AssuredPartners
COMPLIANCE OBSERVER

2nd Quarter 2018

Embedded Out-of-Pocket Maximums

The Affordable Care Act (ACA) requires all non-grandfathered health plans to include an annual limit on individual cost sharing for essential health benefits (EHB). This annual limit is often referred to as an "out-of-pocket maximum" or "maximum out-of-pocket" (MOOP). ***ALL non-grandfathered health plans*** (self-funded and insured plans of all sizes, as well as high-deductible health plans (HDHP)), must apply the ACA's self-only MOOP to all individuals, regardless of whether they have self-only, family or any other tier of coverage. Thus, if one person in a family incurs costs exceeding the annual *self-only* cost-sharing limit, that individual would only be responsible for paying expenses up to that limit ($7,350 for 2018).

Impact on High Deductible Health Plans (HDHP)

The IRS imposes their own rules on HSA compatible HDHP plans, including minimum deductibles AND separate out-of-pocket maximums. Because the HDHP self-only MOOP is less than the ACA's self-only MOOP, in order to continue to qualify as an HDHP, the plan must comply with the lower MOOP. ($6,650 for 2018). Essentially, the ACA requirement "embeds" an individual MOOP in a group health plan with a higher family deductible.

Example: An issuer can offer a family HDHP with a $10,000 family deductible, as long as it applies a maximum annual limitation on cost sharing ($7,350 for 2018) to each individual in the plan, even if the family $10,000 deductible has not yet been satisfied. This standard does not conflict with IRS rules on HDHPs.

Except for preventive care, an HDHP cannot provide benefits for any year until the minimum annual deductible for that year has been met ($2,700 for family coverage for 2018). Because the $7,350 self-only maximum annual limitation on cost sharing exceeds the 2018 minimum annual deductible amount for family HDHP coverage ($2,700), it will not cause the plan to fail to satisfy the requirements for a family HDHP.

Links & Resources:

- HHS 2016 Benefit & Payment Parameters, which implemented the ACA rule on embedded out-of-pocket maximums.
- HHS FAQ on how the ACA rule affects HDHPs

Where Are We with Wellness?

Last December a federal district court judge, in *AARP v. EEOC,* vacated the incentive portion of the final EEOC wellness regulations as of January 1, 2019, stating that the EEOC failed to properly establish sound reasoning that penalties and incentives up to 30% of an individual's health plan cost is "voluntary". The judge ordered the agency to promulgate new regulations by August 31, 2018 and to provide a status report on those new regulations by March 30, 2018.

On March 30, 2018 the EEOC filed a status report indicating it has no intention of issuing new wellness regulations by any certain date, including the court ordered date of August 31st, as it was still waiting for Senate confirmation of new nominees to the EEOC.

Although this decision, or lack thereof, does not affect employer wellness programs for the remainder of 2018, it may hinder an employer's ability to comply with the ADA and GINA rules beginning January 1, 2019, the date the current incentive limits are set to expire.

So how do employers plan for 2019?
There are a few options, each with its own level of risk.

- **Least Risk** – Completely discontinue your wellness program or, at least, any health-risk assessments or medical screenings that are part of your program. Remember, only programs that include health exams, screenings, or inquiries are required to comply with the EEOC regulations.
- **Moderate Risk** – Continue your program relying on the previous final EEOC regulations, but perhaps lower your incentive(s) to some level less than 30% of the cost of your lowest cost employee only health plan. At this point the exact level is still an unknown, but lowering it may show good faith effort in trying to comply in this time of uncertainty.
- **High Risk** – Continue your program but disregard the EEOC regulations entirely, and follow only the HIPAA regulations (as amended by the ACA), which are less restrictive and continue to allow incentives of 30% (50% if the program is designed to prevent or reduce tobacco use).

Employers are encouraged to consult with legal counsel to determine an appropriate wellness strategy for 2019.

