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ADVISORY

2019 health care benefits year in review:

Cadillac plan tax repeal and other highlights

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In 2019, the biggest news in the health care benefits world was the repeal of the Affordable Care Act's so-called Cadillac plan tax. The repeal and other health-related provisions came at the end of the year with Congress' fiscal year 2020 spending package. These changes, federal regulatory actions and continued litigation in federal courts made it an interesting year, paving the way for additional changes in the year ahead.

Year-end legislation from Capitol Hill

The fiscal year 2020 spending bill included several welcome changes:

Cadillac plan tax repeal

The Cadillac plan tax was a 40% excise tax on the cost of certain employer-sponsored health coverage in excess of a specified dollar threshold. The tax was originally scheduled to go into effect in 2018 but was previously delayed until 2022. Even with the delayed effective date, some employers started to modify their health insurance plans to avoid triggering the tax, including increasing deductibles and copays. The push for repeal grew as many policymakers increasingly viewed the tax as having an effect on middle-class workers. Learn more about the now historical tax.

Health insurance tax (HIT) repeal

The HIT is imposed on health insurers based on their relative market share of premiums for major medical plans and certain other health insurance plans. Although the tax is imposed on the health insurance company, it is generally passed through to consumers as part of the premium. The tax went into effect in 2010 and was suspended in 2017, went back into effect in 2018 and was again suspended in 2019. The tax will apply for 2020 but is finally repealed starting in 2021.

One-year extension (through 2020) of the tax credit for employers who provide paid family and medical leave

This tax credit was originally enacted for two years, 2018 and 2019. The extension through 2020 is helpful, particularly for employers with paid family and medical leave plans that already meet the requirements for the credit.

In less-welcome news:

Patient-Centered Outcomes Research Institute (PCORI) fee extended for 10 years

Key details include:

- The fee is imposed on self-funded and fully insured health plans. Excepted benefit plans, including hospital indemnity and other fixed indemnity, specified disease or illness, and vision and dental policies aren't subject to the fee.
- The fee for a year is equal to the average number of lives covered under the plan multiplied by a dollar amount. The dollar amount was originally set at $1 and is indexed for inflation. After the last inflation update, the dollar amount was $2.45.
- The fee is due on July 31 each year. This fee was originally effective for plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2019. The spending bill moved the end date for the fee so that it now applies to plan years ending before Oct. 1, 2029.
- As an example of how the extension works, let's look at a calendar year plan.
  - Before the extension, the last fee the calendar year plan would have paid was for the plan year starting Jan. 1, 2018. The dollar amount for determining the fee was $2.45, and the fee was due July 31, 2019.
  - Under the extension, it appears that the fee will now apply to calendar-year plans for the year beginning Jan. 1, 2019, and will be payable July 31, 2020. The dollar amount is not yet known but would be slightly higher than $2.45 due to inflation adjustments.
  - The IRS PCORI Fee website has further information but as of this writing has not yet been updated to reflect the extension of the fee.

In addition to health provisions, the 2020 spending bill also includes the Setting Every Community Up for Retirement Enhancement (SECURE) Act, which makes a variety of changes to retirement plan rules.

Federal regulatory action from the tri-agencies: The Departments of Labor, Treasury, and Health and Human Services

HRA final rule and follow-up guidance on employer mandate and nondiscrimination requirements

In June 2019, the tri-agencies finalized rules governing individual coverage health reimbursement arrangements (ICHRAs) and excepted benefit health reimbursement arrangements (EBHRAs). The IRS followed up with proposed regulation to clarify how ICHRAs are treated under the employer mandate for applicable large employers (generally, employers with 50 or more full-time equivalent employees in the prior year) and certain nondiscrimination rules.

- The final health reimbursement arrangement rule allows employers to establish an ICHRA to pay employees' premiums for individual market coverage (other than excepted benefit or short-term coverage) and other unreimbursed medical expenses. ICHRAs are considered minimum essential coverage for purposes of the ACA employer mandate penalties. Among other requirements, an employer cannot offer a traditional group health plan and an ICHRA to the same class of employees.
- The second type of new HRA, the EBHRA, may be established without integration with individual coverage as required for ICHRAs. An EBHRA must satisfy four requirements (similar to requirements that apply to excepted benefit flexible spending accounts): (1) the maximum annual contribution is $1,800 (indexed and without regard to any carryovers); (2) the employee must also be offered traditional health coverage from the same employer (but the employee does not have to enroll in that coverage); (3) the employee cannot also be offered an ICHRA; and (4) the terms and conditions must be the same for all "similarly situated" classes of employees. Learn more.

HSAs and preventive care

In July 2019, the IRS issued guidance that, on its face, makes health savings accounts (HSAs) more user-friendly by allowing a high-deductible health plan to cover certain treatments for chronic conditions before the plan's deductible is met. The IRS considered issues related to preventive care for HSA purposes for a while and released IRS Notice 2019-45 less than 30 days after the president signed a June 2019 Executive Order directing the IRS to provide guidance on the issue. Learn more.

Agencies obtain criminal conviction in health plan tax scheme

A recent federal-state criminal enforcement action demonstrates the continued commitment of the DOL and other federal agencies in combating fraudulent tax avoidance schemes involving health benefit arrangements. A recent case publicized by the DOL involves a version of what is commonly referred to as the classic "double dip." This arrangement consists of two basic steps: (1) employees pay for their portion of the cost of an otherwise excludable employer health plan through pretax salary reduction, and (2) employees are paid a portion of their salary reduction contribution purportedly on a tax-free basis to bring their take-home pay back up to the presalary reduction level.

