Tuesday, March 31, 2020, if filing electronically (or by Friday, February 28, 2020, if filing by paper). These deadlines **were not extended** as part of the announced relief.

As a reminder, employers that file at least 250 Forms 1095-C with the IRS must file electronically. The IRS encourages all filers to submit returns electronically.

Q3: With The Indiviudal Mandate Reduced To Zero After December 31, 2018, Is There Any Relief When Furnishing A Form 1095-B?

Yes, but it is generally limited to Forms 1095-B (except as described in Q/A-4 below).

Because the individual shared responsibility penalty is reduced to zero for 2019, an individual does not need the information on Form 1095-B in order to compute his or her federal tax liability or file an income tax return with the IRS. (But see Q/A-7 below regarding individual healthcare mandates in certain states.)

The IRS will not assess a 2019 Section 6055 reporting penalty against reporting entities for failing to furnish Form 1095-B to covered individuals in cases where the following two conditions are met (Alternative Furnishing Method):

1. **Website posting.** The reporting entity posts a notice prominently on its website stating that responsible individuals may receive a copy of their 2019 Form 1095-B upon request, accompanied by an email address and a physical address to which a request may be sent, as well as a telephone number that they can use to contact the reporting entity with any questions.

2. **Provide form within 30 days.** The reporting entity furnishes a 2019 Form 1095-B to any responsible individual upon request within 30 days of the date the request is received.

Insurance carriers (and employers with self-funded plans) that take advantage of this relief must still provide the 2019 Form 1094-B and all 2019 Forms 1095-B to the IRS by the required deadline. In other words, while the carrier (or employer) will not be penalized by the IRS for not supplying covered individuals with Forms 1095-B with respect to their coverage (subject to the two conditions set forth above), the carrier (or employer) must still create Forms 1095-B and provide them to the IRS by the required deadline.

There is no relief from the penalties associated with a failure to file completed forms with the IRS.

Q4: Will The Alternative Furnishing Method Apply To Ales With A Self-Funded Health Plan?

No, except in one situation.

ALEs are still required to provide Forms 1095-C to employees who were full-time for any month of calendar year 2019. Nothing has changed with respect to this requirement, aside from extending the deadline to March 2, 2020. ALEs offering self-funded group health plan coverage must continue to furnish Forms 1095-C to their FTEs, with all applicable parts (I, II and III) of Form 1095-C completed.

Some ALEs who offer self-insured health plan coverage to individuals who are not FTEs (e.g., part-time employees) may consider using the alternative furnishing method with respect to Form 1095-C.

Even if an ALE takes advantage of this alternative furnishing method with respect to an individual covered by the self-insured group health plan who was not a full-time employee in any month of 2019, the employer must still submit completed Forms 1094-C and 1095-C to the IRS by the required deadline.

Q5: Is The Good Faith Penalty Relief Extended?

Yes, penalty relief is extended for employers and other reporting entities that report incorrect or incomplete information on Form 1094-C or Forms 1095-C, when these entities can show that they made good-faith efforts to comply with the information reporting requirements for 2019. This relief applies to missing and inaccurate taxpayer identification numbers and dates of birth, as well as other information required on the return or statement.

Q6: What If The Submissions Are Late?

Employers that do not comply with the due dates for providing a return or statement to an individual or the IRS are subject to penalties (except as described in Q/A-3 and Q/A-4). Employers and other reporting entities should still furnish and file the forms, and the IRS will take such furnishing and filing into consideration when determining whether to abate penalties.

Q7: Our Employees Reside In States With An Individual Healthcare Mandate. Are There Other Things To Consider?