Calendar Year Plans must file Form 5500 by July 31, 2018

FILING REQUIREMENTS
The Employee Retirement Income Security Act (ERISA) requires the plan administrator of certain ERISA plans to file an "annual report" with the U.S. Department of Labor (DOL) containing specified plan information. The Form 5500 and its related schedules satisfy that requirement. Typically, plans must submit the Form 5500 and related schedules by the last day of the seventh calendar month after the end of the plan year. For calendar year plans, this means the Form 5500 is due by July 31, 2018, unless an extension has been filed.

For welfare benefit plans, Form 5500 reports must be filed for both fully insured and self-insured plans. Welfare benefit plans include, but are not limited to, health plans, dental plans, vision plans, disability plans, life insurance plans, accidental death and dismemberment plans, and certain employee assistance programs. Small welfare plans that are unfunded or insured are exempt. To qualify for the small plan exemption, the plan must have fewer than 100 covered participants at the beginning of the plan year.

ERISA places responsibility for filing the Form 5500 on the plan administrator. Contracting with a third party to prepare the Form 5500 does not relieve the plan administrator of its responsibilities or applicable liabilities.

ELECTRONIC FILING
The DOL requires that all Form 5500s for Plan Year 2009 and later must be filed electronically through EFAST2. This includes any prior year delinquent or amended reports. EFAST2 is an all-electronic system designed by the Department of Labor, Internal Revenue Service, and Pension Benefit Guaranty

Corporation to simplify and expedite the submission, receipt, and processing of the Form 5500 and Form 5500-SF.

PENALTIES FOR NONCOMPLIANCE

The DOL has the authority under ERISA to assess penalties of up to $2,140 per day for each day an administrator fails or refuses to file a complete Form 5500. The penalties may be waived if the noncompliance was due to reasonable cause. In addition, ERISA provides for criminal penalties for willful violations of its reporting requirements.

Reduced Penalties - If your welfare plan is late in filing a 5500 form, or your plan never filed a 5500 form because you were not aware that your plan had to do so, the DOL's correction program, the Delinquent Filer Voluntary Compliance Program, is available to file late forms with reduced penalties. However, this program cannot be used once the DOL finds the employer's error through an audit or investigation.

SUMMARY ANNUAL REPORT (SAR)

A summary of the Form 5500 information must be furnished automatically to participants each year that an annual Form 5500 is filed (except for totally unfunded plans, regardless of size). The SAR must be prepared and delivered to participants and beneficiaries who receive SPDs. The plan administrator generally must provide the SAR within nine months of the close of the plan year. If an extension of time to file the Form 5500 is obtained, the plan administrator must furnish the SAR within two months after the close of the extension period.

Links & Resources:

- The DOL's Reporting and Disclosure Guide for Employee Benefit Plans
- The EBSA's Form 5500 Series website (includes links to forms and instructions)

PCORI Fees due July 31, 2018

The Affordable Care Act (ACA) requires health insurance issuers and sponsors of self-insured health plans to pay Patient-Centered Outcomes Research Institute fees (PCORI fees).

The PCORI fees apply for plan years ending on or after Oct. 1, 2012, but do not apply for plan years ending on or after Oct. 1, 2019. For calendar year plans, the fees are effective through 2018 plan years.

PCORI fees are reported and paid annually using IRS Form 720 (Quarterly Federal Excise Tax Return). The applicable PCORI fee you pay this year, ***by July 31, 2018***, is based on your plan year end date in 2017.

- **$2.26 for plan years ending between January 1, 2017 – September 30, 2017**
- **$2.39 for plan years ending between October 1, 2017 – December 31, 2017**

Plans sponsored by all types of employers, including tax-exempt organizations and government entities, are subject to the PCORI fees. Most health plans, including major medical plans, prescription drug plans and retiree-only plans are also subject to the fees, regardless of the number of participants.

Plans exempt from the fees include:

- Excepted benefit plans, as defined under HIPAA – including stand-alone dental and vision plans, accident-only coverage, disability income coverage, liability insurance, workers' compensation coverage, credit-only insurance or coverage for on-site medical clinics.

