CBP
Creative Benefit Plans
INSURANCE MADE EASY

2019: Fourth Quarter

Compliance Digest

Compliance Bulletins Released October-December

2019 Compliance Bulletins

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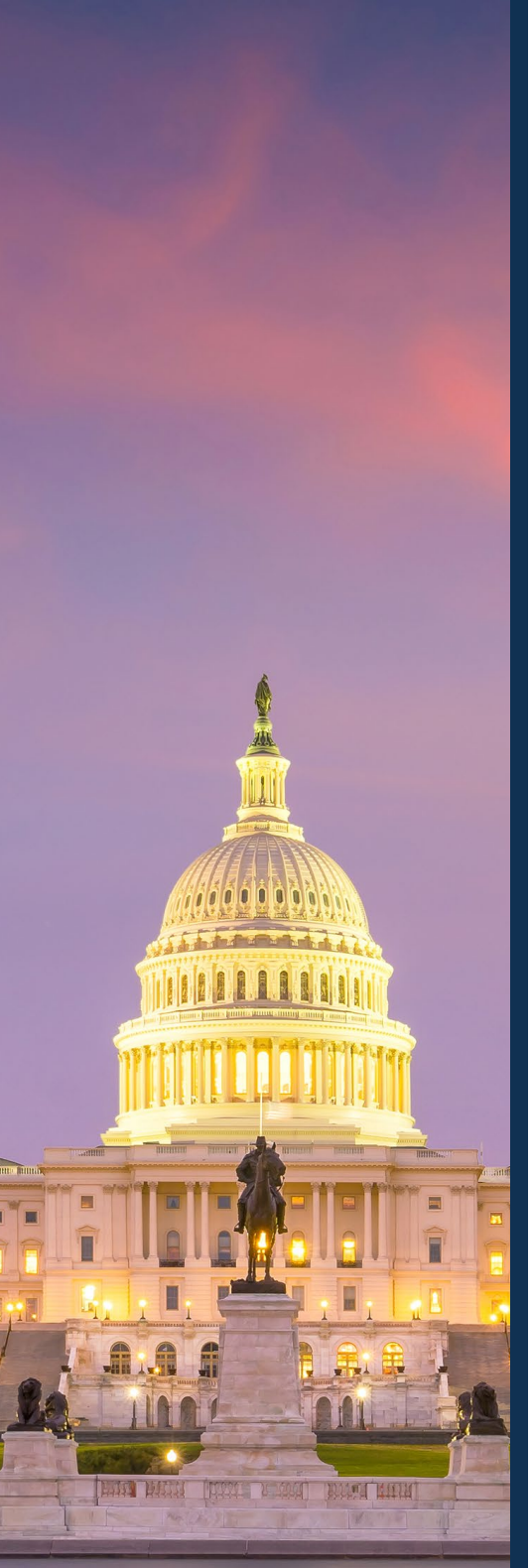


D.C. Implements Individual Taxpayer Health Insurance Responsibility Requirement

Published: October 4, 2019

For tax years ending on or after December 31, 2019, all residents in the District of Columbia (D.C.) must maintain minimal essential health care coverage, qualify for a coverage exemption, or pay a tax penalty. In October 2018, D.C. passed the Individual Taxpayer Health Insurance Responsibility Requirement Amendment Act of 2018 (D.C. Law 22-168), which imposes an individual mandate modeled after the federal individual shared responsibility requirement that was in effect under the Affordable Care Act prior to 2019.

Employers with at least 50 employees, including at least one employee who was a D.C. resident during the applicable calendar year, and other applicable entities including governmental agencies, insurance companies and third-party service providers that provide minimum essential health coverage to D.C. residents are required to comply with filing requirements established by the D.C. Office of Tax Revenue (OTR). Employees are considered D.C. residents for reporting purposes if the employer paid payroll taxes to the District on behalf of the employee for any period during the applicable calendar year.

Plan sponsors and other applicable entities are required to file information with OTR regarding health coverage and issue an annual statement of health coverage to covered individuals. Compliance with the federal IRS requirement to furnish an annual statement of health coverage to employees or covered individuals (i.e., Forms 1095-B and 1095-C) will also satisfy D.C.'s OTR annual statement requirement. For the 2019 tax year, filings are due by June 30, 2020. For tax years beginning after December 31, 2019, the deadline is 30 days after the IRS deadline for submitting 1095-B or 1095-C forms, including any extensions granted by the IRS.

To satisfy the OTR filing requirement, applicable entities should file the same information returns as they file with the IRS including:

- Form 1094-B, Transmittal of Health Coverage Information Returns
- Form 1095-B, Health Coverage
- Form 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns
- Form 1095-C, Employer-Provided Health Insurance Offer and Coverage

All information returns must be filed electronically with OTR by uploading files through MyTax.DC.gov using OTR's prescribed layouts and file formats. All files must be a delimited file with an extension of .txt (.zip files are acceptable). Filing paper information returns is not permitted. An employer may contract with a third-party service provider to file the information returns on its behalf.

Unlike the IRS's ACA Information Returns System (AIR), the MyTax.DC.gov platform does not provide a filing confirmation that acknowledges a successful filing. Instead, OTR will notify filers if filing errors exist. Filers wishing to submit an amendment or correction to a previously filed return may upload one corrected filing per business day until December 31 of the filing year. OTR will not accept corrected filings after the end of the filing year.

Employer Action

Employers with D.C. employees should register with MyTax.DC.gov and complete the sign-up process before the deadline for filing the required information returns. For tax year ending December 31, 2019, the deadline is June 30, 2020. If you have questions about how to register with OTR or how to file returns, please contact OTR's Customer Service Center at e-services.otr@dc.gov or (202) 759-1946. Employers that have questions about whether they are required to file returns may contact the Office of General Counsel at (202) 442-6500.

For more information, see the D.C. OTR website at:
https://otr.cfo.dc.gov/.

New Jersey Updates 2019 Individual Mandate Employer Reporting

Published: October 7, 2019

The State of New Jersey has posted information related to employer reporting under New Jersey's individual health insurance mandate that went into effect January 1, 2019.

Background

The New Jersey Health Insurance Market Preservation Act (the "NJ Act") requires most New Jersey residents to maintain health insurance, starting January 1, 2019. Failure to maintain health insurance, absent an exception, will result in an individual penalty imposed by the State when a person files his or her 2019 New Jersey Income Tax Return. This state mandate essentially replaces the federal individual mandate imposed under the Affordable Care Act (ACA), which was effectively eliminated starting in 2019 under the Tax Cuts and Jobs Act.

As with the ACA, the NJ Act requires certain employers and insurance carriers to report covered participants to the state to confirm that such individuals had actual health coverage in the calendar year.

What's New?

Recently the State of New Jersey updated its "Information for Employers" website with respect to the New Jersey Health Insurance Mandate. Notably, employers must provide the same Forms 1094-C and 1095-C to the State of New Jersey as they provide to employees and other individuals otherwise covered under an employer sponsored plan to the Internal Revenue Service (IRS) under the ACA. The Forms are to be sent to the New Jersey Division of Taxation by March 31, 2020. Previously, this deadline was set at February 15, 2020, a deadline that preceded the general deadline by which Forms need to be filed with the IRS under ACA. Now, forms will be due to the State on the same day as the IRS deadline.

Employer reporting under the NJ Act applies to all employers that withhold and remit New Jersey Gross Income Tax for New Jersey residents, including employers located outside of the state. The State also provides the following guidance for companies:

Fully Insured Plans

Single-Company, Applicable Large Employers (ALEs)
ALEs are generally companies that employed an average of at least 50 full-time-equivalent employees on business days during the preceding calendar year. The insurer files a Form 1095-B for each covered member of the plan. The Employer files a Form 1095-C (Parts I & II) for each person who was a full-time employee of the employer for at least one month of the calendar year.

