IslerDare PC

Your workplace, our insight

Employee Benefits Update April 2020

Roundup of Recent Developments Affecting Health and Welfare Plans

Executive Summary

The focus in recent weeks has been on how the COVID-19 pandemic has impacted your employee benefit plans. However, there have been some other important developments regarding health and welfare plans that we would like to bring to your attention. This Employee Benefits Update addresses the following:

- **Updated Summary of Benefits and Coverage Template:** The Department of Labor ("DOL") and the Department of Health and Human Services ("HHS") released updated templates for the Summary of Benefits and Coverage that must be used for plan or policy years beginning on or after January 1, 2021.

- **District of Columbia Requirements for ACA Reporting:** The deadline for the District of Columbia's mandatory health coverage reporting is approaching.

- **No Statute of Limitations for Employer Shared Responsibility Payment Assessment:** The Internal Revenue Service concluded there is no statute of limitations on the assessment of Employer Shared Responsibility Payments against an applicable large employer for its failure to provide offers of qualifying medical coverage to its full-time employees.

- **Regulations and Penalties for Medicare Secondary Payer Reporting Violations:** The Centers for Medicare and Medicaid Services ("CMS") has proposed regulations for the assessment of monetary penalties against group health plans who fail to comply with Medicare Secondary Payer reporting requirements.

- **Transparency in Coverage Rule:** The IRS, DOL, and HHS have released proposed rules promoting transparency in how group health plans cover certain procedures and benefits.

Important Dates*

April 30:

- Pay final 2019 comprehensive PBGC premium due to the PBGC for plans that filed an earlier estimated variable rate premium in the October 15, 2019 comprehensive filing

May 15:

- Confirm 401(k)/403(b) plan recordkeeper has provided first quarter benefit statements to participants, including fee disclosure information

June 30:

- Process participant ESOP diversification elections that were made by March 31
- Process corrective distributions to "cure" failed ADP/ACP tests for 401(k) plans with eligible automatic contribution arrangements for 2019, to avoid the 10% excise tax

* **NOTE: The IRS has extended some (but not all) compliance deadlines due to the impact of the COVID-19 pandemic. This guidance is updated periodically, so please double-check any compliance deadlines to determine if an extension applies to you.**

I. *Updated Summary of Benefits and Coverage*

The DOL and HHS have released updated templates for the Summary of Benefits and Coverage ("SBCs"), which must be issued by most group health plans. The updated templates along with other materials reflect the Tax Cuts and Jobs Act's elimination of the penalty for violating the ACA's individual mandate. The new SBCs will need to be utilized for plan and policy years beginning on or after January 1, 2021.

The changes include minor formatting changes and the following substantive changes:

- A new coverage calculator: While the use of the new calculator is not mandatory, it was developed to help group health plans and health insurance issuers analyze the estimated out-of-pocket expense that patients can expect to pay under the plan for certain medical scenarios. Group health plans and health insurance issuers have the option to create their own coverage calculators as well.

- Minimum value: "Not Applicable" has been added as a possible answer as to whether the plan meets minimum value standards.

- Minimum essential coverage: The SBC language was updated to remove the individual mandate penalty. It now states that an individual who is eligible for minimum essential coverage ("MEC") may not be eligible for premium tax credits. The SBC also includes the different types of coverages that are considered MEC (*e.g.*, Medicare, Medicaid, TRICARE).

- Coverage examples: The instructions now include guidance on the interaction between the cost-sharing amount and out-of-pocket maximum when applying the permitted rounding rules. Additional categories, such as "Prescription Drugs: Insulin" and "Professional Services: Inpatient" have also been added.

- Uniform glossary: References to the individual mandate have been eliminated from the uniform glossary.

The new SBC template, as well as instructions, can be found here. As a reminder, an SBC must generally be provided to a participant upon initial enrollment, open enrollment, special enrollment and upon request. Employers should work with their carriers, brokers and third party administrators to ensure that the updated SBC templates and related materials are used for plan and policy years beginning in 2021.

II. *District of Columbia Requirements for ACA Reporting in 2020*

The D.C. Office of Tax and Revenue ("OTR") issued Notice 2019-04, which requires that all D.C. residents must have minimal essential health care coverage, have a coverage exemption, or pay a tax penalty for tax years ending on or after December 31, 2019. An individual is considered a D.C. resident if his/her employer withholds wages and pays taxes to D.C. on their behalf **or** has a mailing address in D.C. for any period during the applicable calendar year.

Plan sponsors with at least 50 employees and at least one D.C. resident, as well as health insurers providing minimum essential coverage to D.C. residents during the coverage year, are required to submit coverage reports directly to the OTR by **June 30, 2020**. Applicable entities should electronically file with OTR the same information filed with the IRS, including: (i) 1094-B, *Transmittal of Health Coverage Information Returns*; (ii) 1095-B, *Health Coverage*; (iii) 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*; and (iv) 1095-C, *Employer-Provided Health Insurance Offer and Coverage*. All information must be uploaded through mytax.dc.gov, by setting up an account, with login credentials, and using OTR's recommended layouts and file formats.

Employers with employees in Washington D.C. should work with vendors to set up reporting processes and monitor updates regarding the District's rules and regulations on reporting. Similar reporting obligations have also been imposed on employers who have employees in New Jersey.

III. *No Statute of Limitations for Assessment of Employer Shared Responsibility Payments ("ESRPs")*

Under Internal Revenue Code Section 4980H, an applicable large employer ("ALE") can be penalized for not offering minimum essential coverage to at least 95% of its full-time employees when at least one full-time employee qualifies for a premium tax credit. To ensure compliance with the Affordable Care Act ("ACA"), ALEs must file Forms 1094-C and 1095-C each year with the IRS. The IRS cross-references those forms against the Forms 1040 filed by the employees to determine how many full-time employees received a premium tax credit. The IRS then calculates the potential ESRP liability and sends a Letter 226-J to the ALE, proposing the assessment.