A health FSA qualifies as an excepted benefit if:

- Other group health plan coverage, not limited to excepted benefits, is made available to the eligible class of participants; and
- The maximum benefit payable under the FSA to any eligible participant does not exceed two times the participant's salary reduction election (or, if greater, $500 plus the amount of the salary reduction election)

- Employee assistance programs, disease management programs, or wellness programs – if the program does not provide significant medical care or treatment
- Health Savings Accounts (HSAs)

The fees are based on the average number of covered lives under the plan or policy. This generally includes employees and their enrolled spouses and dependents. Individuals who are receiving continuation coverage (such as COBRA coverage) must be included in the number of covered lives under the plan in calculating the fee.

SPECIAL COUNTING RULE FOR HRAs AND FSAs

HRAs and health FSAs are not completely excluded from the obligation to pay PCORI fees. However, two special rules apply for plan sponsors that provide an HRA or health FSA. Under these special rules:

1. If a plan sponsor maintains only an HRA or health FSA (and no other applicable self-insured health plan), the plan sponsor may treat each participant's account as covering a single life. This means that the plan sponsor is not required to count spouses or other dependents.
2. An HRA is not subject to a separate PCORI fee if it is integrated with another self-insured plan providing major medical coverage, provided the HRA and the plan are established and maintained by the same plan sponsor and have the same plan year. This rule allows the sponsor to pay the PCORI fee only once with respect to each life covered under the HRA and other plan. However, if an HRA is integrated with an insured group health plan, the plan sponsor of the HRA and the issuer of the insured plan will both be subject to the PCORI fees, even though the HRA and insured group health plan are maintained by the same plan sponsor.

The same analysis applies to health FSAs that do not qualify as excepted benefits.

Links and Resources:

- Final Regulations
- PCORI Fee Overview
- PCORI Fee Q&A
- IRS Form 720 and instructions
- PCORI Fee Due Dates & Applicable Rates
- Chart of Health Coverage & Arrangements subject to PCORI Fees

Proposed FAQs on Mental Health and Substance Use Disorder Parity

As part of a continuing effort to promote compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), the Departments of Labor, HHS, and Treasury have released a set of proposed FAQs (Part 39) on nonquantitative treatment limitations (NQTLs). Here are the highlights:

- ***Experimental treatment exclusions***. A plan may exclude treatments it deems experimental or investigational, but the exclusion must be written into the plan's documents and may not be applied more stringently to Mental Health/Substance Abuse Disorder (MH/SUD) benefits than to medical/surgical benefits. For example, a plan may not deny applied behavioral analysis (ABA) therapy as experimental if it covers medical/surgical treatments meeting the same professionally-recognized treatment guidelines.
- ***Dosage limits*.** Setting dosage limits on prescription drugs is considered a medical management technique and therefore a NQTL, even though the limits may be expressed numerically. If a plan follows professionally-recognized treatment guidelines when setting dosage limits for prescription medications, it must apply them no more stringently in setting dosage limits for prescription drugs used to treat MH/SUD conditions, including buprenorphine to treat opioid use disorder.
- ***Particular condition or disorder*.** A general exclusion for a particular condition or disorder is not a NQTL. For example, a plan could exclude all items and services to treat bipolar disorder, including prescription drugs, (although state laws applicable to fully-insured plans may mandate coverage of particular conditions or disorders).
- ***Step therapy***. Step therapy protocols or "fail first" polices must be applied consistently between medical/surgical and MH/SUD benefits. For example, a plan would violate the MHPAEA if it requires a participant to have two unsuccessful attempts at outpatient treatment in the past 12 months to be eligible for certain inpatient SUD benefits, but requires only one unsuccessful attempt at outpatient treatment in the past 12 months to be eligible for inpatient medical/surgical benefits.
- ***Reimbursement rates***. While a plan is not required to pay identical provider reimbursement rates for medical/surgical and MH/SUD providers, a plan's standards for admitting a provider into a network (including the plan's reimbursement rates for providers) is a NQTL. Therefore, a plan may not reduce reimbursement rates for non-physician practitioners providing MH/SUD services unless it also reduces the rates for non-physician practitioners providing medical/surgical services.
- ***Coverage restrictions based on facility type*.** If a plan covers inpatient, out-of-network treatment outside of a hospital setting for medical/surgical conditions when the prescribing physician obtains authorization from the plan and the treatment is medically appropriate, then the plan must provide comparable benefits for inpatient, out-of-network treatment outside of a hospital setting for covered MH/SUD conditions. For example, a plan violates the MHPAEA if it covers inpatient, out-of-network treatment outside of a hospital for medical/surgical conditions but excludes residential treatment for eating disorders.
- ***Emergency room care***. Whether benefits for emergency room care are related to a medical/surgical condition or a MH/SUD condition depends on the circumstances. If the plan defines a particular acute condition affecting a patient's physical health as a medical condition, then benefits for emergency room care for the diagnosis, cure, mitigation, treatment or prevention of the acute condition are medical/surgical benefits, regardless of any underlying MH/SUD condition. For example, if the plan treats lacerations as a medical condition and a participant with an MH/SUD condition seeks emergency treatment for lacerations, the treatment