Single-Company, Not an Applicable Large Employer (Non-ALEs)
Non-ALEs generally are companies that employed an average of fewer than 50 full-time-equivalent employees on business days during the preceding calendar year. The insurer files the Form 1095-B for each covered member on the plan. Employer does not file a Form 1095-C.

Fully Insured Employer Participating in a Multiemployer Plan
Plan Sponsor files a Form 1095-B for enrolled individuals. ALEs also file Form 1095-C (Parts I & II) for each person who was a full-time employee for at least one month of the calendar year.

Self-Insured Plans

Single Company, ALEs
Employer files a Form 1095-C for each person who was a full-time employee for at least one month of the year and for any employee who was enrolled in the self-insured plan. ALEs that offer coverage to non-employees (such as COBRA members or retired employees) must use Forms 1094-B and 1095-B for these non-employees or may file a 1095-C using Code 1G in Part II to report for these non-employees.

Single Company, Non-ALE
Non-ALEs must file a 1095-B for each covered employee.

Self-Insured Employer participating in a Multiemployer plan
Plan Sponsor files a Form 1095-B for each covered employee. ALEs must also file Parts I & II of 1095-C for each covered employee.

Reporting System

Insurers or employers are able to provide confidential or sensitive data to the State of New Jersey using the Division of Revenue and Enterprise Services' (DORES) MFT SecureTransport service. Employers that have MFT SecureTransport service user credentials can now use them to submit the required forms. If you do not have an account or need technical specifications, employers are encouraged to contact e-GovServices@treas.nj.gov to request assistance. The System also encourages employers to participate in the testing period, which initially will run through October 31, 2019. To join the testing program, send an e-mail to the above e-mail address stating "Please tell me how to join New Jersey's Health Mandate filing testing program."

Employer Action

- All employers with employees who are New Jersey residents should evaluate whether they will be subject to these new reporting requirements beginning in 2019. In many cases, such employers will already be generating the Forms required to be filed with the state.

- Employers should be aware of the new March 31, 2020 reporting deadline.

- Employers should join the testing program with the MFT Secure Transport service, if interested.

- Employers should watch for updates on the New Jersey website, particularly if the IRS changes the current Forms for 2019 reporting, and if NJ deploys its own separate forms.

MLR Rebate Checks Recently Issued to Fully Insured Plans

Published: October 10, 2019

As a reminder, insurance carriers are required to satisfy certain medical loss ratio ("MLR") thresholds. This generally means that for every dollar of premium a carrier collects with respect to a major medical plan, it should spend 85 cents in the large group market (80 cents in the small group market) on medical care and activities to improve health care quality. If these thresholds are not satisfied, rebates are available to employers in the form of a premium credit or check.

If a rebate is available, carriers were required to distribute MLR checks to employers by September 30, 2019.

Importantly, employers must distribute any amounts attributed to employee contributions to employees and handle the tax consequences (if any).

This does not apply to self-funded plans.

The rules around rebates are complex and require careful review with ERISA counsel. Among other things, an employer receiving a rebate as a policy holder will need to determine:

- who receives a rebate (e.g., current participants v. former participants);
- the form of the rebate (e.g., premium reduction v. cash distribution);
- the tax impacts of any such rebate (on both the employer and participants receiving the rebate); and
- what, if any, communication to provide participants regarding the rebate.

The following questions and answers summarize information regarding what employer action may be necessary.

What Will the Rebate Amount Be?

Carriers determine MLR on a state basis by market segment (individual, small group, or large group). Carriers do not disaggregate by type of plan within these markets (e.g., PPO v. HMO v. HDHP) or by policyholder so the carrier will have to let you know the amount.

A carrier is not required to provide a rebate to an enrollee if the total rebate owed is less than $20 per subscriber ($5.00 when a carrier pays the rebate directly to each subscriber). This rule regarding de minimis amounts only applies to the carrier, not to employers refunding amounts to participants.

Will there be any Communication?

Yes.
For each MLR reporting year, at the time any rebate of premium is provided, a carrier must provide the policyholder and each current enrollee who was also enrolled in the MLR reporting year in a form prescribed by HHS.

Employers do not have to notify employees, but they may want to address the notices being distributed by the carriers. Language similar to the following provides a starting point for such a notice:

> Employees should have received a notice of rebate from [carrier]. In short, [Employer] received a rebate check in the amount of $_____. Amounts attributable to participant contributions will be used to [reduce premium amounts] for [currently enrolled employees] in accordance with legal requirements. These amounts will be reflected in the [October ___] paychecks.

What will the Form of Rebate to the Employer Be?

Carriers may issue rebates in the form of either a premium credit (i.e., reduction in a premium owed), a lump-sum payment, a lump-sum reimbursement to the account used to pay the premium if an enrollee paid the premium using a credit card or direct debit, or a "premium holiday," if this is permissible under state law.

When will Rebates be Issued?

Rebates must be paid by **September 30** each year. A carrier that fails to timely pay any rebate must additionally pay the enrollee interest at the current Federal Reserve Board lending rate or 10% annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due.

Do Employers Have to Give Some or All of the Rebate to Participants?

Yes, unless they paid 100% for all tiers of coverage.

Carriers will generally send rebate checks to employers and employers must mete out any amounts attributed to employee contributions to employees and handle the tax consequences.

There is no one formula for employers to use, but guidance has been provided to aid employers.

ERISA-covered group health plans

To the extent that rebates are attributable to participant contributions, they constitute plan assets. Plan assets must be handled in accordance with the fiduciary responsibility provisions of Title I of ERISA.

If the employer is the policyholder, determining the plan's portion, if any, may depend on provisions in the plan or the policy or on the manner in which the plan sponsor and the plan participants have shared in the cost of the policy. If the plan or its trust is the policyholder, in the absence of specific plan or policy language to the contrary, the entire rebate would constitute plan assets, and the policyholder would be required to comply with ERISA's fiduciary provisions in the handling of rebates that it receives.

The HHS regulations and related DOL guidance for ERISA plans leave to the policyholder the decision as to how to use the portion of a rebate that constitutes plan assets, subject to ERISA's general standards of fiduciary conduct. The DOL notes that, in choosing an allocation method, "the plan fiduciary may properly weigh the costs to the plan and

the ultimate plan benefit as well as the competing interests of participants or classes of participants provided such method is reasonable, fair and objective." An allocation does not necessarily have to exactly reflect the premium activity of policy subscribers. A plan fiduciary may instead weigh the costs to the plan and the competing interests of participants or classes of participants when fashioning an allocation method, provided the method ultimately proves reasonable, fair, and objective. If the fiduciary finds that the cost of passing through the rebate to former participants would exhaust most of those rebates, the proceeds can likely be allocated to current participants.

Guidance does not address how to handle an MLR rebate where the amount is inconsequential (e.g., a dollar per participant). Taking a cue from DOL Field Assistance Bulletin No. 2006-01, a fiduciary may be able to conclude, after analyzing the relative costs, that no allocation is necessary, when the administrative costs of making correction far exceed the amount of the allocation.

If a plan provides benefits under multiple policies, the fiduciary is instructed to allocate or apply the plan's portion of a rebate for the benefit of participants and beneficiaries who are covered by the policy to which the rebate relates provided doing so would be prudent and solely in the interests of the plan according to the above analysis. But, according to the DOL, "the use of a rebate generated by one plan to benefit the participants of another plan would be a breach of the duty of loyalty to a plan's participants."

Plans that are neither covered by ERISA nor are governmental plans (e.g., church plans)

With respect to policyholders that have a group health plan but not a governmental plan or a plan subject to ERISA, carriers must obtain written assurance from the policyholder that rebates will be used for the benefit of current subscribers or otherwise must pay the rebates directly to subscribers.

