ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES:

PRACTICAL Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, and Dan Taylor provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte, Dallas and Washington, D.C. law firm. Ashley Gillihan, Carolyn Smith and Dan Taylor are members of the Health Benefits Practice. Answers are provided as *general guidance* on the subjects covered in the question and are *not provided as legal advice* to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

2019 HEALTH BENEFITS YEAR IN REVIEW

As we anxiously anticipate further year-end IRS Guidance (hopefully) increasing the FSA carryover amount, let's pause for a few moments to reflect on the 2019 Health Benefits Developments. While there is still a chance that year-end Congressional activity may result in "surprise billing" or" Cadillac Tax" legislation, the bulk of the Health Benefits activity so far has been regulatory.

HRA Final Rule and Follow-up Guidance on Pay or Play and Non-Discrimination Requirements: The agencies finalized regulations governing individual coverage health reimbursement arrangements (ICHRAs) and excepted benefit health reimbursement arrangements (EBHRAs). Subsequently, the IRS issued a proposed regulation clarifying how ICHRAs would be treated under the IRC 105(h) nondiscrimination requirements and the IRC 4980H employer responsibility requirement.

Under the final rule, if certain requirements are satisfied, an employer may establish an HRA to pay employees' premiums for individual market coverage (other than excepted benefit or short-term coverage) and other unreimbursed medical expenses. These individual coverage HRAs (ICHRAs) are considered minimum essential coverage (MEC) for purposes of the ACA employer penalties. Among other requirements, an employer must not offer a traditional group health plan and an ICHRA to the same class of employees.

The second type of new HRA, the excepted benefit HRA (EBHRA), may be established without integration as otherwise required for ICHRAs. The EBHRA must satisfy four requirements (similar to requirements that apply to excepted benefit FSAs): (1) the maximum annual contribution is $1,800 (indexed, and without regard to any carryovers); (2) the employee must also be offered traditional health insurance from the same employer (but the employee does not have to enroll in that coverage); (3) the employee cannot also be offered a premium reimbursement HRA; and (4) the terms and conditions must be the same for all "similarly situated" classes of employees. See our article in the September and October issues of *The Self-Insurer* for more information.

Extensive Proposed Regulation on Health Plan Transparency: Recently introduced proposed regulations would impose significant new transparency requirements on group health plans (other than account based plans). The deadline for comments is January 27, 2020. The proposal would take effect one year after finalization (i.e., likely some time in 2021).

As proposed, health plans would be required to provide the following information to consumers:

- Estimated cost-sharing liability (consumer's share of the cost of an item or service under the plan or coverage).
- Accumulated cost share amounts (the consumer's accrued deductible or out-of-pocket payment amount).
- Negotiated rate (the in-network provider payment amount).
- Out-of-network allowed amount (the maximum amount a plan will consider when calculating the benefit payment for out of network services).
- Items and services content list (for bundled services, health plans would have to disclose a list of each covered item and service and cost-sharing liability as a bundle).
- Notice of prerequisites to coverage (when consumers request cost-sharing information, health plans must inform them if the item or service is subject to concurrent review, prior authorization, step-therapy, or other medical management requirement).
- A "disclosure notice" (must include an explanation disclosing that out-of-network providers may bill consumers, actual charges may vary from the estimate, and estimated cost-sharing is not a guarantee of coverage).

Health plans would be required to make this information available in two ways: (1) through an Internet-based "self-service tool"; and (2) in paper form by mail upon a consumer's request.

The self-service tool must provide real-time responses, be searchable by billing code or descriptive term, and interact with consumer input to deliver meaningful cost-sharing information depending on any tiering, network status, or other factors.

The departments are considering expanding this definition to include mobile applications. Health plans may provide consumers the option to receive the information through other methods, such as by phone, face-to-face, facsimile, or email.