is considered medical/surgical benefits. However, if the plan defines an acute condition affecting an individual's physical health as an MH/SUD condition, then benefits for the associated emergency room care are MH/SUD benefits.

The Departments also released an updated NQTL document request form for plan participants, a Fact Sheet on 2017 enforcement of the parity rules (most of which involved NQTLs) and a self-compliance tool to help employers monitor their own plans.

Links and Resources:

- Updated Request Form
- Fact Sheet on 2017 Enforcement
- Self-Compliance Tool

2019 HSA and HDHP Amounts

The IRS has announced the health savings account (HSA) contribution and HSA-qualified high deductible health plan (HDHP) limits for 2019. These amounts are updated annually to reflect cost-of-living adjustments. For employers sponsoring HSA-qualified HDHPs, these limits will affect benefit plan administration and communication materials for 2019.

SELF-ONLY COVERAGE	2019	2018	CHANGE
Maximum HSA contribution	$3,500	$3,450	+$50
Minimum deductible for HDHP	$1,350	$1,350	no change
Maximum out-of-pocket limit for HDHP	$6,750	$6,650	+$100

FAMILY COVERAGE	2019	2018	CHANGE
Maximum HSA contribution	$7,000	$6,900	+$100
Minimum deductible for HDHP	$2,700	$2,700	no change
Maximum out-of-pocket limit for HDHP	$13,500	$13,300	+$200

The catch-up contribution amount for individuals age 55 or older remains at $1,000 (this amount is fixed by statute). Please see IRS Revenue Procedure 2018-30 for full details.

IRS Continues to Issue Employer-Shared Responsibility Payment (ESRP) Letters

The IRS continues to send out 226J letters attempting to collect penalties from employers it believes did not meet the ACA's employer mandate for 2015. Most employers are able to get the proposed penalties waived or significantly reduced by providing corrected reporting information.

Letter 226J contains several documents including an ESRP Summary Table and Explanation, Form 14764 ("ESRP Response"), and Form 14765 ("Employee Premium Tax Credit (PTC) Listing"). To avoid penalties, employers must respond to the IRS as instructed by the date indicated in the letter. The IRS will reply with one of several versions of Letter 227, which either closes the inquiry or provides information on next steps. The IRS has published Understanding your Letter 226J and Understanding your Letter 227 to assist employers in this process.