Many recent schemes are often coupled with an otherwise innocuous "wellness plan." For employers and employees who may be duped into these schemes, the chilling aspect is that, as noted by the DOL, "the employer-clients and employee-participants are now individually responsible" for underpaid employment and income taxes. Penalties on underpayments may be waived by the IRS for employers and employees who were not aware the arrangement was fraudulent, but the amount of unpaid taxes, plus interest, can still be collected. As regulators continue to pursue these unlawful arrangements, employers need to be sure they are dealing with a legitimate plan in order to avoid unexpected tax liabilities for themselves and their employees. Learn more.

IRS delays some ACA reporting

The IRS issued Form 1095 reporting relief for certain ACA reporting requirements. While Form 1095 generally applies to health insurers, it may also apply to employers with self-funded plans. Notice 2019-63:

- Delays the due date for furnishing 2019 Form 1095 to covered individual recipients until March 2, 2020.
- Provides that no penalties will be assessed for failing to furnish a Form 1095-B or a Form 1095-C (these forms are required with respect to individuals covered under a self-insured plan that are not full time at any time during the year) to recipients if prominent notice is placed on a website that a copy may be requested and a copy of the notice is provided within 30 days of the request. NOTE: These provisions do NOT extend to required forms filed with the IRS.
- Extends good faith relief to all ACA 2019 forms.

DOL-proposed rule on electronic disclosure for retirement plans

The DOL proposed a revamped electronic disclosure rule under ERISA in October 2019. While the new rule significantly pushes the electronic communication ball forward for retirement plans, it isn't applicable to group health and welfare plans (including excepted benefits, FSAs and HRAs). Similar changes for health and welfare plans may come down the pike in 2020. Learn more.

Sweeping transparency rule proposed for most health plans

In November 2019, the tri-agencies proposed a new rule that, if enacted, will require most individual and large- and small-group health plans to provide detailed cost-sharing information to plan participants and publicly disclose information regarding in-network negotiated rates with providers and allowed amounts for out-of-network providers. The proposed rule doesn't apply to excepted benefit plans, such as dental, vision, hospital indemnity and other fixed indemnity, and specified disease and critical illness policies. There are also some other limited exceptions. Learn more.

Health benefit litigation in federal courts

Appellate court ruling in litigation challenging the constitutionality of the ACA

You may remember in December 2018, a federal district court judge ruled that since Congress reduced the ACA individual mandate penalty to $0 in 2017, the individual mandate is unconstitutional and, therefore, the entire ACA is invalid. The decision made headline news, but it was appealed and had no immediate effect on the law. In December 2019, the federal court of appeals agreed that the individual mandate is now unconstitutional but did not agree with the cursory opinion that the entire ACA must necessarily fall. The appellate court sent the case back to the district court for a thorough analysis of which, if any, parts of the ACA are now unconstitutional. What's next?

- In the meantime, the law continues to remain in effect. Ultimately, this issue is expected to reach the Supreme Court, but a final decision will take some time.
- The effective elimination of the ACA individual mandate has prompted some states to pass individual mandate laws that also require reporting by coverage providers, including employers who sponsor group health plans. To date, the following states have passed such laws: New Jersey; Washington, D.C.; Vermont; Rhode Island and California. New Jersey and D.C.'s laws are effective in 2019, which means reporting will be due in 2020. The others become effective in 2020, with reporting to commence in 2021 (for 2020). Insurers and plan sponsors that cover residents in these states should ensure compliance with these requirements.

Federal district court declares new association health plan (AHP) rule invalid

Background: In 2018, the DOL issued a final rule allowing more employers to form AHPs, thus avoiding stricter ACA mandates for small-group insured plans. Among other changes, the AHP final rule allows "working owners" such as sole proprietors and partners to participate in an AHP plan even if the business has no employees other than the owner and spouse. The AHP final rule also allows businesses to form an AHP based on geography, even if there is no other industry connection. The geographic nexus could be as large as a single state or encompass more than one state if part of a single metropolitan area. The final AHP rule didn't have an effect on the ability of employers to form associations under the preexisting DOL guidance, which is more restrictive. AHPs that qualify under the prerule guidance are commonly referred to as Path 1 AHPs. AHPs that rely on the 2018 final rule are commonly referred to as Path 2 AHPs.

> In 2019, a federal district court judge ruled that the key parts of the 2018 final DOL AHP are invalid because they're inconsistent with ERISA. The DOL did not request a stay of the decision pending appeal, so this means that the final AHP rule is no longer in effect, even as the litigation continues.

What's next: Due to the court decision, the DOL issued some very limited transition relief for existing coverage under a Path 2 AHP plan, but this relief is time limited. In light of the court decision, navigating the legal environment for AHPs can be difficult at this time and involve a variety of federal and state law issues. Employers, insurers or others interested in AHP coverage should consult their legal advisors regarding the relevant issues.

Looking ahead

A lot happened in 2019, including dramatic tax changes at the end of the year. Looking ahead, 2020 also promises to be a busy year. The tri-agencies are expected to finalize proposed rules issued in 2019 and address additional areas pursuant to the president's executive order issued in June, including potentially raising the limit on permissible health FSA carryovers and possible guidance on whether certain expenses, such as direct primary care arrangements and health sharing ministries, qualify as a medical expense. We might see some congressional developments, such as surprise billing legislation. On top of all this, a lame-duck session is always possible in an election year. Stay tuned for these and new issues in the year ahead.

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