Subject: 1) ACA – A Year in Review; 2) Women's Preventive Services Update; 3) Form 1095 Benefit Statement Issuance Date Delayed; and 4) Year-end Reminders
Date: December 17, 2018

The Affordable Care Act is akin to the "Energizer Bunny" – no matter what is thrown at it, it keeps on going.

In 2017, the Congress made multiple attempts to repeal, replace, or repeal and replace the law, to no avail. The attempts in 2018 to modify the Affordable Care Act (ACA) were more indirect. Litigation challenging and rescinding various aspects of the ACA continues to reign.

Spoiler Alert: On December 14, 2018, Judge Reed O'Connor of the Fifth Circuit Court of Appeals opined that the individual mandate, in the absence of the tax repealed by the Tax Cuts and Jobs Act, is unconstitutional; and since it is a cornerstone of the ACA, then the entire ACA must fall. This late breaking decision will be appealed and likely be decided by the Supreme Court. In the meantime, the ACA remains in force.

In this *Health Reform Bulletin*, we will look at the issues being considered, and contemplate where we might be going. Beyond these ruminations for the year, this edition also highlights recent pronouncements relating to the women's preventive services mandate, and an extension of the Form 1095 disclosure statements. We've also included some year-end reminders to ensure on-going compliance with the ACA, since it remains the law of the land.

The Affordable Care Act – A Year in Review

The Individual Shared Responsibility Matter

Under the ACA, beginning in 2014, virtually all Americans are required to maintain a minimum level of coverage, called minimum essential coverage (MEC), or be liable for a shared responsibility tax. However, the Tax Cuts and Jobs Act reduced the penalty tax to zero for tax years beginning on January 1, 2019, but left in place the requirement to maintain MEC.

In February, 2018, a coalition of 20 State Attorneys General from primarily Republican states led by Texas Attorney General Ken Paxton and Wisconsin Attorney General Brad Schimel filed a lawsuit with the U.S. District Court for the Northern District of Texas [*Texas v. U.S.*, 4:18-cv-001 67, U.S. District Court, Northern District of Texas (Fort Worth)] arguing that repeal of the individual tax should cause the entire ACA to fall.

In April, a coalition of 16 Attorneys General from primarily Democratic states led by California Attorney General Xavier Becerra filed an action to intervene in the lawsuit. A month later, the judge of the Texas Court granted intervention in the matter. The 20-coalition group who initiated the action sought a preliminary injunction to suspend the law while the case winds its way through the Court. In response, the Democratic coalition of State Attorneys General filed a motion in opposition to a preliminary injunction seeking to ensure all aspects of ACA remain in force while court proceedings are carried out. Oral arguments requesting a preliminary injunction in the matter of Texas v. United States were heard on September 5, 2018. As mentioned above in the *Spoiler Alert*, Judge O'Connor rendered his **opinion** on December 14, 2018.

On September 13, 2018, the Maryland Attorney General Brian E. Frosh filed a lawsuit in the U.S. District Court for the District of Maryland against the Departments of Health and Human Services, Treasury and Justice, seeking a declaratory judgment affirming the constitutionality of the ACA. AG Frosh argues that the benefits derived from the ACA have improved access to health care for all Marylanders by way of guaranteed access and allowing expansion of Medicaid, as well as reducing overall costs including uncompensated care costs due to community rating and cost sharing restrictions.

Cost Sharing Challenges

The ACA provides that certain low income individuals are entitled to cost share payments for certain out-of-pocket expenses. The cost-sharing reductions are monies paid to insurers to help offset co-payments and other out-of-pocket costs for certain lower income individuals whose income falls below 250% of the federal poverty level and who obtain their coverage through the marketplace.

On October 12, 2017, the Departments of Health and Human Services and Treasury, by way of a Department of Justice opinion, announced that the cost sharing reductions authorized under the ACA would cease immediately. Insurers continue to be obligated to provide these cost sharing reductions to eligible individuals but would not receive reimbursement from the federal government.

To this end, insurers have, and will, continue to incorporate this additional cost into premium. In effect, this ultimately increases the premium for coverage. For those obtaining coverage through the marketplace and receiving a premium subsidy, the increased premium will impact the amount of the federal subsidies requirement. The premium subsidy is not impacted with the rollback of the cost sharing requirements. Those not entitled to premium subsidy will feel the primary burden of the premium increase.