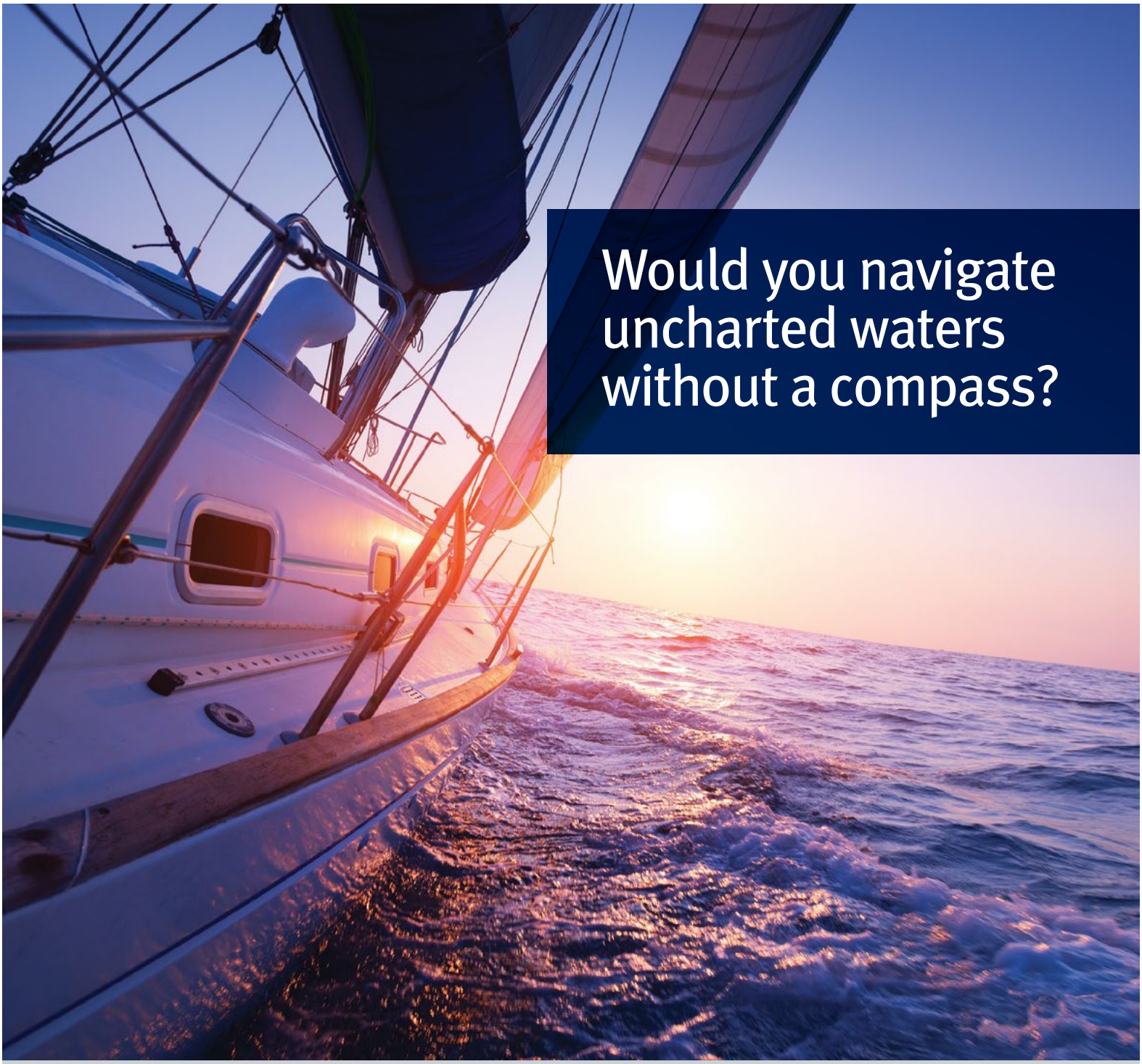
The proposal would also require health plans to publicize in-network provider negotiated rates and data outlining the historical allowed amounts for covered items or services provided by out-of-network providers.

The agencies believe this requirement will "expose price differences" so consumers can judge the reasonableness of provider prices and shop for the best price.

As proposed, these files would have to be *updated monthly*, and the departments are considering requiring more frequent updates, such as within 10 calendar days of the effective date of new rates.

June 24th President Executive Order: President Trump issued an Executive Order on June 24th that required Treasury to address 3 issues:

- The ability of patients to select high-deductible health plans that can be used alongside a health savings account, and that cover low-cost preventive care, before the deductible, for medical care that helps maintain health status for individuals with chronic conditions. See discussion of Notice 2019-45 below.
- The eligibility of expenses related to certain types of arrangements, potentially including direct primary care arrangements and healthcare sharing ministries, as eligible medical expenses under IRC 213(d).
- Guidance to increase the amount of funds that can carry over without penalty at the end of the year for flexible spending arrangements. See related article in this *Flex Reporter.*



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HSAs and Preventive Care: On July 17, 2019, the IRS issued new guidance that makes health savings accounts (HSAs) more user-friendly by allowing a high deductible health plan (HDHP) to cover certain treatments for chronic conditions before the plan's deductible is satisfied.

