



Written by Corrie Cripps

ACA ROUND-UP FOR 2020: ITEMS AFFECTING EMPLOYER-SPONSORED GROUP HEALTH PLANS

During this open enrollment season, plan sponsors of group health plans should be aware of any Affordable Care Act (ACA) changes that may affect the design and administration of their plans.

The case *Texas v. United States*¹ is the ongoing litigation challenging the constitutionality of the ACA. A decision on this case is expected at any time from the Fifth Circuit Court of Appeals (“Fifth Circuit”). Any decision appears likely to be appealed to the Supreme Court. Whether or not the Supreme Court will take the case depends on how the Fifth Circuit rules. If the Supreme Court does not take the case, the Fifth Circuit’s decision will remain the law; however, the agencies will most likely need to issue regulatory guidance on how they interpret the decision.

As of the date of this article, the Trump administration is continuing to enforce the ACA. As such, plans will need to ensure they are maintaining compliance with the ACA provisions. The following is a summary of the recent regulatory actions that will affect self-insured plans in 2020.

ACA CONTRACEPTIVE MANDATE

Update on the Obama-Era Rules

On June 5, 2019, U.S. District Judge Reed O’Conner of the Northern District of Texas issued a nationwide injunction² against the Affordable Care Act’s (ACA’s) contraceptive mandate and its accommodation process, stating the mandate can no longer be enforced against employers who object to contraceptive coverage as it violates the Religious Freedom Restoration Act (RFRA). The injunction applies to all employers and individuals who object to contraceptive coverage based on sincerely held religious beliefs.

The case, *DeOtte v. Aza*³, was filed in October 2018 on the grounds that the plaintiffs (two Christian couples and one business whose owner is a Christian [Braidwood Management Inc.]) are forced to choose between purchasing health insurance that includes contraceptive coverage or not having insurance.

The basis of the claim is having to choose between covering contraceptives under its group health plan, complying with the accommodation process of the contraceptive mandate, or paying a penalty for noncompliance.

The court ruled that requiring employers with religious objections to use the contraceptive mandate’s accommodation violates RFRA, as does requiring individuals to obtain coverage with contraceptives.

This decision will apply to all employers that object to the contraceptive mandate, based on sincerely held religious beliefs, regardless of size or status as a nonprofit or for-profit entity. Since these employers are now exempt from the accommodation process, employees under these employer group health plans will no longer have coverage for some or all contraceptive services.

As for individuals, this decision allows individuals who object to some or all contraceptive services based on sincerely held religious beliefs to “...purchase or

obtain health insurance that excludes coverage or payments for some or all contraceptive services from a health insurance issuer, or from a plan sponsor of a group plan, who is willing to offer a separate benefit package option, or a separate policy, certificate, or contract of insurance that excludes coverage or payments for some or all contraceptive services.”

Based on this injunction, it is not clear if self-funded plans will need to offer a separate plan that does not include contraceptive coverage for employees who are religious objectors.

There is a safe harbor for officials who enforce the contraceptive mandate. Under the safe harbor, the federal government can ask whether an employer or individual that fails to comply with the contraceptive mandate is a sincere religious objector and file notice in court “...if the defendants reasonably and in good faith doubt the sincerity of that employer or individual’s asserted religious objections”. Federal regulators can also enforce the mandate against those who are found by a court to not be sincere religious objectors.

Update on the Trump Administration Rules

There are at least three lawsuits—brought in California, Massachusetts, and Pennsylvania—challenging the Trump administration’s final rules on religious and moral objections to the contraceptive mandate.^{4,5}

Those rules were set to go into effect in January 2019 until they were enjoined by federal district court judges in Pennsylvania and California.

The rulings in Pennsylvania and California do not permanently block the new rules on the contraceptive coverage exemptions; however, the rulings stop the rules from going into effect while legal challenges are pursued.

Those employers who are potentially eligible for the expanded exemptions of the Trump administration's final rules and wish to utilize an exemption in the future will need to closely monitor the latest developments.

OUT-OF-POCKET LIMITS FOR NON-GRANDFATHERED PLANS

2020 Out-of-Pocket Maximums

For non-HDHPs:

The Health and Human Services Department issued a Final Rule on its Notice of Benefit and Payment Parameters for 2020 (2020 NBPP Final Rule).⁶ The ACA 2020 maximum annual limitation on cost-sharing is \$8,150 for individual coverage and \$16,300 cumulative for family coverage. (Note that the ACA's embedded self-only limitation is \$8,150 for family plans).

For HSA-compatible HDHPs:

In Revenue Procedure 2019-25, the Internal Revenue Service (IRS) provided the inflation-adjusted Health Savings Account (HSA) contribution limits effective for calendar year 2020, along with minimum deductible and maximum out-of-pocket expenses for the high-deductible health plans (HDHPs) that HSAs are coupled with.⁷

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For HDHP self-only coverage, the minimum deductible amount cannot be less than \$1,400. The 2020 maximum out-of-pocket expense amount for self-only coverage is \$6,900. For 2020 family coverage, the minimum deductible amount is \$2,800 and the out-of-expense maximum is \$13,800. (Note that the ACA's embedded self-only limitation is \$8,150 for family plans).