In the meantime, because insurers are still required by law to offer cost share reductions and absorb the costs even without government reimbursement, they were allowed to cover the loss by increasing premium on silver plans ("silver-loading") offered through the marketplaces beginning in 2018. Several states continue to bring forth challenges based on the termination of cost sharing subsidies.

A ruling by Judge Elaine D. Kaplan of the Court of Federal Claims in Montana on September 4, 2018 determined that the law does clearly and unambiguously require cost sharing payments be made pursuant to the ACA, notwithstanding Congress' failure to appropriate them; therefore, insurers are entitled to payment of cost sharing amounts.

Several actions brought by insurers, including a class action lawsuit led by Common Ground Healthcare Cooperative, are seeking reimbursements from the government over the termination of cost sharing reduction payments.

The Executive Order

An **Executive Order** issued on October 12, 2017 directed the ACA's tri-governing agencies (Departments of Health and Human Services, Labor and Treasury) to address three methods to expand health coverage: 1) formation of association health plans, 2) expand short-term, limited-duration insurance, and 3) expand the rules to allow individual premium to be reimbursed through health reimbursement arrangements (HRAs). Thus far, these agencies have fulfilled their directives by issuing blueprints for expanding all three proposals, as follows.

- *Association Health Plans*

  The Department of Labor (DOL) released finalized rules and standards for establishing association health plans (AHP) on June 21, 2018. The overall intent of these rules is to allow small employers and individuals to join together to purchase health coverage without many of the regulatory requirements otherwise imposed on small employers by the ACA. For a more detailed summary of these rules, please see our *Health Reform Bulletin 139*.

  There are a number of legal challenges being raised to these rules. Specifically, a dozen state attorneys generals have filed a lawsuit in the U.S. District Court for the District of Columbia on July 26, 2018 against the DOL challenging the formation of AHPs, based on premise that regulations circumvent requirements of ERISA which requires a commonality of interest standard.

In addition, some states have begun or are considering enacting laws limiting the formation of AHPs, while others setting up the regulatory framework to establish them.

There are also concerns that have plagued AHPs historically, e.g., misdeeds by the plan, or its sponsor or administrator, could cause a rise in fraudulent entities, leaving people with unpaid claims.

Further, the advent of these rules could push the healthier groups out of the small employer market into AHPs. Another concern is whether the plan designs offered by AHP would be less comprehensive than plans offered through the small employer insurance market, thus, leaving people with minimalist coverage, albeit perhaps, at a lower cost.

- *Short-term Limited Duration Policies*

Under the ACA, short-term limited duration insurance policies are limited to a period of no more than three months. To achieve the goal set forth in the Executive Order, regulations were issued on August 3, 2018 expanding the duration of these policies from three months to up to 364 days, with the ability to renew, not to exceed 36 months from the origination date. See our *Health Reform Bulletin 140* for a summary of these rules.

Notably, these short-term limited duration policies do not qualify as minimum essential coverage. Further, these policies are not required to comply with the market provisions such as limitation on preexisting condition exclusions, providing maternity and mental health benefits, the guaranteed issue and guaranteed renewal requirements, among others.

Proponents to these regulations believe that this change would allow a cost-effective option for individuals. Opponents to this type of plan design believe they will diminish the risk pool, leaving only high risk claims individuals in the ACA marketplace.

States can regulate the availability and scope of these policies; for example, a state could provide that a short-term policy is limited to 90 days. Several states have recently enacted laws to limit the duration of these policies to three months, as well as prohibit renewals or extensions.

In addition, litigation relating to these types of policies has begun. On September 14, 2018, a coalition of consumer advocates and safety net health plans sued the tri-governing agencies based on the fact that these types of plans do not have to comply with the ACA's market reforms, i.e., individuals could be subject to preexisting condition exclusions, premiums based on health status, limited benefit coverage, as well as the risk of rescission of coverage.

- *Expansion of Health Reimbursement Arrangements (HRAs)*

Pursuant to the third prong of the Executive Order, the tri-governing agencies published **proposed regulations** on October 29, 2018. Importantly, these regulations are being issued as non-reliant proposed regulations, i.e., these regulations cannot be relied upon at this time. The comment period for these regulations closes December 28, 2018, after which, the agencies will develop final regulations. At the earliest, if these regulations are finalized, they are expected to take effect for plan years beginning on or after January 1, 2020.