Final Rules for Association Health Plans Released by the DOL

On June 21, 2018, the DOL issued the highly-anticipated final regulations and FAQs on association health plans (AHPs). These final regulations provide an alternative for a group or association of employers to be treated as an "employer" sponsoring a single ERISA-covered multiple employer group health plan (a multiple employer welfare arrangement ("MEWA")). Many small employers were awaiting these regulations to see if these rules would allow them to form a MEWA that is treated as a single plan thereby avoiding some Affordable Care Act (ACA) reforms (i.e. those that apply to the individual and small group insurance markets including the essential health benefits requirement). The previously-established guidance surrounding MEWAs states that a MEWA is a single ERISA plan only where it is established by a "bona fide" association of employers with the ability to control said association and have a legitimate organizational relationship. While the previous guidance has not been displaced and can still be relied on, the final regulations provide an additional method for groups to meet the "employer" definition. The final rules provide the following:

- ***Commonality of Interest***. The final regulations broaden ERISA's definition of "employer" and create a "commonality-of-interest" test that is less static for the employer members of an association. The final regulations adopt the standard from the proposed rules and allow employers to come together to offer health coverage if they either (1) are in the same trade, industry, line of business, or profession; or (2) have a principal place of business within a region that does not exceed the boundaries of the same state or same metropolitan area (even if the metropolitan area includes more than one state). However, adding to the proposed rule, the final regulations include a requirement that a group or association of employers have at least one substantial business purpose unrelated to the provision of health coverage or other employee benefits, even if the principal purpose of the group or association is to offer such coverage to the members of the association.
- ***Employer Control***. Under the final regulations, which adopted the proposed rules with some changes, the functions and activities of the group or association must be controlled by its employer members. Additionally, the employer members that participate in the group health plan must control the plan. To determine control and whether it exists in form and in substance, a facts

and circumstances test shall be used. The preamble of the final regulations identifies pertinent factors and clarifies that members are not required to manage the day-to-day affairs of the group, association, or plan. The requirement that the group or association sponsoring the AHP cannot be a health insurer or owned or controlled by a health insurer is also included in the final regulations.

- ***Working Owners***. The regulations verify that only employees and former employees of employer members (and their families) are allowed to participate in AHPs. However, if working owners meet certain conditions, the final regulations allow such individuals with no common law employees (such as sole proprietors and other self-employed individuals) to be covered by the AHP by electing to act as employer members of an association and be treated as employees of their businesses. Working owners generally must work at least 20 hours per week or 80 hours per month, which is fewer hours than under the proposed regulations. Notably, the final rule does not include the condition that an individual would not be treated as a working owner if the individual was eligible to participate in any subsidized group health plan maintained by any other employer of the individual or his/her spouse.
- ***Health Nondiscrimination Requirement***. Consistent with the HIPAA nondiscrimination provisions, the final regulations do not allow a group or association to restrict membership in the association based on any health factor. The regulations also prohibit these associations from treating member employers as distinct groups of similarly situated individuals. However, the final regulations clarify that AHPs may make distinctions between employer members in certain circumstances. For example, it is permitted to make distinctions based on a factor other than a health factor (such as industry, occupation, or geography).

The applicability date set forth by the DOL varies depending on certain plan factors. Fully insured AHPs have the applicability date of September 1, 2018. Existing self-insured AHPs complying with the DOL's pre-regulation rules have the applicability date of January 1, 2019. Further, new self-insured AHPs formed under these final regulations have a April 1, 2019 applicability date.

AssuredPartners will continue to update you on these regulations as more guidance and information becomes available.

Links and Resources:

- Regulations
- FAQs
- News Release

Source: *EBIA Weekly, June 21, 2018 (*Thomson Reuters *EBIA Checkpoint)*

DID YOU KNOW?

Under the ACA's Summary of Benefits and Coverage (SBC) rules, plans and issuers are required to issue a ***60-day advance notice*** when:

- A material modification is made that would affect the content of the SBC;
- The change is not already included in the most recently provided SBC; and
- The change is a **mid-plan-year** change (i.e. it does not occur in connection with a coverage renewal)

A "material modification" is any change to a plan's coverage that would be considered by the average plan participant to be an important change in covered benefits or other terms of coverage.

This requirement can be satisfied either by a separate notice describing the material modification or by providing an updated SBC reflecting the modification.

Should you have any questions or concerns about any of the topics addressed in this Newsletter, please contact a member of your AssuredPartners' Benefits Team.