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Employee Benefits Update

August 2019

New Developments Regarding Healthcare Plans and Retirement Plans

Executive Summary

- **New Health Care Coverage for Employees and Employers**: On June 13, 2019, the tri-agencies released a new policy, creating two types of health reimbursement arrangements (HRAs): Individual Coverage HRAs and Excepted Benefit HRAs.
- **Electronic Filing of Top-Hat Submissions**: Beginning June 16, 2019, all top-hat submissions must be filed electronically through the EBSA website.
- **Changes to Affordable Care Act (ACA) Section 1557 Rule**: New proposed regulations would eliminate protections introduced in 2016, based on gender identity and termination of pregnancy.
- **Summary Annual Reports (SAR)**: New SAR models for welfare plans and pension plans have been released.
- **Direct Liability for Business Associates**: Several state attorneys received a judgement against a software company for violating HIPAA security standards and failing to safeguard electronic protected health information.
- **Updated List of Preventive Care Benefits for HDHPs**: The IRS expanded the list of services that can be considered preventive health care services under a high-deductible medical plan, and that therefore can be provided before those deductibles are met.
- **2020 Affordability Standards**: The IRS slightly lowered the percentage of household income used to determine whether an employee's share of group health insurance premiums is considered "affordable" under the ACA.

Important Dates

September 16:

- File Form 8928 to report excise taxes for noncompliance with certain group health plan requirements
- Forms 5500 due if calendar-year plans are eligible for an automatic extension (without filing a Form 5558)
- Minimum funding deadline for pension plans

September 30:

- Distribute SAR for calendar-year plans, if 5500 was filed on July 31

October 1:

- Notice of individual HRAs to be provided for calendar year open enrollment effective January 1, 2020

October 14:

- Distribute notice of Medicare Part D

I. *New Health Care Coverage Option*

On June 13, 2019, the United States Departments of Health and Human Services, Labor and Treasury issued a final regulation intended to expand the use of health reimbursement arrangements (HRAs). An HRA is an employer-funded, account-based health plan that reimburses an employee for medical care expenses. The final regulation permits two additional types of HRAs: (i) an individual coverage HRA (ICHRA), and (ii) an excepted benefit HRA (EBHRA).

Individual Coverage HRA (ICHRA): An ICHRA reimburses employees' premiums for major medical insurance purchased in the individual market. The following requirements must be met:

- Employees (and dependents) must be enrolled in major medical insurance purchased on the individual market (i.e., the coverage cannot consist solely of excepted benefits, such as dental or vision).
- Employers cannot offer a traditional group health plan to the same class of employees (*e.g.*, full-time, part-time, etc.) to whom an ICHRA is offered.
- All employees in the same class generally must be offered ICHRAs under the same terms and conditions.
- Employees enrolled in an ICHRA must have an opportunity to opt out and waive future reimbursements from the ICHRA at least once a year.
- Employers must have reasonable procedures to verify that ICHRA participants (and dependents, if applicable) have, or soon will have, individual health insurance for the plan year.

Employers offering ICHRAs must provide a notice with information about the ICHRA at least 90 days before the beginning of the plan year (or no later than the date on which an employee is first eligible to participate if the employee is not eligible at the beginning of the plan year).

Excepted Benefit HRA (EBHRA): EBHRAs allow employers to contribute up to $1,800 per year (as indexed for inflation) to an EBHRA to reimburse an employee for medical care expenses, including "excepted benefit" expenses such as dental and vision expenses, as well as premiums for those excepted benefits and short-term, limited duration insurance, but not premiums for group health plan (other than COBRA coverage), individual health insurance, or Medicare Part B or D coverage.

- EBHRAs must be uniformly available to all similarly situated individuals (e.g. full-time or part-time, geographic locations, etc.) and must be offered in conjunction with a traditional group health plan – although employees are not required to enroll in that traditional group health plan in order to enroll in the EBHRA.

Employers can begin offering ICHRAs (subject to the notice requirement) and EBHRAs during annual open enrollment for coverage and benefits effective January 1, 2020, so these new programs offer additional options for employers to consider during their open enrollment planning for 2020.