In a nutshell, the proposed regulations allow two additional types of HRAs. One type of HRA would allow integration with an individual health policy. Under current law, an HRA can only be integrated with a comprehensive group health plan in order to avoid the market provisions of the ACA. The other type of HRA would allow an excepted benefit HRA with a limited dollar amount. Following is a brief summary of these two types of HRAs.

Individual-Integrated HRA. Under this design, an employer can integrate an HRA with individual health coverage if certain conditions are met:

1. *Enrollment in individual coverage.* To participate in the HRA, the individual must actually enroll in individual coverage for each month covered by the HRA. Individual coverage providing only excepted-benefits would not qualify for this purpose. The HRA must also provide that, subject to applicable

COBRA or other continuation of coverage requirements, if the individual health coverage terminates, the individual cannot then seek reimbursement under the HRA for claims incurred once that coverage terminates. Further, if the HRA-participant or his/her dependent loses individual coverage, then the individual would forfeit the HRA. Individuals participating in this type of HRA would be ineligible for premium assistance that might otherwise be available.

2. *No traditional group coverage allowed.* A plan sponsor who offers an HRA integrated with individual coverage to a class of employees cannot also offer traditional group health plan coverage to the same class of employees. Thus, there can be no choice between an HRA integrated with individual coverage and a traditional group plan.
3. *Same terms and conditions*. The HRA integrated with individual coverage must be offered on the same terms with regard to the amount and conditions to all participants within a class. Notably, the regulations allow age-based adjustments to the maximum amount of reimbursement, as well as adjustments if the participant adds additional dependents.
4. *Opt-out*. The HRA must allow individuals to opt-out and waive future reimbursements from the HRA at least annually. Upon termination of employment, the remaining amounts in the HRA are forfeited, or the participant is permitted to permanently opt-out of and waive future reimbursements from the HRA.

Excepted-Benefit HRA. These regulations would allow a limited purpose type of HRA to be offered to a class of employees who are offered other comprehensive group health coverage. The HRA, in this instance, could be used to reimburse up to $1,800 per year (subject to inflationary indexing) for excepted benefits such as dental and vision.

No dual HRA coverage. If these rules are finalized in their current form, no employee is eligible for both an excepted HRA and an individual-integrated HRA.

Impact on ACA's Employer Shared Responsibility Provision. The proposed HRA rules indicate future rulemaking for employers subject to the ACA's employer shared responsibility (ESR) requirement that would allow a safe harbor arrangement; thus, protecting an applicable large employer adopting this type of HRA from the risk of ESR penalties. The government continues to look for ways (see IRS Notice 2018-88) to ensure that an individual-integrated HRA could be designed to allow an employer who is subject to the ESR requirement avoid the risk of penalty by offering adequate and affordable coverage with this type of HRA. Further, the government is contemplating ways in which an individual-integrated HRA could satisfy the IRC Section 105(h) discrimination rules, currently applicable to self-funded plans.

As mentioned at the beginning of this HRA discussion, these are not reliant regulations, therefore, no action can be taken based on these regulations at this time. The current law prohibiting employers from contributing to individual premium, other than through a qualified small employer HRA (QSEHRA) or retiree-only HRA, still apply. It should also be noted that these types of proposed HRAs could be impacted by on-going ACA related litigation mentioned above; in particular, the *Texas v. United States* matter, challenging the constitutionality of the individual mandate. I suspect there will be many comments submitted on these regulations, and they are likely to evolve in the months to come. HRAs will certainly be a topic for further consideration in 2019.

Expansion of State Waiver Process

Under current law, states can apply for a waiver from certain provisions of the ACA by seeking what is known as a Section 1332 Innovation Waiver from the federal government. This type of waiver allows a state to pursue alternative approaches for coverage in the individual and small group markets, among other goals. Recently, the government **announced** the establishment of "State Relief and Empowerment Waivers". This type of waiver is intended to expand opportunities to states, and provide more flexibility in their design of providing health benefits to low income individuals.