The final rule issued on February 27, 2015 provides that subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates within three (3) months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do.

When Do Rebates Need to Be Made to Participants?

As soon as possible following receipt and, in all cases, within 3 months of receipt.

What is the Form of Rebate to Participants?

There is no one way to determine this, but guidance has been provided to aid employers.

Reductions in future premiums for current participants is probably the best method.

If proceeds are to be paid to participants in cash, the DOL is likely to require that payments go to those who participated in the plan at the time the proceeds were "generated," which may include former employees. An option that may be easier to administer is to keep the proceeds in the plan and provide a "premium holiday" (suspension of required premiums) or a reduction in the amount of employee-paid premiums.

The interim final regulations for non-ERISA governmental plans require that rebates be used to reduce premiums for all health plan options for subscribers covered when the rebate is received, to reduce premiums for current subscribers to the option receiving the rebate, or as a cash refund to current subscribers in the option receiving the rebate. In each case, the regulations allow the rebate to be allocated evenly or in proportion to actual contributions to premiums. Note that the rebate is to be used to reduce premiums for (or pay refunds to) employees enrolled during the year in which the rebate is actually paid (rather than the MLR reporting year on which the rebate was calculated).

To recap, here are some options to consider:

- **Reduce future premiums for current plan participants.** This is administratively easy with limited tax issues with respect to participants.
- **Cash payments to current participants.** This is administratively burdensome and results in tax consequences to participants.
- **Cash payments to former participants.** This is administratively burdensome and results in tax consequences to former participants.

The employer could also consider, with counsel, whether providing benefit enhancements or payment of reasonable plan expenses would be considered permissible.

What are the Federal Tax Implications to Employees?

Pre-Tax Premium Payments

When employees pay their portion of the premiums for employer-sponsored health coverage on a pre-tax basis under a cafeteria plan, MLR rebates will be subject to federal income tax and wages. Briefly:

- For rebates that are distributed as a reduction in premium (thus reducing an individual's pre-tax premium payment during the year), there is a corresponding increase to the employee's taxable salary that is also wages taxable for employment tax purposes.

- Rebates that are distributed as cash will result in an increase in taxable income that is also wages subject to employment taxes.

The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

After-Tax Premium Payments

When employees pay their portion of the premiums on an after-tax basis, MLR rebates generally are not subject to federal income tax or employment taxes. This applies when the rebate is provided as a reduction in premiums or as a cash. The result is the same regardless of whether the MLR rebates are provided only to employees participating in the plan both in the year employees paid the premiums being rebated and the year in which the MLR rebates are paid, or to all employees participating in the plan during the year the MLR rebates are paid (even if some employees did not participate in the plan during the year to which the rebate applies.)

What are the Tax Implications to Employers?

Employers should review the tax implications of a rebate with tax advisors. Generally, amounts used for benefits (e.g., to pay premiums with respect to insured plans) should not be taxable.

When Employees Pay Premiums on a Pre-Tax Basis, Does Reducing a Participant's Premiums Mid-Year Allow Them to Make Election Changes?

Probably not.

If employee contributions are paid on a pre-tax basis and there is a mid-year rate change, the cafeteria plan must determine whether such a change is permitted under the Section 125 rules.

If the plan incorporates the permitted election change rules, the relevant issue is whether this change in cost is permitted under the regulations.

- If there is an insignificant decrease, there can be an automatic adjustment.

- If there is a significant decrease, employees may make a corresponding change including commencing participation in the cafeteria plan for the first time for the option with a decrease in cost.

Generally, MLR rebates are expected to be fairly low dollar amounts and may not rise to the level of a significant change. Employers should consider either taking the position that the cost change is insignificant or that the cost change is significant and the "corresponding change" is to simply allow the reduction or increase. The cafeteria plan document should be consistent with the employer's position.

California Enacts A "Two Notice" Requirement for FSAs

Published: October 17, 2019

On August 30, 2019, California Governor Gavin Newsom signed into law Assembly Bill 1554, which applies to employers with employees working in California who participate in a flexible spending arrangement (FSA), including a health FSA, dependent care FSA, or adoption assistance FSA.

The new state law requires employers to notify California employees who participate in an FSA of any deadline to withdraw funds before the end of the plan year. The notice must be made in two different forms (one of which may be electronic), including by electronic mail, telephone, text message, postal mail, or in-person.

The language of the new state law does not clearly indicate what the notification deadline is. According to the legislative history, California intended the two notices to be provided before the end of the FSA plan year, but the statutory language could be interpreted to require their delivery before an employee stops participating in the FSA during the year (for example, because of termination of employment). Cautious employers should follow the latter approach, which means delivering the two notices to participants shortly after the FSA plan year begins or, in the case of mid-year enrollments, shortly after they begin participating in the FSA.

The new state law is effective on January 1, 2020. Employers that fail to comply with the new state law could be required to indemnify employees for losses caused by the employer's "want of ordinary care" under California employment law.

The new state law does not address the issue of federal ERISA preemption, which generally overrides state laws that relate to an ERISA plan. Whether this new state law is preempted by ERISA with respect to health FSAs offered by private sector employers is not clear; further guidance would be helpful. However, dependent care FSAs, adoption assistance FSAs, and health FSAs that are governmental plans or church plans are not ERISA plans, and would be subject to the new state law.

The California Department of Industrial Relations has not indicated whether it will provide guidance to employers on the specific requirements of the new state law or on the ERISA preemption issue.

As a best practice, employers with employees working in California should comply with the notice requirements and maintain applicable records.

Proposed Rules Clarify Individual Coverage HRAs

Published: October 18, 2019

On September 30, 2019, the IRS published proposed regulations to clarify the application of the employer mandate under the Affordable Care Act ("ACA") and certain nondiscrimination rules under the Internal Revenue Code ("Code") Section 105(h) to health reimbursement arrangements ("HRAs") integrated with individual health insurance coverage (individual coverage HRAs, or "ICHRAs"). Notably, the proposed regulations provide information on how to determine when an individual policy is "affordable" and of a "minimum value" and provide some relief under the Code Sec. 105(h) rules.

Background

Beginning with the 2020 plan year, employers are permitted to offer an ICHRA. This is an arrangement where the employer integrates individual health insurance coverage with an HRA when other traditional group health plan coverage is not offered, subject to certain conditions.

The rules that created this new HRA did not address how it would interact with the employer mandate and nondiscrimination provisions.

Employer Mandate

The employer mandate penalties apply to applicable large employers ("ALEs") who fail to offer minimum essential coverage to at least 95% of their ACA full-time employee population (the "A" Penalty) or who do so, but that coverage is not affordable or not of a minimum value (the "B" Penalty).

This section describes highlights from the proposed regulation on this topic.

Minimum Essential Coverage

An offer of an ICHRA counts as an offer of minimum essential coverage for "A" Penalty purposes.

Affordability

- Safe Harbor. There are currently three affordability safe harbors (federal poverty line, W-2 and rate of pay). The proposed rule confirms use of one of these safe harbors to determine affordability of an ICHRA is permitted. Additionally, the proposed regulations provide a new safe harbor for ICHRAs – an ALE may base affordability on the lowest cost silver plan for self-only coverage offered through the Exchange where the employee's primary site of employment or residence is located.

- Date to determine lowest cost silver plan. ALEs use the monthly premium for January of the prior calendar year (or for January of the current calendar year for a non-calendar-year plan) to determine the lowest cost silver plan.

- Classes of employees. An ALE may choose to apply the safe harbors for any class of employees, provided the ALE does so on a uniform and consistent basis for all employees in the class.