II. *Electronic Filing of Top-Hat Submissions*

Top-hat plans, which are unfunded plans that allow a select group of highly-compensated employees to defer compensation, must file a letter with the Department of Labor within 120 days of their original effective date in order to be exempt from the Form 5500 annual reporting requirements. As of June 17, 2019, top-hat plan statements must be filed electronically through the Department of Labor's Employee Benefit Security Administration website (available at dol.gov/agencies/ebsa). Statements sent by mail or personal delivery will no longer be accepted.

III. *Proposed Changes to the Affordable Care Act Section 1557 Nondiscrimination Rule*

Section 1557 of the Affordable Care Act (the "ACA") prohibits health programs or facilities that receive federal funds from discriminating based on race, color, national origin, sex, age, or disability. In 2016, the Department of Health and Human Services ("HHS") issued final regulations defining sex discrimination to include discrimination based on gender identity and termination of pregnancy. Recently, however, the government proposed several changes to the 2016 final regulations, including reducing the number of organizations covered by Section 1557 and eliminating nondiscrimination protections based on gender identity and termination of pregnancy.

HHS is expected to issue final regulations in 2019; until that time, however, the 2016 regulations remain in effect.

IV. *Summary Annual Reports*

The Summary Annual Report (SAR) is a summary of an employer's Form 5500 that must be distributed to plan participants two months after the Form 5500 is due (whether by its regular or extended filing deadline).

A new model SAR notice has been issued by the Department of Labor and can be found here. It should be used for any SARs that you are distributing in 2019, with respect to the 5500s filed for your 2018 plan years.

V. *Recent State Action Involving Direct Liability of Business Associates*

Under HIPAA, a business associate performs functions or activities on behalf of, or provides certain services to, a HIPAA-covered entity. Contractors, third-party administrators for self-funded health plans, service providers, vendors, and health care clearinghouses all can be business associates with access to HIPAA-protected health information.

A group of state attorneys general was recently awarded a consent judgement against a business associate for violating HIPAA security standards and various state consumer-protection and data-security laws, and for failing to adhere to HIPAA's minimum necessary standard, which resulted in a breach of 326,000 client medical records. The company, while not admitting liability, agreed to pay $900,000 to the states and to comply with HIPAA and applicable state laws.

State attorneys general have individually taken action against business associates to enforce HIPAA's privacy and security rules; however, this enforcement action is the first time multiple states have come together to enforce HIPAA.

VI. *IRS Updates List of Preventive Care Benefits*

In order to qualify as a high-deductible health plan (HDHP), which then allows participants (and their employers) to contribute to health savings accounts, a HDHP plan may not pay benefits until a participant's deductible has been met, unless they are expenses for "preventive care". While preventive care generally means care that identifies or prevents illness, injury, or medical conditions—and does not include care for existing illnesses, injuries or medical conditions—the IRS recently expanded its list of preventive care services for HDHPs, recognizing that medical care for certain existing illnesses, injuries or medical conditions qualify as preventive care for someone with that chronic condition. As part of your benefit plan design for 2020 open enrollment, you may wish to take this guidance into account if you offer one or more HDHP options. Under the IRS guidance, the following list of services and items can now be included in the definition of preventive care, and paid before a participant in an HDHP has satisfied his or her deductible:

- Angiotensin Converting Enzyme (ACE) inhibitors;
- Anti-resorptive therapy;
- Beta blockers;
- Blood pressure monitors;
- Inhaled corticosteroids;
- Insulin and other glucose lowering agents;
- Retinopathy screening;
- Peak flow meter;
- Glucometer;
- Hemoglobin A1c testing;
- International Normalized Ratio (INR) testing;
- Low-density Lipoprotein (LDL) testing;
- Selective Serotonin Reuptake Inhibitors (SSRIs); and
- Statins.

VII. *2020 ACA Affordability Rates*

The IRS has released the 2020 contribution percentage that will be used to determine if group health plan coverage is considered "affordable" for purposes of the ACA's employer shared responsibility penalty. For 2020, the percentage of an employee's household income that an employer can require the employee to pay for group health plan coverage is 9.78%, down slightly from 2019's affordability rate of 9.86%. As a result of this change, you may need to adjust your employee premium rates for self-only coverage offered in 2020, in order to minimize any ACA penalties.

If you would like to discuss any of the above topics, please feel free to contact any member of our Employee Benefits group below.

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