Women's Preventive Services Update

In October 2017, the governing agencies issued two sets of interim final regulations that significantly broaden the entities entitled to receive an accommodation, or the exemption, from providing certain women's health preventive services, specifically, coverage for contraceptive services (see *Health Reform Bulletin* 133). One set

of rules provides that virtually any non-government plan, including one sponsored by closely-held and publicly traded entity, private entities, as well as institutions of higher education and private universities offering student health coverage, can either choose the accommodation, i.e., the insurer or third party administrator (TPA) would provide the services at no cost to their population for some or all of the contraceptive services, or choose to be exempt altogether from providing some or all contraceptive services. The second set of rules provides an accommodation or exemption for a slightly narrower group of entities, specifically, all non-government, non-publicly traded entities based on a moral opposition to providing contraceptive services.

On November 15, 2018, the agencies issued final regulations on this matter, which take effect on January 14, 2019. In essence, the final rules mirror the interim final regulations in that the **religious** and **moral** exemption to contraceptive services mandate is available to all non-government entities; an exemption based on moral convictions is available to all entities except government and publicly traded entities. Further, the optional accommodation process for seeking an exemption from the mandate continues to be made available.

Form 1095 Benefit Statement Issuance Date Delayed

On November 29, 2018, the IRS issued guidance (**Notice 2018-94**) announcing an extension for providing the 2018 Form 1095-B and Form 1095-C disclosure statements to individuals; these statements are generally due by January 31st following the reporting year. Thus, the due date for furnishing benefit statements (Form 1095-B and Form 1095-C) to individuals has been extended from January 31, 2019 to March 4, 2019. Due to this extension, there will be no further 30-day automatic extension available. Similar to prior disclosure delays issued by the IRS, the guidance provides that taxpayers can file their personal income tax return without having to attach the relevant Form 1095 to their tax returns.

As background, the Forms **1094** and **1095** are used to satisfy the IRC Section 6055 and 6056 reporting requirements (the 2018 forms are discussed in our *Health Reform Bulletin 141*). The Form 1094-B and 1095 B-series is used for reporting minimum essential coverage (MEC) by insurers and sponsors of self-funded plans. The Form 1094-C and 1095-C series is used for reporting employer provided coverage by an applicable large employer subject to the Affordable Care Act's shared responsibility requirement.

Important to note that the filing due dates of the 2018 Forms 1094-B and 1095-B, and the 2018 Forms 1094-C and 1095-C reports to the IRS have not been extended. These reports must be submitted to the IRS no later than February 28, 2019; or by April 1, 2019, if filing electronically. An automatic 30-day extension of time to file the 1094/1095 forms remains available by submitting the Form 8809 with the IRS on or before the filing due date.

In addition, this guidance reinstates the good faith compliance standard that was allowed in prior years. This means that the potential IRS-imposed penalties for failure to comply with the reporting and disclosure requirements could be reduced or waived, even if incorrect or incomplete information is reported on the return or statement, such as missing and inaccurate taxpayer identification numbers and dates of birth, as long as the responsible reporting entity makes a good faith effort to complete the required forms accurately and timely.

Year-end Reminders

- ❑ **Preventive Health Services**

  Prior to the beginning of each plan year, a group health plan sponsor or administrator should review its coverage for preventive services to determine whether any additional benefits need be offered. For insured plans, generally, the insurer manages this process.

  As background, the Affordable Care Act requires health plans to cover certain preventive services, without imposing any cost-sharing requirements (co-pay, co-insurance, or deductible), when such services are delivered by in-network providers. The types of covered preventive services, some of which are recommended by the U. S. Preventive Services Task Force (USPSTF), are updated periodically. Generally, once the USPSTF approves a particular recommendation, the service would become applicable as of the first plan year beginning one year following issuance of the recommendation. The USPSTF website provides a list of its recommended A and B preventive services by **date** and **alphabetically**. Further, a complete list of ACA-required preventive services can be accessed from the **Healthcare.gov website**.