- Primary site. An employee's primary site of employment generally is the location at which the employer reasonably expects the employee to perform services on the first day of the plan year (or on the first day the ICHRA may take effect, for an employee who is not eligible for the ICHRA on the first day of the plan year). Special rules address what happens when an employee's worksite changes.

- Remote work. In the case of an employee who regularly works from home or at another worksite that is not on the employer's premises but who may be required by his or her employer to work at, or report to, a particular worksite, such as a teleworker with an assigned office space, the worksite to which the employee would report to provide services if requested is considered the primary site of employment. For other employees who work remotely, the employee's residence is the primary site of employment.

- Age. The lowest cost silver plan for an employee is the lowest cost silver plan for the lowest age band in the applicable rating area. The employee's age is based on the employee's age as of the first day of the plan year (or, if the employee becomes eligible for the ICHRA after the first day of the plan year, the first date the ICHRA can become effective for that employee).

- Wellness incentives. If there is a wellness incentive, the premium is determined without regard to that incentive unless the incentive relates exclusively to tobacco use, in which case the incentive is treated as earned.

- Data availability. Lowest cost silver plan data will be made available by HHS for employers in all states that use the federal Exchange. CMS has released a tool. Regarding state exchanges, HHS has begun discussing the information it plans to make available.

Minimum Value

An ICHRA that is affordable is deemed to provide minimum value.

Code Section 105(h) Nondiscrimination

For self-funded health plans, including HRAs, any maximum limit attributable to employer contributions must be uniform for all participants and for all dependents of employees who are participants and may not be modified by reason of a participant's age or years of service.

The proposed rules indicate that:

- An ICHRA does not fail Code Sec. 105(h) nondiscrimination testing solely due to the variation based on age.

- The maximum amount available under an ICHRA may vary within a class of employees or between classes without violating the uniform employer contribution requirement if (a) within each class, the maximum dollar amount only varies in accordance with the "same terms" requirement under the ICHRA rules, and (b) with respect to differences in the maximum dollar amount for different classes.

Note that satisfying the terms of the safe harbors under the proposed regulations does not automatically satisfy the prohibition on nondiscriminatory operation. Thus, for example, if a disproportionate number of HCIs qualify for and utilize the maximum HRA amount allowed under the same terms requirement based on age in comparison to the number of non-HCIs who qualify for and use lower HRA amounts based on age, the ICHRA may still be found to be discriminatory, with the result that excess reimbursements of the HCIs will be included in their income.

An ICHRA that only reimburses insurance premiums is treated as an insured plan and is not subject to the Code § 105(h) rules.

Code Section 125

An employer generally may not provide an Exchange plan as a benefit under its cafeteria plan. However, for an employee who purchases off-Exchange individual health insurance coverage, the employer may permit the employee to pay the balance of the premium for the coverage through its cafeteria plan.

Effective Date

- The proposed regulations related to the employer mandate apply beginning January 1, 2020.

- The proposed regulations under Code Section 105(h) apply beginning with the 2020 plan year.

- Employers may rely on the proposed regulations until the plan year beginning after six months following the publication of any final regulations.

For the regulations, visit: https://www.govinfo.gov/content/pkg/FR-2019-09-30/pdf/2019-20034.pdf

IRS Announces 2020 Health Insurer Fee

How it Will Impact the Insurance Marketplace

Published: November 6, 2019

The IRS recently released Notice 2019-50, which outlines the health insurer fee for the 2020 tax year.

Background

To help fund the creation and ongoing operation of the federal and state marketplace exchanges, the Affordable Care Act (ACA) requires that all insurers offering fully-insured health insurance programs pay an annual tax. The tax is not applicable to self-funded group health plans sponsored by an employer, but does apply to a self-funded Multiple Employer Welfare Arrangement (MEWA).

The amount of this tax, often called the health insurance tax (HIT) or fee (HIF), paid by insurers, is calculated based on each insurer's proportionate share of the marketplace. Congress suspended this tax for 2019 due to concerns with the impact the tax was having on premiums, but without any legislative action the tax will resume next year. Although the tax was initially $8 billion (referred to as the applicable amount) in its first year (2014), the amount has increased each year, with the IRS expecting to collect a little over $15 billion dollars cumulatively from all carriers in 2020.

Impact on Plan Sponsors

The health insurance tax will impact all insurers offering medical, dental and vision insurance (called "covered entities"), through both off-exchange and on-exchange individual markets, the small and large group marketplace, and programs like Medicare Advantage and Medicare Part D. And although plan sponsors do not need to take any action pursuant to Notice 2019-50, they will not escape being impacted by the fee. Most carriers have indicated that they will set their premium levels for 2020 to incorporate these additional fees. If the IRS implements the tax as planned, the fee is expected to add an estimated 3-4% on medical plan renewals, with the biggest impact on Medicare Advantage and Part D premiums.

Reminder:
Massachusetts HIRD Reporting Due December 15

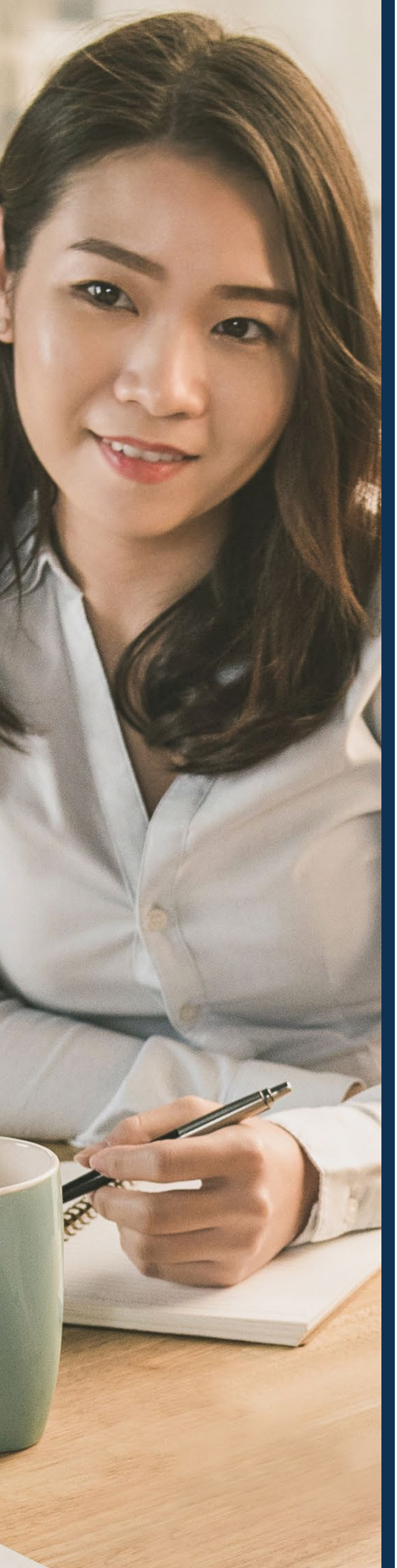
Published: November 7, 2019

As a reminder, Massachusetts employers must file the annual Health Insurance Responsibility Disclosure HIRD) form through the MassTaxConnect (MTC) web portal (https://mtc.dor.state.ma.us/mtc/_/). The HIRD reporting will be available to be filed starting November 15th and must be completed by December 15th. Please note, this is a change from the previously announced November 30th deadline.

The HIRD form collects employer-level information about employer-sponsored health insurance (ESI) offerings. The HIRD form assists MassHealth in identifying members with access to qualifying ESI who may be eligible for the MassHealth Premium Assistance Program.