Drug Manufacturer Coupons

Per the 2020 NBPP Final Rule, health plans are not required to count drug manufacturer coupons toward the annual limit on cost-sharing when a medically appropriate generic equivalent is available.

On August 26, 2019, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, "the Departments") issued a joint FAQ regarding limitations on cost-sharing under the ACA.⁸ Specifically, the FAQ addresses whether non-grandfathered group health plans must count drug manufacturers' coupons toward the annual cost-sharing/out-of-pocket limits under the ACA.

Per this new FAQ, it came to the attention of the Departments that the drug manufacturer coupon provision of the 2020 NBPP Final Rule could create a conflict with the IRS regulations pertaining to HDHPs. Specifically, Q&A 9 of IRS Notice 2004-50 provides that the provision of drug discounts will not disqualify an individual from being eligible (for the HDHP) if the individual is responsible for paying the costs of the

drugs (considering the discount) until the deductible is met.⁹

This Q&A requires the HDHP to disregard the drug assistance when determining whether the minimum deductible for an HDHP had been satisfied by only allowing amounts actually paid by the individual to be taken into account for that purposes.

The 2020 NBPP Final Rule, layered with the existing IRS Q&A, creates conflicting policy. As a result, the Departments, as stated in this August 2019 FAQ, realize this "ambiguity" and intend to undertake future rulemaking for 2021. In addition, until 2021, the Departments will not initiate an enforcement action if a group excludes the value of drug assistance from the annual limitation on cost sharing, *including in circumstances in which there is no medically appropriate generic available.*

Plans, however, when implementing or utilizing such a provision should be cognizant that this does not conflict with the existing Q&A for HDHPs.

Prior to adopting such a provision, the plan, employer, and all related entities should ensure they understand the impact for the participants and the plan.



NEW (OR MODIFIED) PREVENTIVE CARE RECOMMENDATIONS FOR NON-GRANDFATHERED HEALTH PLANS

The Affordable Care Act's (ACA) preventive services mandate for non-grandfathered plans requires certain preventive services be covered in-network without cost-sharing for plan participants. The ACA uses the following when determining the preventive services that must be covered:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force (USPSTF) recommendations.

2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention (CDC).
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

The final preventive services regulations, issued in July 2015, contain guidelines for when plans must incorporate any modified recommendations.¹⁰

The following are new or modified preventive care recommendations that become effective in 2020:

- 1. Skin Cancer Prevention (Date Issued: March 2018; Best practice is to incorporate by the first day of the plan year on or after January 1, 2020)**

The USPSTF updated its 2012 recommendation on skin cancer prevention. In this updated recommendation, the USPSTF expanded the age range for behavioral counseling interventions to include persons aged 6 months to 24 years with fair skin types (the previous recommendation applied to persons aged 10 to 24 years, based on the evidence available at that time).¹¹

- 2. Screening for Osteoporosis to Prevent Fractures (Date Issued: June 2018; Best practice is to incorporate by the first day of the plan year on or after January 1, 2020)**



The USPSTF recommends osteoporosis screening for postmenopausal women younger than 65 years at increased risk of osteoporosis (created from prior osteoporosis screening mandates, this requirement clarifies the population for screening, introduces reference to menopause, and references clinical risk assessment for determining increased risk).¹²

3. Spinal muscular atrophy screening for newborns (Date Issued: July 2018; Best practice is to incorporate by the first day of the plan year on or after January 1, 2020)

The Uniform Panel of the Discretionary Advisory Committee on Heritable Disorders in Newborns and Children (an HRSA task force) added newborn screening for certain kinds of spinal muscular atrophy.¹³

4. Interventions to Prevent Obesity-Related Morbidity and Mortality in Adults (Date Issued: September 2018; Best practice is to incorporate by the first day of the plan year on or after January 1, 2020)

The USPSTF updated its previous 2012 recommendation statement on screening for obesity in adults. While it is still a “B” recommendation, the USPSTF expanded the description of behavioral counseling interventions. As with the 2012 recommendation, the 2018 recommendation is that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions.¹⁴ The only update to the recommendation is the expansion of the type of behavioral counseling interventions.

5. Screening for Intimate Partner Violence, Elder Abuse, and Abuse of Vulnerable Adults (Date Issued: October 2018; Best practice is to incorporate by the first day of the plan year on or after January 1, 2020)

This USPSTF recommendation incorporates new evidence since 2013 and provides additional information about the types of ongoing support services that appear to be associated with positive outcomes.¹⁵

ACA REPORTING

Both the Employer Shared Responsibility Mandate (“Employer Mandate”) and the Individual Shared Responsibility Mandate (“Individual Mandate”) of the ACA continue to apply. As such, Applicable Large Employers (ALEs) will need to ensure they file the applicable forms for Internal Revenue Code (IRC) §§ 6055 and 6056 reporting in early 2020.

CONCLUSION

For plans and TPAs, being well-informed on regulatory developments is always of the utmost importance. Plan sponsors should review their plan documents as well as their plan administration procedures to ensure they are compliant. ■

Corrie Cripps is a plan drafter/compliance consultant with The Phia Group. She specializes in plan document drafting and review, as well as a myriad of compliance matters, notably including those related to the Affordable Care Act.



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