A handful of states (including the District of Columbia) have enacted individual healthcare mandates that apply to residents. As part of this requirement, carriers and employers must provide statements to residents and reporting to the states to demonstrate minimum essential coverage and enable covered employees and other individuals to avoid state penalties. States have either adopted (or are expected to adopt) the federal forms, 1095-B and 1095-C, to satisfy this requirement. While there may be limited federal relief with respect to furnishing

Furnishing Form 1095-C to Individuals Who Were NOT Full-Time Employees

The Notice does provide relief to ALEs required to furnish 2019 Forms 1095-C to individuals covered under a self-funded group health plan **who were not FTEs for any month of calendar** year 2019. In this limited instance, ALEs may use the alternative furnishing method and will not face 2019 Section 6055 penalties, provided the ALE meets two conditions (outlined in Q/A-3):

- Post a prominent notice on website stating the Form 1095-C (or 1095-B) is available by request; and
- Provide the Form 1095-C (or Form 1095-B) within 30 days of a request.

In most cases, the individuals targeted for this relief are those who receive Form 1095-C with Code 1G in line 14 of Part II. Examples of covered individuals who are not full-time employees for any month of the calendar year, but who may receive coverage under the employer's self-funded group health plan, include:

- Part-time employees covered under the plan.
- A spouse or child receiving COBRA coverage.
- A former employee receiving COBRA coverage who had a COBRA qualifying event in 2018 or earlier.
- Individuals covered under a self-funded retiree medical plan who retired in 2018 or earlier.

these forms, carriers and employers may want to continue to provide these forms to covered employees and other individuals who are subject to a state mandate.

The following is a list of states (including the District of Columbia) with an individual healthcare mandate and effective dates for compliance.

State or Jurisdiction	Effective Date of Individual Healthcare Mandate	Employer Reporting Begins in 2020	Employer Reporting Begins in 2021
California	January 1, 2020		X
New Jersey	January 1, 2019	X	
Rhode Island	January 1, 2020		X
Vermont	January 1, 2020		X (however, employers may not be required to report coverage to the state)
Washington, DC	January 1, 2019	X	

Massachusetts established an individual mandate in 2007. Reporting to individuals is provided via Form 1099-HC. Employers with at least 6 employees who are residents of the state must file an HIRD. As the Massachusetts requirement predates these recent healthcare mandates and uses different reporting forms, it is not included on this list.

Q8: What About Future Relief?

The Notice asks for comments as to whether an extension of the due date to furnish Forms 1095-C (and Forms 1095-B) and continued extension of the good faith relief will be necessary for future years and why. There is information in the Notice on how taxpayers may submit comments.

Q9: Have Revised Forms 1094/1095-C And 1094-1095-B Been Released For 2019?

Yes. The IRS recently released draft Forms 1094/1095-C and 1094/1095-B information returns and instructions for calendar year 2019, but they have very few changes from the prior year's versions. Since they were released so late, there was much that there might be significant modifications to the forms and reporting requirements, perhaps related to the fact that beginning January 1, 2019, the penalty for an individual not maintaining MEC was reduced to zero. However, at least based on the 2019 draft forms and instructions, this is not the case. There were relatively few changes made from the prior year, as detailed below.

- **Draft 2019 Form 1094-C:** No changes.
- **Draft 2019 Form 1095-C:** No changes to the form itself.

  Identifying the "Plan Start Month" in Part II remains optional for 2019, although it may become mandatory for 2020.

  The Instructions for Recipient on the back of the form had a few changes to reflect the elimination of the individual mandate penalty, and to underscore that information reported on the form is relevant to determining if an individual qualifies for subsidies through the Marketplace/Exchange. Changes include:
  - deleting a statement that the information is reported on the form "to assist you in completing your income tax return"
  - adding a statement that "[i]f you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit"

Draft 2019 Instructions for Forms 1094-C and 1095-C:

In addition to routine updates to the furnishing and filing deadlines, and the dates used in examples, the following changes were made:

- deleting a reference that individuals reported to have MEC under a self-insured plan "are not liable for

the individual shared responsibility payment for the months that they are covered under the plan"

- adding a statement that "[e]ligibility for certain types of minimum essential coverage can affect a taxpayer's eligibility for the premium tax credit"

- updating the calendar year penalty caps for the failure of an ALE to (1) file correct information returns, or (2) provide correct payee statements, to $3,339,000 each (from $3,275,500 in 2018)

- updating the applicable percentage for affordability safe harbors and the Qualifying Offer Method to 9.86% for plan years beginning in 2019 (from 9.56% in 2018)

Changes to the draft 2019 Forms 1094-B, 1095-B, and applicable instructions are similar to the changes described above.