Massachusetts law requires every employer with six or more employees in Massachusetts to annually submit a HIRD form. If you are an employer who currently has (or had) six or more employees in any month during the past 12 months preceding the due date of this form (December 15 of the reporting year), you are required to complete the HIRD form. An individual is considered to be your employee if you as the employer included such individual in your quarterly wage report to the Department of Unemployment Assistance (DUA) during the past 12 months. You are required to complete the HIRD form if you reported six or more employees (includes all employment categories) in any DUA wage report during the past 12 months.

For more information about the Premium Assistance Program and additional employer resources, visit the MassHealth Premium Assistance web page: https://www.mass.gov/service-details/other-health-insurance-and-masshealth-premium-assistance.



2020 Cost of Living Adjustments

Published: November 12, 2019

The IRS recently released cost of living adjustments for 2020 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans – Health Flexible Spending Arrangements

For plan years beginning in 2020, the dollar limitation under Code Section 125(i) for voluntary employee salary reductions for contributions to health flexible spending arrangements increases to $2,750.

The Affordable Care Act (ACA) amended Code Section 125 to place a $2,500 limitation on voluntary employee salary reductions for contributions to health flexible spending arrangements, subject to inflation for plan years beginning after December 31, 2013.

Qualified Transportation Fringe Benefits

For calendar year 2020, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Code Section 132(f)(2)(B)) increases to $270.

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Beginning with the 2018 calendar year, employers can no longer deduct qualified transportation fringe benefits; employees may still pay for these benefits on a tax-favored basis.

Highly Compensated

The compensation threshold for a highly compensated individual or participant (as defined by Code Section 414(q)(1)(B) for purposes of Code Section 125 nondiscrimination testing) increases to $130,000 for 2020.

Under the cafeteria plan rules, the term highly compensated means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B). Prop. Treas. Reg. 1.125-7(a)(9).

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2020 increases to $185,000.

For purposes of cafeteria plan nondiscrimination testing, a key employee is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year. Prop. Treas. Reg. 1.125-7(a)(10).

Non-Grandfathered Plan Out-Of-Pocket Cost-Sharing Limits

The 2020 maximum annual out-of-pocket limits for all non-grandfathered (NGF) group health plans are $8,150 for self-only coverage and $16,300 for family coverage.

These limits generally apply with respect to any essential health benefits (EHBs) offered under the group health plan. Federal guidance established that starting in the 2016 plan year, the self-only annual out-of-pocket limit applies to each individual, regardless of whether the individual is enrolled in other than self-only coverage, including in a family HDHP.

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2020, to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) under Code Section 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed $5,250 ($10,600 for family coverage).

Health Savings Accounts

As announced in May 2019, the inflation adjustments for health savings accounts (HSAs) for 2020 were provided by the IRS in Rev. Proc. 2019-25.

Annual contribution limitation.

For calendar year 2020, the limitation on HSA contributions for an individual with self-only coverage under a high deductible health plan is $3,550. For calendar year 2020, the limitation on HSA contributions for an individual with family coverage under a qualifying high deductible health plan is $7,100.

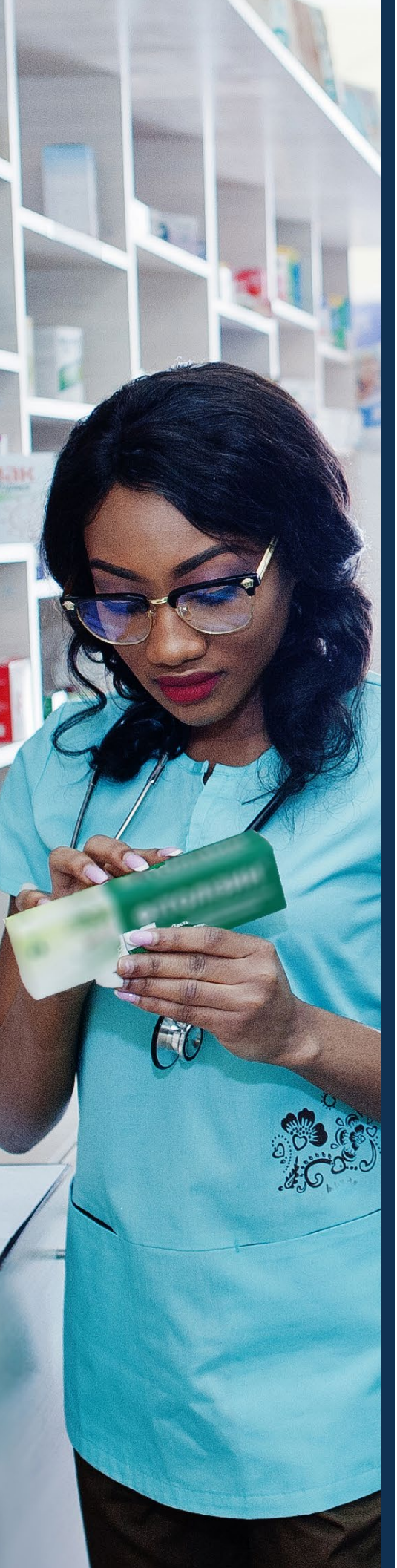
Qualifying high deductible health plan.

For calendar year 2020, a “qualifying high deductible health plan” is defined as a health plan with an annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $6,900 for self-only coverage or $13,800 for family coverage.

Non-calendar year plans: In cases where the qualifying high deductible health plan renewal date is after the beginning of the calendar year, any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date. See IRS Notice 2004-50, 2004-33 I.R.B. 196, Q/A-86 (Aug.16, 2004).

Catch-up contribution.

Individuals who are age 55 or older and covered by a qualifying high deductible health plan may make additional catch-up HSA contributions each year until they enroll in Medicare. The additional contribution, as outlined in Code 223(b)(3)(B), is $1,000 for 2009 and thereafter.



CMS Reporting to Include Prescription Drug Information

Published: December 4, 2019

For quarters beginning on and after January 1, 2020, the Centers for Medicare and Medicaid Services (CMS) will require Responsible Reporting Entities (RREs) to include information on prescription drugs in their Section 111 quarterly reporting. Prior to 2020, reporting on prescription drugs was voluntary.

Self-funded group health plans that separately contract with a pharmacy vendor (i.e., a pharmacy benefit manager (PBM)) should be aware that it may be the PBM (and not the medical third-party administrator (TPA)) who is the RRE for prescription drug coverage. PBMs may be reaching out for additional information from employers/plan sponsors in order to meet these reporting requirements.

Employers sponsoring fully insured plans or self-funded plans where prescription drug benefits are provided as part of a medical, hospital, and pharmacy benefit contract through a TPA will likely experience little to no impact as a result of this change.

Background

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 created reporting requirements for group health plans to CMS. These requirements were effective January 1, 2009. In most cases, the insurance carrier and TPA are the RREs. An employer may be the RRE when it both sponsors and administers the group health plan (not common). This reporting requirement was implemented in order to better facilitate Medicare Secondary Payer requirements, identifying instances where the group health plan should have paid primary to Medicare.

What's New

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act) imposes additional reporting requirements related to prescription drug benefits on RREs, effective January 2020. Specifically, the law requires reporting for Medicare beneficiaries who have prescription drug coverage (other than or in addition to Medicare Part D) which is primary to Medicare. This includes prescription drug coverage for someone who may be Medicare-eligible and currently is employed or is the spouse or family member of a worker who is covered by a prescription drug plan.

Which entity is considered to be the RRE for the purpose of reporting primary prescription drug coverage will depend on how the employer/plan sponsor structures its contracts for medical, hospital, and prescription drug coverage. It should not be assumed that the RRE will be the entity that has direct responsibility of processing and paying the prescription drug claims.