In February 2020, the IRS Office of the Chief Counsel issued a memorandum stating there is no statute of limitations when assessing the ESRP because no tax return contains all the data needed to calculate the ESRP. In light of the IRS' position, it is important for employers to ensure compliance with the ACA's employer shared responsibility requirements and to maintain robust coverage and election records that can be used to demonstrate its compliance if needed.

IV. *Regulations and Penalties for Violations of Medicare Secondary Payer ("MSP") Reporting*

In 2007, Congress enacted MSP reporting requirements designed to prevent Medicare from making primary payments when a group health plan ("GHP") or non-group health plan ("NGHP") is responsible to pay primary, and to identify and recover conditional payments that Medicare did not have responsibility for paying. To accomplish this, Responsible Reporting Entities ("RREs") must report, on a quarterly basis, information related to coverage of Medicare beneficiaries. RREs generally include group health insurers and third party administrators.

In February 2020, CMS issued proposed regulations regarding the civil monetary penalties for failure to comply with the reporting obligations and the guidelines for imposing such penalties. Highlights include the following:

- Notice Process: CMS will engage in an informal "pre-notice" process, allowing the RRE an opportunity to present mitigating evidence before the formal notice being issued. Then, a formal notice of proposed penalty, which contains the reason for the assessment, the amount of the penalty and the appeal rights is issued. The RRE's rights include the ability to: (i) request a hearing with an administrative law judge, (ii) appeal an administrative law judge decision to the HHS appeals board, and (iii) pursue the matter in federal court (subject to jurisdictional considerations, such as amount in controversy thresholds being met).

- Reason for imposing penalties: There are four basic situations in which penalties would be imposed:

  (1) The failure to report Medicare beneficiary records within the required timeframe;

  (2) The quarterly report exceeds error tolerance thresholds established by CMS in any four of eight consecutive reporting periods;

  (3) There are contradictions between data and information received and those submitted in response during the demand letter recovery process; and

  (4) The failure to timely report **if** no good faith was exercised to identify Medicare status.

- Amount of civil monetary penalties assessed: Generally, the amount of the penalty depends on the grounds for imposing the penalty and can also differ depending on whether the plan is a GHP or NGHP. For example, failing to report the information in a timely manner and/or discrepancy in information received can result in a maximum penalty of $365,000 per year regardless of whether a GHP or NGHP is involved. However, penalties for poor quality of data can result in a flat assessment per individual against a GHP, whereas a tiered penalty approach is used if a NGHP is involved.

- Statute of limitations: There is a five-year statute of limitations once CMS identifies the non-compliance.

CMS is currently reviewing public comments. CMS will issue a Final Rule, which will be effective upon publication in the Federal Register.

V. *Transparency in Coverage Rule*

Proposed regulations were released by the IRS, HHS and DOL in response to an Executive Order on Improving Price and Qualify Transparency in American Healthcare to Put Patients First, which aims to increase price transparency in the healthcare sector. The proposed rules would require non-grandfathered group health plans and health insurance issuers to provide an internet-based tool to disclose cost-sharing information in plain language for a covered item or service, including prescription drugs, from a particular provider or providers to participants, beneficiaries, or enrollees, upon request.

The following seven items must be included in the disclosure:

(1) Estimated cost-sharing liability – the amount a participant is responsible for;

(2) Accumulated amounts – the amount of cost-sharing that a participant has incurred at the time the request is made with respect to a deductible or an out-of-pocket limit;

(3) Negotiated rates for in-network providers – the amount that the plan has contractually agreed to pay to an in-network provider for a covered item or service;

(4) Out-of-network allowed amount – the maximum amount that the plan would pay for a covered item or service furnished by an out-of-network provider;

(5) Items and service list for a bundled payment – a list of covered items and services for which cost-sharing information is being disclosed for a bundled payment;

(6) Notice of prerequisites to coverage – notice informing the individual that they may need to satisfy certain medical management techniques (such as a prior authorization or step-therapy) before the item or service would be covered; and

(7) Disclosure notice – which must include the following three disclaimers: (i) that the out-of-network providers may bill for the difference between providers' billed charges and the sum of the amount collected, (ii) that the actual charges for covered items and services may be different from those described in a cost-sharing liability estimate, and (iii) that the estimated cost-sharing liability for a covered item or service is not a guarantee that coverage will be provided.

The cost-sharing information must be disclosed via an internet-based self-service tool and in paper form. Individuals should be able to search the internet-based tool by item, service, in-network provider, and out-of-network provider. The information provided must be accurate and have real-time responses. If an individual requests the information from a group health plan or third-party administrator, the information must be mailed to the requesting party no later than two business days after the request is received. These rules will be effective for plan years beginning on or after one year following the date that the rules are finalized, and will require

employers to work with their carriers, brokers and third party administrators to implement the required disclosures.

If you would like to discuss any of the above developments affecting your health and welfare plans, please contact any member of our Employee Benefits and Executive Compensation Group below.

IslerDare PC

Your workplace, our insight

1945 Old Gallows Road
Suite 650
Vienna, VA 22182
(703) 748-2690

411 East Franklin Street
Suite 203
Richmond, VA
(804) 489-5507

Andrea I. O'Brien
aobrien@islerdare.com

Jeanne Floyd
jfloyd@islerdare.com

Vi D. Nguyen
vnguyen@islerdare.com

Ashley Hedge
ahedge@islerdare.com