The IRS had been considering issues relating to preventive care for HSA purposes for some time.

IRS Notice 2019-45 was released less than 30 days after the President signed an Executive Order directing the Treasury and IRS to issue guidance on the issue.

Notice 2019-45 provides some helpful clarification as to the scope of preventive services that may be provided under an HDHP for persons with chronic conditions.

Employers who offer HDHPs/HSAs or are considering doing so should review their plans with the new guidance in mind and consult their advisors as to any design changes.

In some cases health plans had previously adopted a broader list of preventive care expenses that is otherwise reflected in Notice 2019-45 (and the prior guidance from IRS regarding preventive care).

As for possible future guidance, hopefully the IRS will continue to look at these issues and provide updates more frequently than the 5 to 10-year timeframe mentioned in the Notice.

The need to appropriately define the scope of permitted preventive care services remains an on-going issue, as HSAs expand, more individuals need to manage chronic illnesses, and there are continued improvements in medical care. See the November edition of *The Self-Insurer* for our prior article on this issue.

Agencies Obtain Criminal Conviction in Double Dip Tax Scheme: A recent federal-state criminal enforcement action demonstrates the continued commitment of the Department of Labor (DOL) and other federal agencies in combating fraudulent tax avoidance schemes involving health benefit arrangements. The recent case publicized by the DOL involves a version of what is commonly referred to as the classic "double dip".[1]

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. See our article in the August issue of *The Self-Insurer* for more information.

Invalidated DOL Fiduciary Rule Still on DOL Business Plan: The DOL's far-reaching investment fiduciary rule would have imposed significant new disclosure and approval burdens on entities that receive investment-related compensation from covered plans, including HSAs.

The Fifth Circuit declared the DOL rule invalid, and the DOL quickly issued a non-enforcement bulletin. See DOL EBSA Field Assistance Bulletin 2018-2 (May, 2018).

While an updated fiduciary rule has been on the DOL Business Plan, nothing has been released yet. Entities that might be considered brokers under SEC rules may be impacted by a similar regulatory regime finalized by the SEC.

DOL Electronic Disclosure Rule: DOL introduced a revamped electronic disclosure rule under ERISA. While the new rule significantly pushes the electronic communication ball forward for retirement plans, it is not applicable to health and welfare plans (including FSAs and HRAs). Nonetheless, we expect similar changes coming down the pike for health and welfare plans (perhaps in 2020).

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FOR QUICK REFERENCE:
2020 COST-OF-LIVING ADJUSTMENTS FOR POPULAR BENEFITS

BENEFIT	2020	2019
HSA contribution max (including employee and employer contributions)	$3,550 ($7,100 family)	$3,500 ($7,000 family)
HSA additional catch-up contributions	$1,000 (this is not indexed)	Same
HDHP annual deductible minimum	$1,400 ($2,800 family)	$1,350 ($2,700 family)
Limit on HDHP OOP expenses	$6,900 ($13,800 family)	$6,750 ($13,500 family)
Health FSA salary reduction max	$2,750	$2,700
QSEHRA max reimbursement	$5,250 ($10,600 family)	$5,150 ($10,450 family)
Transit and parking benefits	$270	$265
401(k) employee elective deferral max	$19,500 (Catch-up contributions $6,500)	$19,000 (Catch-up limit unchanged)
Highly compensated employee	$130,000 (applies for 2021 plan year under look-back rule)	$125,000 (applies for 2020 plan year under look-back rule)
Key employee	$185,000	$180,000

2019 ADJUSTED CIVIL PENALTIES UNDER ERISA (HIGHLIGHTS)

Violation	2019 per day penalty	2018 per day penalty
Failing to File Form 5500	$2194	$2140
Failure to provide CHIPRA notice	$117	$114
Failure to comply with GINA	$117	$114
Failure to provide SBC	$1156	$1128

Is there more to come?

As this goes to press, the year isn't quite done. Federal agencies are still at work and the Fifth Circuit has yet to render its decision on appeal from a District Court decision last December challenging the Constitutionality of the ACA.

2020 looks to once again be an exciting year. Key late breaking December developments will be in the March *Flex Reporter* in the New Year! ■

References

1 See, DOL press release https://www.dol.gov/newsroom/releases/ebsa/ebsa20190619. The facts and background of the case are drawn from this press release.