In general, the RRE will be the entity that has the direct relationship with the employer/plan sponsor regarding the prescription drug coverage. The following entities are most likely to be RREs for the purpose of reporting primary prescription drug coverage to CMS:

- Carrier. If the group health plan is fully insured, the insurance carrier is the RRE.

- TPA. If the group health plan is self-funded and the employer/plan sponsor directly contracts with a TPA to provide medical, hospital, and pharmacy benefits, the TPA is the RRE. This is the case even if the TPA separately contracts with a PBM for pharmacy benefits.

- PBM. If the group health plan is self-funded and the employer/plan sponsor directly contracts with the TPA to provide medical and hospital benefits and the employer/plan sponsor independently contracts with a separate third party (such as a PBM) to administer prescription drug coverage, the PBM is the RRE for purposes of the prescription drug reporting. The TPA remains the RRE as it pertains to reporting on medical and hospital benefits.

Employer Action

In most instances, employers sponsoring health plans are not considered RREs and therefore not responsible for compliance with the Section 111 reporting to CMS, including the new requirement related to prescription drugs.

However, particularly as it relates to group health plans with a carved-out pharmacy benefit, the PBM may be undertaking new reporting responsibilities and may be requesting additional information from an employer/plan sponsor. CMS strongly encourages employers to cooperate with RREs so they can fulfill their reporting responsibilities.

Deadline Extended for 2019 Forms 1095-C

Published: December 9, 2019

On December 2, 2019, the IRS issued Notice 2019-63, which provides:

- An extension of time, until **March 2, 2020**, for employers to provide Forms 1095-C to their full-time employees and other individuals; and
- An extension of relief from penalties for the 2019 reporting year for employers and other entities that make good-faith efforts to comply with the reporting requirements.

Notice 2019-63 does not, however, extend the deadline to provide completed Forms 1094-C and 1095-C (and Forms 1094-B and 1095-B) to the IRS (as described in Q/A-2 below). Nor does it provide any relief from providing Forms 1095-C to full-time employees ("FTEs"). This means that all Applicable Large Employers ("ALEs") must continue to provide Form 1095-C to any employee that was full time for any month of 2019.

However, the Notice provides an alternative furnishing method for Form 1095-B (and in some cases Form 1095-C), with relief from the 2019 Section 6055 reporting penalty, for:

- Insurance carriers that are otherwise required to furnish Form 1095-B to covered individuals for calendar year 2019;
- Employers with self-funded health plans that are otherwise required to furnish Form 1095-B to covered individuals for calendar year 2019; and
- Employers with self-funded health plans that are otherwise required to furnish Form 1095-C to covered individuals who were not full-time employees in any month of calendar year 2019.

Briefly, the alternative furnishing method allows carriers (and in some cases employers) to avoid 2019 Section 6055 penalties associated with a failure to furnish the applicable form to covered individuals by posting information to a website and timely providing the completed applicable Form upon request.

The following FAQs provide additional details.

Q1: What Was Extended?

2019 Forms 1095-C must be furnished to FTEs and other individuals by **Monday, March 2, 2020** (rather than by January 31, 2020).

This extension of time also applies to insurance carriers providing 2019 Forms 1095-B to individuals covered under an insured plan, and to employers providing 2019 Forms 1095-B to individuals covered under a self-funded health plan (but see Q/A-3).

The Notice states that the new deadline of March 2, 2020, will not be further extended by the IRS.

Q2: Were The Deadlines For Reporting To The IRS Extended?

No, the 2019 Form 1094-C and all supporting Forms 1095-C (and the 2019 Form 1094-B and all supporting Forms 1095-B) must be filed with the IRS by Tuesday, March 31, 2020, if filing electronically (or by Friday, February 28, 2020, if filing by paper). These deadlines **were not extended** as part of the announced relief.

As a reminder, employers that file at least 250 Forms 1095-C with the IRS must file electronically. The IRS encourages all filers to submit returns electronically.

Q3: With The Indiviudal Mandate Reduced To Zero After December 31, 2018, Is There Any Relief When Furnishing A Form 1095-B?

Yes, but it is generally limited to Forms 1095-B (except as described in Q/A-4 below).

Because the individual shared responsibility penalty is reduced to zero for 2019, an individual does not need the information on Form 1095-B in order to compute his or her federal tax liability or file an income tax return with the IRS. (But see Q/A-7 below regarding individual healthcare mandates in certain states.)

The IRS will not assess a 2019 Section 6055 reporting penalty against reporting entities for failing to furnish Form 1095-B to covered individuals in cases where the following two conditions are met (Alternative Furnishing Method):

1. **Website posting.** The reporting entity posts a notice prominently on its website stating that responsible individuals may receive a copy of their 2019 Form 1095-B upon request, accompanied by an email address and a physical address to which a request may be sent, as well as a telephone number that they can use to contact the reporting entity with any questions.

2. **Provide form within 30 days.** The reporting entity furnishes a 2019 Form 1095-B to any responsible individual upon request within 30 days of the date the request is received.

Insurance carriers (and employers with self-funded plans) that take advantage of this relief must still provide the 2019 Form 1094-B and all 2019 Forms 1095-B to the IRS by the required deadline. In other words, while the carrier (or employer) will not be penalized by the IRS for not supplying covered individuals with Forms 1095-B with respect to their coverage (subject to the two conditions set forth above), the carrier (or employer) must still create Forms 1095-B and provide them to the IRS by the required deadline.

There is no relief from the penalties associated with a failure to file completed forms with the IRS.

Q4: Will The Alternative Furnishing Method Apply To Ales With A Self-Funded Health Plan?

No, except in one situation.

ALEs are still required to provide Forms 1095-C to employees who were full-time for any month of calendar year 2019. Nothing has changed with respect to this requirement, aside from extending the deadline to March 2, 2020. ALEs offering self-funded group health plan coverage must continue to furnish Forms 1095-C to their FTEs, with all applicable parts (I, II and III) of Form 1095-C completed.

Some ALEs who offer self-insured health plan coverage to individuals who are not FTEs (e.g., part-time employees) may consider using the alternative furnishing method with respect to Form 1095-C.

Even if an ALE takes advantage of this alternative furnishing method with respect to an individual covered by the self-insured group health plan who was not a full-time employee in any month of 2019, the employer must still submit completed Forms 1094-C and 1095-C to the IRS by the required deadline.

Q5: Is The Good Faith Penalty Relief Extended?

Yes, penalty relief is extended for employers and other reporting entities that report incorrect or incomplete information on Form 1094-C or Forms 1095-C, when these entities can show that they made good-faith efforts to comply with the information reporting requirements for 2019. This relief applies to missing and inaccurate taxpayer identification numbers and dates of birth, as well as other information required on the return or statement.

Q6: What If The Submissions Are Late?

Employers that do not comply with the due dates for providing a return or statement to an individual or the IRS are subject to penalties (except as described in Q/A-3 and Q/A-4). Employers and other reporting entities should still furnish and file the forms, and the IRS will take such furnishing and filing into consideration when determining whether to abate penalties.

Q7: Our Employees Reside In States With An Individual Healthcare Mandate. Are There Other Things To Consider?

A handful of states (including the District of Columbia) have enacted individual healthcare mandates that apply to residents. As part of this requirement, carriers and employers must provide statements to residents and reporting to the states to demonstrate minimum essential coverage and enable covered employees and other individuals to avoid state penalties. States have either adopted (or are expected to adopt) the federal forms, 1095-B and 1095-C, to satisfy this requirement. While there may be limited federal relief with respect to furnishing

Furnishing Form 1095-C to Individuals Who Were NOT Full-Time Employees

The Notice does provide relief to ALEs required to furnish 2019 Forms 1095-C to individuals covered under a self-funded group health plan **who were not FTEs for any month of calendar** year 2019. In this limited instance, ALEs may use the alternative furnishing method and will not face 2019 Section 6055 penalties, provided the ALE meets two conditions (outlined in Q/A-3):

- Post a prominent notice on website stating the Form 1095-C (or 1095-B) is available by request; and
- Provide the Form 1095-C (or Form 1095-B) within 30 days of a request.