Q10: What Should Employers Do Next?

Employers should consider the following:

- Employers should take note of the extended deadline, March 2, 2020, to furnish 2019 Forms 1095-C to full-time employees and other individuals.

- Final versions of the 2019 Forms 1094-C and 1095-C, along with relevant instructions, should be released soon. Hopefully, the final versions include additional guidance on the relief announced in this Notice.

- ALEs should complete Form 1095-C (including all relevant parts) and timely furnish the statements to full-time employees. ALEs should also timely transmit form 1094-C along with all Forms 1095-C to the IRS.

- Employers with fully insured plans should be aware that their carriers may not issue Forms 1095-B directly to covered employees for 2019. Individuals asking for a copy should be directed to the carrier. Employers should anticipate that covered employees residing in a state with an individual healthcare mandate may need to contact the carrier to obtain a Form 1095-B before filing a state income tax return.

- ALEs with self-funded health plans that extend coverage to individuals other than full-time employees should decide whether to continue to furnish Forms 1095-C as done in prior years, or to take advantage of the new alternative furnishing method with respect to those covered individuals, USI has identified a few administrative reasons why ALEs may be reluctant to adopt this new furnishing method for 2019:
  - While the Notice offers limited relief with respect to furnishing a Form 1095-C to covered individuals who were not full-time employees for any month of calendar year 2019, the ALE must ensure that Form 1095-C (including Part III) is completed and submitted to the IRS on behalf of these individuals. As the information must be included in the final submission, it is unclear whether taking advantage of the Section 6055 penalty relief makes any practical or administrative sense.
  - Employers looking to take advantage of this relief will need to post the required notice on a website and provide the completed Form 1095-C within 30 days of a request. Failure to do so could subject to the employer to associated penalties.
  - Given the timing of Notice 2019-63, vendors or other third parties that assist in preparation and distribution of 2019 Forms 1094-C and 1095-C may not be able to accommodate this new process.
  - Employers with employees who reside in states with an individual healthcare mandate will want to work with vendors to ensure forms are provided and reported to the state in a timely and complete manner.

- While good faith penalty relief was extended under the Notice, be aware that the IRS is actively assessing fines associated with failures to file Forms 1094-C and 1095-C with the IRS by the deadline (as described in Q/A-2 above). Timely reporting remains an area of active IRS enforcement.

Final Forms 1094-C and 1095-C Issued

Published: December 16, 2019

The IRS released final 2019 Form 1094-C, Form 1095-C and applicable instructions. Applicable large employers ("ALEs") must furnish the Form 1095-C to full-time employees and file Forms 1094-C and all 1095-Cs with the IRS.

What's New

While the Forms remain substantially the same to last year's versions, the instructions highlight recent changes as announced in Notice 2019-63:

- **Extension of due date to furnish Form 1095-C.** 2019 Form 1095-C is due to employees by March 2, 2020 (instead of January 31, 2020).

- **Relief for failure to furnish 1095-Cs to certain employees enrolled in self-insured health plan.** The IRS will not impose a penalty for failure to furnish Form 1095-C to any employee enrolled in an ALE member's self-insured health plan who is not a full-time employee for any month of 2019 if certain conditions are met.

- **Extension of good faith relief for reporting and furnishing.** The IRS will not impose a penalty for incorrect or incomplete information on Form 1095-C, if there is a good faith effort to comply with the information reporting requirements.

For more details on these changes, review our prior piece issued on December 9, 2019 entitled Deadline Extended for 2019 Forms 1095-C.