❑ Employer Shared Responsibility Provisions

- ***Applicability.*** For purposes of the ACA's employer shared responsibility requirement as well as the reporting and disclosure requirements, applicable large employer (ALE) status is determined each calendar year, based on the average size of the employer's workforce during the prior year. Thus, if you averaged at least 50 full-time employees, including full-time equivalent employees, during 2017, you are most likely an ALE for 2019 and are subject to the reporting and disclosure requirements due in early 2019.
- ***Affordability Standard.*** For purposes of determining affordability, coverage under an employer-sponsored plan is deemed affordable if the employee's required contribution to the plan does not exceed 9.86% (indexed for 2019; 9.56% in 2018) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.
- ***Increase in Excise Tax Penalties.*** The chart below reflects the amount of penalties for purposes of calculating the 'no coverage' excise tax pursuant to Code Section 4980H(a), and the 'inadequate or unaffordable' excise tax pursuant to Code Section 4980H(b) for 2017 and 2018, as well as the estimated amounts for 2019. These are the excise taxes that could apply if an applicable large employer is found not to have offered health coverage to a full-time employee.

'No Coverage' Excise Tax IRC § 4980H(a)		'Inadequate or Unaffordable' Excise Tax IRC § 4980H(b)	
2017	$2,260	2017	$3,390
2018	$2,320	2018	$3,480
2019 (estimated)	*$2,500*	*2019 (estimated)*	*$3,750*

- ***Reporting and Disclosure Obligations.*** The Forms **1094** and **1095** are used to satisfy the IRC Section 6055 and 6056 reporting requirements. The Form 1094-B and 1095 B-series is used for reporting minimum essential coverage (MEC) by insurers and sponsors of self-funded plans. The Form 1094-C and 1095-C series is used for reporting employer provided coverage by an applicable large employer subject to the ACA's shared responsibility requirement.
  - ✓ Forms 1094 and 1095 must be filed with the IRS by February 28, 2019 (paper filings) or, E-file by April 1, 2019.
  - ✓ As mentioned above, the deadline for furnishing the Form 1095 to individuals listed in Forms 1094 and 1095 has been extended from January 31, 2019 to March 4, 2019.

❑ **Small Business Tax Credit (SBTC).** Small businesses and tax-exempt employers who provide health care coverage to their employees under a qualified health care arrangement are entitled to a tax credit, known as the small business tax credit (SBTC). To be eligible for the SBTC, the employer must employ fewer than 25 full-time equivalent employees, whose average annual wages are less than $54,200 (indexed for 2019; the wage ceiling in 2018 is $53,200). The tax credit phases out for eligible small employers when the number of its full-time employees (FTEs) exceeds 10; or, when the average annual wages for the FTEs exceeds $27,100 in the 2019 tax year (the phase-out wage limit in 2018 is $26,600). As a reminder, only qualified health plan coverage purchased through a SHOP marketplace is available for the tax credit, and only for a 2-consecutive year period.

For purposes of calculating the SBTC, the Form 8941 is filed annually on the employer's tax return as a general business credit; tax exempt entities would file the Form 8941 with its Form 990-T. The IRS has released the 2018 edition of the **Form 8941**, together with **instructions**, for purposes of calculating the small business tax credit.

❑ Additional ACA-related Fees

Patient-Centered Outcomes Research Institute (PCORI) Fees. For policy and plan years ending between October 1, 2017 and September 30, 2018, the PCORI fee was $2.39. The fee increases to $2.45 for policy and plan years ending between October 1, 2018 and September 30, 2019. The PCORI fees are paid annually via IRS Form 720 (generally due July 31st of each year). Under current law, the PCORI fee will no longer be assessed for policy/plan years ending on or after October 1, 2019.

Moratorium on Certain ACA Fees. As a reminder, a short-term government funding law enacted in January of this year placed moratoriums on three ACA-related fees (see *Health Reform Bulletin* 137):

- Code Section 4980I, popularly known as the **Cadillac tax** that would be assessed on the amount paid for high cost employer-sponsored health insurance coverage exceeding certain threshold levels ($10,200 for individuals; $27,500 for family, subject to indexing) which was to take effect in 2020 has been suspended until 2022.
- A one-year moratorium applies for the 2019 tax year on the **annual fee** required to be paid by 'covered entities' (insurers) who engage in providing health insurance for U.S. health risks. This fee had been suspended for the 2017 year, was reinstated for the 2018 year, and suspended again for the 2019 year.
- A two-year moratorium applies to the 2.3% **medical device excise tax** for 2018 and 2019.