In most cases, the individuals targeted for this relief are those who receive Form 1095-C with Code 1G in line 14 of Part II. Examples of covered individuals who are not full-time employees for any month of the calendar year, but who may receive coverage under the employer's self-funded group health plan, include:

- Part-time employees covered under the plan.
- A spouse or child receiving COBRA coverage.
- A former employee receiving COBRA coverage who had a COBRA qualifying event in 2018 or earlier.
- Individuals covered under a self-funded retiree medical plan who retired in 2018 or earlier.

these forms, carriers and employers may want to continue to provide these forms to covered employees and other individuals who are subject to a state mandate.

The following is a list of states (including the District of Columbia) with an individual healthcare mandate and effective dates for compliance.

State or Jurisdiction	Effective Date of Individual Healthcare Mandate	Employer Reporting Begins in 2020	Employer Reporting Begins in 2021
California	January 1, 2020		X
New Jersey	January 1, 2019	X	
Rhode Island	January 1, 2020		X
Vermont	January 1, 2020		X (however, employers may not be required to report coverage to the state)
Washington, DC	January 1, 2019	X	

Massachusetts established an individual mandate in 2007. Reporting to individuals is provided via Form 1099-HC. Employers with at least 6 employees who are residents of the state must file an HIRD. As the Massachusetts requirement predates these recent healthcare mandates and uses different reporting forms, it is not included on this list.

Q8: What About Future Relief?

The Notice asks for comments as to whether an extension of the due date to furnish Forms 1095-C (and Forms 1095-B) and continued extension of the good faith relief will be necessary for future years and why. There is information in the Notice on how taxpayers may submit comments.

Q9: Have Revised Forms 1094/1095-C And 1094-1095-B Been Released For 2019?

Yes. The IRS recently released draft Forms 1094/1095-C and 1094/1095-B information returns and instructions for calendar year 2019, but they have very few changes from the prior year's versions. Since they were released so late, there was much that there might be significant modifications to the forms and reporting requirements, perhaps related to the fact that beginning January 1, 2019, the penalty for an individual not maintaining MEC was reduced to zero. However, at least based on the 2019 draft forms and instructions, this is not the case. There were relatively few changes made from the prior year, as detailed below.

- **Draft 2019 Form 1094-C:** No changes.

- **Draft 2019 Form 1095-C:** No changes to the form itself.

  Identifying the "Plan Start Month" in Part II remains optional for 2019, although it may become mandatory for 2020.

  The Instructions for Recipient on the back of the form had a few changes to reflect the elimination of the individual mandate penalty, and to underscore that information reported on the form is relevant to determining if an individual qualifies for subsidies through the Marketplace/Exchange. Changes include:
  - deleting a statement that the information is reported on the form "to assist you in completing your income tax return"
  - adding a statement that "[i]f you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit"

Draft 2019 Instructions for Forms 1094-C and 1095-C:

In addition to routine updates to the furnishing and filing deadlines, and the dates used in examples, the following changes were made:

- deleting a reference that individuals reported to have MEC under a self-insured plan "are not liable for

the individual shared responsibility payment for the months that they are covered under the plan"

- adding a statement that "[e]ligibility for certain types of minimum essential coverage can affect a taxpayer's eligibility for the premium tax credit"

- updating the calendar year penalty caps for the failure of an ALE to (1) file correct information returns, or (2) provide correct payee statements, to $3,339,000 each (from $3,275,500 in 2018)

- updating the applicable percentage for affordability safe harbors and the Qualifying Offer Method to 9.86% for plan years beginning in 2019 (from 9.56% in 2018)

Changes to the draft 2019 Forms 1094-B, 1095-B, and applicable instructions are similar to the changes described above.

Q10: What Should Employers Do Next?

Employers should consider the following:

- Employers should take note of the extended deadline, March 2, 2020, to furnish 2019 Forms 1095-C to full-time employees and other individuals.

- Final versions of the 2019 Forms 1094-C and 1095-C, along with relevant instructions, should be released soon. Hopefully, the final versions include additional guidance on the relief announced in this Notice.

- ALEs should complete Form 1095-C (including all relevant parts) and timely furnish the statements to full-time employees. ALEs should also timely transmit form 1094-C along with all Forms 1095-C to the IRS.

- Employers with fully insured plans should be aware that their carriers may not issue Forms 1095-B directly to covered employees for 2019. Individuals asking for a copy should be directed to the carrier. Employers should anticipate that covered employees residing in a state with an individual healthcare mandate may need to contact the carrier to obtain a Form 1095-B before filing a state income tax return.

- ALEs with self-funded health plans that extend coverage to individuals other than full-time employees should decide whether to continue to furnish Forms 1095-C as done in prior years, or to take advantage of the new alternative furnishing method with respect to those covered individuals, USI has identified a few administrative reasons why ALEs may be reluctant to adopt this new furnishing method for 2019:
  - While the Notice offers limited relief with respect to furnishing a Form 1095-C to covered individuals who were not full-time employees for any month of calendar year 2019, the ALE must ensure that Form 1095-C (including Part III) is completed and submitted to the IRS on behalf of these individuals. As the information must be included in the final submission, it is unclear whether taking advantage of the Section 6055 penalty relief makes any practical or administrative sense.
  - Employers looking to take advantage of this relief will need to post the required notice on a website and provide the completed Form 1095-C within 30 days of a request. Failure to do so could subject to the employer to associated penalties.
  - Given the timing of Notice 2019-63, vendors or other third parties that assist in preparation and distribution of 2019 Forms 1094-C and 1095-C may not be able to accommodate this new process.
  - Employers with employees who reside in states with an individual healthcare mandate will want to work with vendors to ensure forms are provided and reported to the state in a timely and complete manner.

- While good faith penalty relief was extended under the Notice, be aware that the IRS is actively assessing fines associated with failures to file Forms 1094-C and 1095-C with the IRS by the deadline (as described in Q/A-2 above). Timely reporting remains an area of active IRS enforcement.

Final Forms 1094-C and 1095-C Issued

Published: December 16, 2019

The IRS released final 2019 Form 1094-C, Form 1095-C and applicable instructions. Applicable large employers ("ALEs") must furnish the Form 1095-C to full-time employees and file Forms 1094-C and all 1095-Cs with the IRS.

What's New

While the Forms remain substantially the same to last year's versions, the instructions highlight recent changes as announced in Notice 2019-63:

- **Extension of due date to furnish Form 1095-C.** 2019 Form 1095-C is due to employees by March 2, 2020
(instead of January 31, 2020).

- **Relief for failure to furnish 1095-Cs to certain employees enrolled in self-insured health plan.** The IRS will not impose a penalty for failure to furnish Form 1095-C to any employee enrolled in an ALE member's self-insured health plan who is not a full-time employee for any month of 2019 if certain conditions are met.

- **Extension of good faith relief for reporting and furnishing.** The IRS will not impose a penalty for incorrect or incomplete information on Form 1095-C, if there is a good faith effort to comply with the information reporting requirements.

For more details on these changes, review our prior piece issued on December 9, 2019 entitled Deadline Extended for 2019 Forms 1095-C.