Deadlines

ALEs should begin to prepare for calendar year 2019 reporting. Forms and filings are due as follow:

Deadlines	Comments for Self-Funded Plans Providing Coverage to Individuals Other Than Full-Time Employees
Forms 1095-C due to ACA full-time employees by **March 2, 2020.**	ALEs sponsoring a self-funded health plan that provides coverage to individuals who are not full-time employees will either need to provide a Form 1095-C to these individuals by March 2, 2020 or satisfy the requirements of the relief announced in Notice 2019-63 by posting a website notice and upon request, providing the Form 1095-C within 30 days.
Form 1094-C and all corresponding Forms 1095-C must be filed electronically with the IRS by **March 31, 2020**; employers filing fewer than 250 statements may file by paper to the IRS no later than **February 28, 2020**.	If a self-funded employer takes advantage of the relief available in Notice 2019-63, the employer must still file the Forms 2019-C with the IRS for individuals who are not full-time employees but were covered by the self-funded health plan in 2019.

Penalties

Failure to furnish a correct Form 1095-C may result in penalties of $270/Form with an annual calendar year maximum of $3,339,000. Failure to file correct Forms 1095-C and 1094-C with the IRS may result in penalties of $270/Form with an annual calendar year maximum of $3,339,000.

Resources

- 2019 Form 1095-C, https://www.irs.gov/pub/irs-prior/f1095c--2019.pdf
- 2019 Form 1094-C, https://www.irs.gov/pub/irs-prior/f1094c--2019.pdf
- Instructions to 2019 From 1094-C and 1095-C, https://www.irs.gov/pub/irs-prior/i109495c--2019.pdf

Proposed Transparency Rules for Health Plans

Published: December 17, 2019

On November 27, 2019, the Departments of Health and Human Services (HHS), Labor (DOL) and the Treasury (collectively, the Departments) published a proposed rule that would impose new "transparency in coverage" requirements on group health plans and health insurance carriers.

Under the proposed rule, non-grandfathered group health plans and all health insurance carriers would be required to comply with the following transparency disclosure requirements:

Information Disclosed	Who Can Access the Information	Format of Disclosure
Cost-sharing information on covered items and services.	Participants and beneficiaries (and their authorized representatives).	• Internet-based self-service tool • Paper format (upon request)
Negotiated rates with in-network providers, and historical out-of-network allowed amounts.	All consumers and members of the public.	Machine readable files.

The rule is only in proposed form, which means that group health plans and insurance carriers are not yet required to comply with the new requirements. If finalized, the new requirements would be effective for plan years beginning on or after one year following finalization of the rule. For example, if the rule is finalized

on June 1, 2020, then a group health plan with a January 1 plan year would be required to comply with the new requirements on January 1, 2022.

If finalized "as-is", the requirements impose substantial new disclosure obligations on group health plans. While carriers will generally be responsible for these disclosures with respect to fully insured plans, self-funded plans will need to work with third party administrators or other vendors to meet the new requirements. The rule does not apply to excepted benefits (e.g., dental, vision, health flexible spending arrangements (health FSAs)), or to health reimbursement arrangements (HRAs) or other account-based plans that simply make a certain dollar amount available, or to short-term limited duration insurance.

The following provides highlights from the proposed rule.

Overview

The stated goal of the proposed rule is to support a market-driven health care system by giving employees and other consumers the information they need to make informed decisions about their health care purchases. For example, the rule provides participants and beneficiaries with price and benefit information in advance that can enable them to evaluate their health care options and make cost-conscious decisions. The Federal Government is of the view that price transparency will, over time, potentially lower overall health care costs in the market.

Disclosure to Participants and Beneficiaries

At the request of a participant or beneficiary (or authorized representative), a group health plan or insurance carrier must provide specified cost-sharing information with respect to a covered item or service that the individual might receive from a particular provider. The disclosure is similar to an "explanation of benefits" (or EOB), except that it is provided before medical treatment, not afterwards.