❑ ACA Cost Share Restrictions

The chart below reflects the 2019 and 2018 inflationary adjustments applicable to out-of-pocket (OOP) limits including deductibles, co-insurance and co-payments in ACA plans. These cost-share restrictions apply to insured plans offered via the marketplace, and insured and self-funded plans offered outside marketplace. These amounts differ from the OOP limits applicable to high deductible health plans used in conjunction with a health savings account (HSA).

	2019		*2018*	
	SELF-ONLY	FAMILY	SELF-ONLY	FAMILY
ACA Plans - Out-of-Pocket (OOP) Limits	$7,900	$15,800	$7,350	$14,700
Health Savings Accounts	INDIVIDUAL	FAMILY	INDIVIDUAL	FAMILY
HDHP Annual Deductible	$1,350	$2,700	$1,350	$2,700
HDHP Annual Out-of-Pocket Limit	$6,750	$13,500	$6,650	$13,300
Contribution Limit	$3,500	$7,000	$3,450	$6,900

ACA-required Reporting Reminders

Form	*To Whom*	*Due Date*
Form W-2. ACA-required reporting includes: ◆ Aggregate cost of health coverage (Box 12, using Code DD). *Note, employers filing <250 Form W-2s per year remain exempt from reporting the aggregate cost of health coverage on the Form W-2 until future IRS guidance is issued.* ◆ Total amount of permitted benefits received under a qualified small employer health reimbursement arrangement (QSEHRA) (Box 12 - Code FF) ◆ Additional Medicare tax withholding on earnings exceeding $200,000 per calendar year (Box 6)	Internal Revenue Service (IRS) http://www.irs.gov/ Form W-2 Instructions (2018)	January 31, 2018
Form 720 for purposes of Patient Centered Outcome Research (PCOR) fee	IRS	July 31st of each year

Additional ACA-Related Disclosure Reminders

Note: This is not an exhaustive list of ACA-required disclosures. For a more descriptive list of notice obligations relating to the ACA and other welfare benefit plans, ask your CBIZ representative for a Chart of Notice Obligations.

Form	*To Whom*	*Due Date*
Summary of Benefits and Coverage (SBC) *Note: SBC template available from Department of Labor (DOL) and CMS Center for Consumer Information & Insurance Oversight (CCIIO)*	All plan participants	From Plan Sponsor to Plan Participants: 1. Upon application 2. By the first day of coverage 3. Within 90 days of enrollment by special enrollees 4. Upon contract renewal 5. Upon request
Advanced 60-day Notice of Material Change in Benefits	All plan participants	No later than 60 days prior to any material change in any terms of plan affecting Summary of Benefits and Coverage (SBC) content not reflected in the most recently-provided SBC (other than in connection with renewal or reissuance of coverage)
Notice of Marketplace Options ◆ Model notice for use by employers **who offer coverage** to some or all employees: ▪ English (**pdf** or **word**) ▪ Spanish (**pdf** or **word**) ◆ Model notice for employers who **do not offer health coverage:** ▪ English (**pdf** or **word)** ▪ Spanish (**pdf** or **word**)	All new hires including full-time and part-time employees, without regard to eligibility status for the health plan	Within 14 days of date of hire

Increased Penalties for Certain Compliance Violations

Federal government agencies who enforce the ACA, including the Departments of Labor, Treasury and Health and Human Services, have authority to adjust civil penalties attributable to compliance failures. As a general rule, the DOL announces its respective adjusted penalties in January of each year; thus, at the time of this writing, the 2019 amounts have not been announced yet, and designated "to be determined"(TBD) below.

	2019 Penalty Amount	*2018 Penalty Amount*
Failure to provide Summary of Benefits and Coverage	TBD *(minimum of 2018 amount)*	Up to $1,128 per failure
Failure to file a correct information return *(Example: Form 1094/1095 and W-2)*	$270 per return (total penalty cap of $3,339,000 per calendar year)	$270 per return (total penalty cap of $3,275,500 per calendar year)
Failure to provide correct payee statement *(Example: Forms 1094/1095 and W-2)*	$270 per statement (total penalty cap of $3,339,000 per calendar year)	$270 per statement (total penalty cap of $3,275,500 per calendar year)