Subject: **1) Status of ACA Litigation; 2) Murky Future of AHPs; 3) Benefit and Payment Parameters for 2020; and 4) Extended Transition Period for ACA Compliant Policies**
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Status of ACA Litigation

Litigation challenging and rescinding various aspects of the Affordable Care Act (ACA) continues to reign. Last December, Judge Reed O'Connor of the Fifth Circuit Court of Appeals opined that the individual mandate, in the absence of the tax repealed by the Tax Cuts and Jobs Act, is unconstitutional; and since it is a cornerstone of the ACA, then the entire ACA must fall (see our prior CBIZ Health Reform Bulletin 142). Briefs to appeal the Court's ruling were submitted on May 1, 2019 by a collective group of State Attorneys General, as well as individuals. Of particular note, the Department of Justice (DOJ) also filed its brief stating that it would no longer defend any aspects of the law whereas previously, the DOJ indicated it would defend certain aspects of the law. Oral arguments on the matter is expected to begin the week of July 8, 2019.

Meanwhile, the law continues to be in full force and effect.

Murky Future of Association Health Plans

The future of formation and operation of association health plans is in a state of quagmire. Last year, the Department of Labor (DOL) released rules to permit formation of an amplified version of association health plans. For an overview of these rules, see our CBIZ Health Reform Bulletin 139 (6/22/18) and the update contained in HRB 142 (12/14/18). While newly formed association health plans have been established pursuant to the amplified rules, there are a number of legal challenges being raised.

As background, generally, ERISA applies to single employer welfare benefit plans. A single employer includes a group of commonly controlled entities, as defined in IRC Section 414. When two or more unrelated employers participate in a single health benefit plan, a multiple employer welfare arrangement (MEWA) exists. In this instance, ERISA applies at the individual employer level unless the MEWA qualifies as a bona fide association. To qualify as a bona fide association, two requirements must be satisfied; a commonality of interest requirement, and a control test, as follows:

1. The *commonality of interest* requirement provides that the entity maintaining the bona fide association and the participating employers, must be tied by a common economic or representational interest beyond simply the provision of benefits. This is a facts-and-circumstances test; some of the factors considered in determining the commonality of interest test are:
    - How does the bona fide association solicit members?
    - Who is entitled to participate? Who actually participates?
    - How is the bona fide association formed?
    - What is the bona fide association's purpose?
    - What is the relationship of the participating members beyond the bona fide association membership?
2. The *control test* requires that the individual employer-members have the right to control and direct the activities of the plan, i.e., the bona fide association cannot exist for the primary purpose of offering health coverage.

If these two tests are not satisfied, then ERISA applies at the individual employer level. This means that each participating employer-member is responsible for its own 5500 requirement, its own disclosure requirements, such as plan documentation, summary plan descriptions, summary of material modifications, HIPAA compliance documents, compliance with the ACA, and so forth. The participating employer-members could appoint the association as plan administrator, which would make the association responsible for these disclosures. Conversely, if ERISA applies at the association level, then the association is responsible for these disclosures.

Amplified Association Health Plans

The regulations issued last summer expand the current criteria for establishing a bona fide association plan (referred to herein as "amplified AHP") wherein ERISA would apply at the association level. These rules are intended to make it easier to satisfy the commonality of interest test for participating employers by limiting the standards to either a common geographic area or by common industries. Further, the regulations relax the control requirement test by indicating that the primary purpose of the association can be to provide group health benefits. Self-employed individuals are able to participate in these types of amplified AHPs even if the self-employed individual employs no employees.