Briefly, the disclosure must include:

- An estimate of the participant's or beneficiary's cost-sharing liability at the time the request is made, considering all deductibles, coinsurance, copayments and other cost-sharing provisions under the group health plan;
- Accumulated amounts of cost-sharing that the participant or beneficiary has already incurred under the plan at the time the request is made;
- For an in-network item or service, the negotiated rate (reflected as a dollar amount) with the in-network provider;
- For an out-of-network item or service, the out-of-network allowed amount for the requested item or service if furnished by an out-of-network provider;
- If the item or service is subject to a bundled payment arrangement, cost sharing information for each item and each service within the bundle;
- Notification (if applicable) that the covered item or service is subject to concurrent review, prior authorization, step therapy protocol, or other prerequisite to coverage; and
- Notification on balance billing for out-of-network items and services, that the actual charges may be different from the estimate provided, and other required disclosures. A model notice is available.

This information must be provided in plain language through a self-service tool on an internet website that allows real-time responses based on cost-sharing information that is accurate at the time of the request. There are detailed requirements as to what the website must allow the user to do, including looking up information via a billing code (e.g., CPT code) or by using the name of the provider (both in-network and out-of-network). If requested by a participant or beneficiary (or authorized representative), the information must be mailed to the individual in paper format within two business days of receipt of the request.

The proposed rule permits fully insured group health plans to enter into a written agreement with the insurance carrier which requires the carrier to disclose the required information to participants and beneficiaries (and their authorized representatives). If the carrier fails to provide full or timely information, the carrier will be liable but not the plan. This special rule does not apply to self-funded plans. While employers sponsoring self-funded health plans may contract with third parties to provide the applicable notices, if the
third-party fails to provide full or timely information on behalf of the plan, the plan (and employer) remain liable.

Disclosure to the Public

The proposed rule also requires group health plans and insurance carriers to make publicly available two machine-readable computer files which contain the following information:

1. Negotiated Rate File: A file that lists every negotiated rate under the group health plan with respect to each covered item or service furnished by in-network providers. The disclosure would include billing codes used by the plan to identify each item or service, with a plain language description of each billing code. If the plan has negotiated different rates for items or services furnished by various network providers, then each different negotiated rate must be disclosed. In addition, if the plan has negotiated a bundled payment arrangement (for example, for childbirth), then the plan must identify the items and services within the bundle by the relevant billing codes.

2. Allowed Amount File: A file that lists each unique out-of-network allowed amount in connection with covered items or services furnished by a particular out-of-network provider during the 90-day period that begins 180 days prior to the publication of the file. For example, if the group health plan received 23 claims from an out-of-network provider for rapid flu tests during the 90-day period, and the plan calculated out-of-network allowed amounts of $100 for three claims, $150 for 10 claims, and $200 for the remaining 10 claims, then it would need to disclose all of this information in the file.

The proposed rule lays out specific formats and methods for these files, which must be updated on a monthly basis. In addition, the Departments released tables that outline the proposed data elements that a plan or issuer would be required to use in each readable file.

- Negotiated Rate File, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-negotiated-rate-file.pdf

- Allowed Amount File, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-allowed-amounts-file.pdf

The proposed rule permits fully insured group health plans to enter into a written agreement with the insurance carrier which requires the carrier to disclose the two machine-readable computer files to the public. If the carrier fails to provide full or timely information, the carrier will be liable but not the plan. For self-funded plans, the rule permits the plan to reduce the burden of disclosure by entering into a HIPAA business agreement and contracting with a health care claims clearinghouse or third party administrator to disclose the information on behalf of the plan, but the plan would remain liable for any failure by the clearinghouse or administrator to comply with the new rule.

Employer Action

This summary provides a high-level overview of the very detailed proposed rule on the new transparency disclosure requirements. The Departments will collect comments on the proposed rule until January 14, 2020, and any final rule will be published at a later date.

These rules are in proposed form, which means that no action is required at this point. Employers should be aware that additional transparency disclosure requirements may be coming, and will likely add additional administrative costs and other burdens to their employer-sponsored group health plan. If the new rule is finalized, plans should have at least a year from the time the final rule is published to address compliance with any new requirements.