Deadlines

ALEs should begin to prepare for calendar year 2019 reporting. Forms and filings are due as follow:

Deadlines	Comments for Self-Funded Plans Providing Coverage to Individuals Other Than Full-Time Employees
Forms 1095-C due to ACA full-time employees by **March 2, 2020.**	ALEs sponsoring a self-funded health plan that provides coverage to individuals who are not full-time employees will either need to provide a Form 1095-C to these individuals by March 2, 2020 or satisfy the requirements of the relief announced in Notice 2019-63 by posting a website notice and upon request, providing the Form 1095-C within 30 days.
Form 1094-C and all corresponding Forms 1095-C must be filed electronically with the IRS by **March 31, 2020**; employers filing fewer than 250 statements may file by paper to the IRS no later than **February 28, 2020**.	If a self-funded employer takes advantage of the relief available in Notice 2019-63, the employer must still file the Forms 2019-C with the IRS for individuals who are not full-time employees but were covered by the self-funded health plan in 2019.

Penalties

Failure to furnish a correct Form 1095-C may result in penalties of $270/Form with an annual calendar year maximum of $3,339,000. Failure to file correct Forms 1095-C and 1094-C with the IRS may result in penalties of $270/Form with an annual calendar year maximum of $3,339,000.

Resources

- 2019 Form 1095-C, https://www.irs.gov/pub/irs-prior/f1095c--2019.pdf
- 2019 Form 1094-C, https://www.irs.gov/pub/irs-prior/f1094c--2019.pdf
- Instructions to 2019 From 1094-C and 1095-C, https://www.irs.gov/pub/irs-prior/i109495c--2019.pdf

Proposed Transparency Rules for Health Plans

Published: December 17, 2019

On November 27, 2019, the Departments of Health and Human Services (HHS), Labor (DOL) and the Treasury (collectively, the Departments) published a proposed rule that would impose new "transparency in coverage" requirements on group health plans and health insurance carriers.

Under the proposed rule, non-grandfathered group health plans and all health insurance carriers would be required to comply with the following transparency disclosure requirements:

Information Disclosed	Who Can Access the Information	Format of Disclosure
Cost-sharing information on covered items and services.	Participants and beneficiaries (and their authorized representatives).	• Internet-based self-service tool • Paper format (upon request)
Negotiated rates with in-network providers, and historical out-of-network allowed amounts.	All consumers and members of the public.	Machine readable files.

The rule is only in proposed form, which means that group health plans and insurance carriers are not yet required to comply with the new requirements. If finalized, the new requirements would be effective for plan years beginning on or after one year following finalization of the rule. For example, if the rule is finalized

on June 1, 2020, then a group health plan with a January 1 plan year would be required to comply with the new requirements on January 1, 2022.

If finalized "as-is", the requirements impose substantial new disclosure obligations on group health plans. While carriers will generally be responsible for these disclosures with respect to fully insured plans, self-funded plans will need to work with third party administrators or other vendors to meet the new requirements. The rule does not apply to excepted benefits (e.g., dental, vision, health flexible spending arrangements (health FSAs)), or to health reimbursement arrangements (HRAs) or other account-based plans that simply make a certain dollar amount available, or to short-term limited duration insurance.

The following provides highlights from the proposed rule.

Overview

The stated goal of the proposed rule is to support a market-driven health care system by giving employees and other consumers the information they need to make informed decisions about their health care purchases. For example, the rule provides participants and beneficiaries with price and benefit information in advance that can enable them to evaluate their health care options and make cost-conscious decisions. The Federal Government is of the view that price transparency will, over time, potentially lower overall health care costs in the market.

Disclosure to Participants and Beneficiaries

At the request of a participant or beneficiary (or authorized representative), a group health plan or insurance carrier must provide specified cost-sharing information with respect to a covered item or service that the individual might receive from a particular provider. The disclosure is similar to an "explanation of benefits" (or EOB), except that it is provided before medical treatment, not afterwards.

Briefly, the disclosure must include:

- An estimate of the participant's or beneficiary's cost-sharing liability at the time the request is made, considering all deductibles, coinsurance, copayments and other cost-sharing provisions under the group health plan;
- Accumulated amounts of cost-sharing that the participant or beneficiary has already incurred under the plan at the time the request is made;
- For an in-network item or service, the negotiated rate (reflected as a dollar amount) with the in-network provider;
- For an out-of-network item or service, the out-of-network allowed amount for the requested item or service if furnished by an out-of-network provider;
- If the item or service is subject to a bundled payment arrangement, cost sharing information for each item and each service within the bundle;
- Notification (if applicable) that the covered item or service is subject to concurrent review, prior authorization, step therapy protocol, or other prerequisite to coverage; and
- Notification on balance billing for out-of-network items and services, that the actual charges may be different from the estimate provided, and other required disclosures. A model notice is available.

This information must be provided in plain language through a self-service tool on an internet website that allows real-time responses based on cost-sharing information that is accurate at the time of the request. There are detailed requirements as to what the website must allow the user to do, including looking up information via a billing code (e.g., CPT code) or by using the name of the provider (both in-network and out-of-network). If requested by a participant or beneficiary (or authorized representative), the information must be mailed to the individual in paper format within two business days of receipt of the request.

The proposed rule permits fully insured group health plans to enter into a written agreement with the insurance carrier which requires the carrier to disclose the required information to participants and beneficiaries (and their authorized representatives). If the carrier fails to provide full or timely information, the carrier will be liable but not the plan. This special rule does not apply to self-funded plans. While employers sponsoring self-funded health plans may contract with third parties to provide the applicable notices, if the
third-party fails to provide full or timely information on behalf of the plan, the plan (and employer) remain liable.

Disclosure to the Public

The proposed rule also requires group health plans and insurance carriers to make publicly available two machine-readable computer files which contain the following information:

1. Negotiated Rate File: A file that lists every negotiated rate under the group health plan with respect to each covered item or service furnished by in-network providers. The disclosure would include billing codes used by the plan to identify each item or service, with a plain language description of each billing code. If the plan has negotiated different rates for items or services furnished by various network providers, then each different negotiated rate must be disclosed. In addition, if the plan has negotiated a bundled payment arrangement (for example, for childbirth), then the plan must identify the items and services within the bundle by the relevant billing codes.

2. Allowed Amount File: A file that lists each unique out-of-network allowed amount in connection with covered items or services furnished by a particular out-of-network provider during the 90-day period that begins 180 days prior to the publication of the file. For example, if the group health plan received 23 claims from an out-of-network provider for rapid flu tests during the 90-day period, and the plan calculated out-of-network allowed amounts of $100 for three claims, $150 for 10 claims, and $200 for the remaining 10 claims, then it would need to disclose all of this information in the file.

The proposed rule lays out specific formats and methods for these files, which must be updated on a monthly basis. In addition, the Departments released tables that outline the proposed data elements that a plan or issuer would be required to use in each readable file.

- Negotiated Rate File, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-negotiated-rate-file.pdf

- Allowed Amount File, https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/transparency-in-coverage-allowed-amounts-file.pdf

The proposed rule permits fully insured group health plans to enter into a written agreement with the insurance carrier which requires the carrier to disclose the two machine-readable computer files to the public. If the carrier fails to provide full or timely information, the carrier will be liable but not the plan. For self-funded plans, the rule permits the plan to reduce the burden of disclosure by entering into a HIPAA business agreement and contracting with a health care claims clearinghouse or third party administrator to disclose the information on behalf of the plan, but the plan would remain liable for any failure by the clearinghouse or administrator to comply with the new rule.

Employer Action

This summary provides a high-level overview of the very detailed proposed rule on the new transparency disclosure requirements. The Departments will collect comments on the proposed rule until January 14, 2020, and any final rule will be published at a later date.

These rules are in proposed form, which means that no action is required at this point. Employers should be aware that additional transparency disclosure requirements may be coming, and will likely add additional administrative costs and other burdens to their employer-sponsored group health plan. If the new rule is finalized, plans should have at least a year from the time the final rule is published to address compliance with any new requirements.

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