A group or association of employers can establish an amplified AHP as long as it meets the following requirements:

1. The primary purpose of the group or association is formed for the purpose of offering and providing health coverage to its employer-members and their employees. While the primary purpose of an amplified AHP can be to offer employer-members health coverage, it must also have at least one *substantial business purpose* unrelated to offering and providing health coverage or other employee benefits, such as promoting common business or economic interest in a given trade or employer community. In addition, employer-members must meet a *commonality of interest standard*. This means that the employer-members be:
    - In the same trade, industry, line of business or profession; or
    - Each employer-member has a principal place of business in the same state or metropolitan area, even if it crosses state-lines, such as in the Washington D.C. or Kansas City metropolitan areas.
2. The functions and activities of the group or association, as well as the plan itself, is controlled by its participating employer-members. For this purpose, "control" is determined by a facts and circumstances test.

Legal Challenges

Following release of the DOL rules, 11 states and the District of Columbia challenged the authority of these amplified AHP regulations in *State of New York et al. v. United States Department of Labor et al* (Civ. Action 18-1747, D.C. D.C]). On March 28, 2019, the U. S. District Court for the District of Columbia ruled on the matter.

First, the Court found that the DOL exceeded its authority in the broadened definition of "association". Of particular concern to the Court is the lack of any significant commonality of interest standard as required by ERISA. As noted above, amplified AHPs can be established specifically for the purpose of providing health coverage, whereas ERISA requires bona fide association health plans to exist independent of the provision of health care. Further, the Court took exception with the new rules permitting self-employed individuals to participate in an amplified AHP because, by its very nature, ERISA is intended to specifically protect employee-participants.

The Court deemed certain parts of the amplified AHP regulations be vacated, i.e., held invalid; specifically, the broadened definition of "bona fide group or association of employers" and the "commonality of interest" provisions contained in the definition of employer, and the provisions relating to "dual treatment of working owners as employers and employees".

The Court returned the amplified AHP regulations to the Department of Labor (DOL) for further consideration. Following the Court's ruling, the DOL released a **statement of its position**, together with **FAQs**, relating to the effect of the court ruling on the matter. Accordingly, the agency intends to work with HHS, the states and other affected parties to minimize consequences of the conflict in the following ways:

- Insured AHPs formed in accordance with the DOL's amplified AHP regulations issued last year can continue coverage in force through the end of the plan year (or if later, the contract term). Beyond the end of the plan year or contract term, the coverage could be subject to ACA's insurance market reform rules applicable to small employer plans, essential health benefits, and premium rating rules.
- The DOL intends to make efforts to ensure claim payments incurred by current participants and beneficiaries covered under an amplified AHP are made.
- Further, no enforcement action will be made by the DOL for potential violations, as long as benefit claims continue to be made; and, as long as the amplified AHP-members show good faith reliance on the broadened rules through the end of the applicable plan year or contract term.

The future of existing AHPs formed in accordance with the amplified AHP regulations issued last year remains uncertain. Stay tuned for developments.

Benefit and Payment Parameters for 2020

The Department of Health and Human Services published its finalized **Benefit and Payment Parameters for 2020** on April 25, 2019, together with a **Fact Sheet**. These uniform standards, as required under the Affordable Care Act, are intended for health insurers and the marketplace to ensure health coverage options for consumers, as well as provide planning guidance for insurers and employers. Following are highlights of these rules:

- **Cost-sharing limits**. The ACA imposes certain cost-sharing restrictions, such as deductible and out-of-pocket limits on health plans. These annual out of pocket limits apply to insured plans offered through the marketplace, and insured and self-funded plans offered outside marketplace. Below are cost sharing limitations for 2018 through 2020:

	Self-only Coverage (Individual)	*Other than Self-only Coverage (Family)*
2018	$7,350	$14,700
2019	$7,900	$15,800
2020	$8,150	$16,300

  As a reminder, the out-of-pocket (OOP) limits applicable to a high deductible health plan (HDHP) used in conjunction with a health savings account (HSA) differs from these ACA-imposed cost sharing limits. For 2019, the OOP limit for HDHP plans is $6,750 for single coverage; $13,500 for family coverage. It is anticipated that the IRS will release the 2020 inflationary adjustments applicable to HSAs in the near future.

- **Affordability standard – individual coverage**. The required contribution percentage by individuals for minimum essential health coverage (MEC) for purposes of determining eligibility for a hardship exemption under the individual shared responsibility requirement (IRC Section 5000A) occurs if the cost to the individual to purchase coverage exceeds 8.24% for 2020 (decreased from 8.30% in 2019) of household earnings.

  This affordability standard is distinct from the employer's shared responsibility affordability standard, and distinct from the affordability standard for purposes of entitlement to premium assistance. For 2019, coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.86% of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

- **Prescription Drugs.** Beginning in 2020, an insurer issuing both individual and group health plans of any size can, but is not obligated to, count manufacturer offsets, such as coupons and the like, toward an individual's maximum out-of-pocket limit under the health plan if there is a medically-appropriate generic drug available. The insurer cannot adopt these so-called accumulator programs if there is no generic equivalent available.

- **Benchmark Plan Designs.** Under current law, states can utilize one of several plan design categories for defining essential health benefits (EHB). A plan is permitted to use any of the 51 state-based benchmark plans, or the Federal Employee Health Benefit Plan benchmark plan to make its EHB determination.

The final 2020 benefit and payment parameters maintains these standards; as such, for plan years 2020 and beyond, states have the following additional options for selecting an EHB-benchmark plan. A state can:

- Select one of the 50 EHB-benchmark plans used by other states for the 2017 plan year;
- Replace one or more of the ten required EHB categories of benefits under its own benchmark plan used for the 2017 plan year, with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or
- Select a set of benefits tailored as its own EHB-benchmark plan, as long as it meets the scope of benefits requirements and other specified requirements, as outlined in **separate CMS guidance**.

It is important to remember that a self-funded plan, even though it is not required to comply with all EHBs, must select a safe harbor benchmark plan against which it measures EHBs that it does, in fact, offer. This is relevant for a number of ACA purposes including restrictions relating to cost-sharing, annual and lifetime limits and preexisting condition exclusions.

- **Annual Open Enrollment Period.** For the 2020 plan year, the annual open enrollment period for obtaining coverage through the federal marketplace will run from November 1, 2019 through December 15, 2019. State marketplaces may have different open enrollment periods.

- **Special Enrollment Periods.** The final benefit and payment parameter rules establish a new special enrollment period for individuals who enroll in "off-exchange" individual coverage, and experience a sudden decrease in household income and are determined to be newly eligible for the advanced premium tax credit. The individual would have a 60-day special enrollment window, and must provide proof of the change in income, as well as proof of prior minimum essential coverage.

- **Federal Exchange User Fees.** Insurers participating in the federal marketplace are subject to a user fee to help pay for the operational expenses of the marketplace. For 2020, the user fee rate is reduced to 3.0% (3.5% for 2019) of the monthly premium charged by the insurer. Insurers in state-based exchanges that use the federal exchange platform will be charged 2.5% (down from 3.0% in 2019).

Extended Transition Period for ACA Compliant Policies

Certain so-called 'grand-mothered' policies in the individual and small group markets that are not grandfathered and have enjoyed exemption from some of the ACA's insurance market reform provisions since January 1, 2014. The CMS' Center for Consumer Information and Insurance Oversight has extended the exemption several times, and granted **another exemption** on March 25, 2019.

Accordingly, individual and small group health policies renewing prior to October 1, 2020 (but ending by December 31, 2020) can be renewed, free from many of the ACA's market reforms, including:

- Fair health insurance premiums;
- Guaranteed availability of coverage;
- Guaranteed renewability of coverage;
- Prohibition of pre-existing condition exclusions or other discrimination based on health status with respect to adults, except with respect to group coverage;
- Prohibition of discrimination against individual participants and beneficiaries based on health status except with respect to group coverage;
- Non-discrimination in health care;
- Comprehensive health insurance coverage; and
- Approved clinical trials.

Unless extended again, or if changes are made by Congress or the Administration in the interim, beginning January 1, 2021, these policies must be ACA-compliant.

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