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Employee Benefits Compliance Update

USI Insurance Services Employee Benefits Compliance Practice

In This Issue

THE USI ONE ADVANTAGE®

Update on ACA Employer Play or Pay Penalty Enforcement - Letter 227 and CP220J Notice

In brief:

- IRS Letter 226-J informs an employer that it has potential liability for an Employer Shared Responsibility Payment (ESRP).
- After an employer responds, IRS Letter 227 informs the employer of the next steps, or that the case is closed.
- A CP220J Notice is the bill the IRS sends an employer if an ESRP is ultimately assessed.

The Internal Revenue Service (IRS) has provided more information to employers about the procedures it is following to assess penalties under the employer mandate ("play or pay") provisions of the Affordable Care Act (ACA). This article discusses those procedures, and what employers can expect to happen after being contacted by the IRS about possible ACA penalties.

Background

In late 2017, the IRS began sending out "226-J" letters to employers that appeared to owe a penalty for 2015 under the ACA's employer shared responsibility mandate, specifically sections 4980H(a) and (b) of the Internal Revenue Code, as reported in our November 2017 Employee Benefits Compliance Update. Our article in the December 2017 Employee Benefits Compliance Update outlined how an employer should respond to the IRS if it receives a Letter 226-J, depending on its circumstances, and included a link to the IRS Web page "Understanding your Letter 226-J."

According to a report from the Treasury Inspector General for Tax Administration, the IRS has identified over 30,000 employers as having potential liability for a 2015 Employer Shared Responsibility Payment (ESRP). 226-J letters for 2015 continue to be sent out. The report also states that IRS is currently analyzing its data to identify employers that have potential liability for a 2016 ESRP, as the first step in preparing 226-J letters for 2016.

Letter 227

After reviewing an employer's response to a Letter 226-J, the IRS will either close the case, or outline the next steps, if any, by sending a Letter 227 to the employer. There are five different versions of Letter 227, depending on the stage of the case, whether the IRS agreed or disagreed with the employer's position, and whether an ESRP is still considered to be owed. The IRS has posted a Web page entitled "Understanding your Letter 227," which includes sample drafts of the letter.

Here is a summary of the five versions of Letter 227:

- Letter 227-J acknowledges receipt of the employer's signed agreement to the proposed ESRP on Form 14764, and confirms that the ESRP will be assessed against the employer. After issuance of this letter, the case will be closed. **No response is required**; however, an employer can choose to make a full or partial payment of the ESRP immediately. If not, a bill for the amount owed will be sent to the employer.
- Letter 227-K acknowledges receipt of information provided by the employer, and shows the proposed ESRP has been reduced to zero. After issuance of this letter, the case will be closed. **No response is required.**
- Letter 227-L acknowledges receipt of information provided by the employer, and shows the proposed ESRP has been revised. The letter includes an updated Form 14765 (Employee Premium Tax Credit Listing) and revised calculation table. **A response is required**; the employer can either agree with the revised proposed ESRP, or request a meeting with an IRS representative and/or the IRS Appeals Office.
- Letter 227-M acknowledges receipt of information provided by the employer, and shows that the proposed ESRP did not change. The letter includes an updated Form 14765 (Employee Premium Tax Credit Listing) and revised calculation table. **A response is required**; the employer can either agree with the proposed ESRP, or request a meeting with an IRS representative and/or the IRS Appeals Office.
- Letter 227-N is issued after an employer has requested and participated in a pre-assessment conference with the IRS Appeals Office. Letter 227-N acknowledges the decision reached by the Appeals Office and shows the ESRP that is being assessed based on the Appeals Office review. After issuance of this letter, the case will be closed. **No response is required**; however, an employer can choose to make a full or partial payment of the ESRP immediately. If not, a bill for the amount owed will be sent to the employer.

CP220J Notice

A Letter 227 is not a bill. Even if an employer has received a Letter 227-J or 227-N stating that an ESRP is owed, it can choose to wait until it receives a bill (also called a "Notice and Demand") for the ESRP in the form of a **CP220J Notice**, before paying the amount owed to the IRS.

A CP220J Notice will outline the amount of ESRP due, the due date, and payment options. Interest will be charged on any balance outstanding after the due date until the amount is paid in full. ESRP payments, if assessed, are subject to lien/levy and will be collected in the same manner as other IRS assessments.

For more information, the IRS has a web page titled "Understanding Your CP220J Notice," which includes a link to a sample CP220J Notice.

Short-Term, Limited-Duration Insurance Final Regulations Issued but Face an Uncertain Future

In brief:

- Various federal regulatory agencies have issued final regulations that lengthen the maximum initial policy term and maximum coverage duration of short-term, limited-duration health insurance.
- Since short-term, limited-duration insurance is not subject to the mandates under the Affordable Care Act (ACA), it is generally much less expensive than ACA-compliant coverage and may be attractive to younger, healthier individuals who do not have access to subsidized Marketplace exchange coverage.
- However, such coverage should not have any significant impact on employer-provided health insurance coverage, and existing and emerging state regulation may dampen the impact of these new federal rules across the country.

On August 3, 2018, the Internal Revenue Service, Department of Labor, and Department of Health and Human Services (the tri-agencies) published final regulations to lengthen the maximum duration of short-term, limited-duration insurance that is excluded from the definition of individual health insurance coverage that is otherwise subject to various mandates and consumer protections provided under the Affordable Care Act (ACA). In finalizing these rules, the tri-agencies continue to implement the directive in President Trump's October 12, 2017 executive order to increase access to more affordable consumer choices for health coverage. Although these final federal rules become effective on October 2, 2018, the sale of these products will also remain subject to state insurance regulation. In turn, some states have taken, or are actively considering taking, action to more tightly regulate them.

Background

Short-term, limited-duration insurance is a type of health insurance coverage that is primarily designed to fill gaps in coverage that may occur when an individual is transitioning between jobs or otherwise needs individual coverage outside of the open enrollment period (and does not qualify for COBRA continuation coverage or for a special enrollment period). These policies pre-date the ACA and have been excluded from the definition of individual health insurance for certain purposes since the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Nevertheless, even though they do not qualify as "minimum essential coverage" for purposes of the ACA's individual and employer mandates, the popularity of these policies has soared in recent years because they are not subject the ACA's market reforms. This enables these policies to impose medical underwriting requirements, base premiums on health status, exclude coverage for preexisting conditions, impose annual or lifetime limits, exclude broad categories of benefits (such as prescription drugs and treatment for mental health and substance use disorders), and require higher out-of-pocket cost-sharing than allowed under the ACA. As a result, they are much less expensive than ACA-compliant individual health coverage, making them particularly attractive to younger and healthier individuals who are ineligible for subsidized Marketplace exchange coverage but who are still interested in having some health insurance in place.

Key Changes in Final Regulations

Under the final regulations, federal law will now allow for the issuance of short-term, limited duration insurance that:

- Has an initial coverage term of less than 12 months (or up to 364 days), which is an increase from the previous three-month maximum allowed under the prior regulations that were finalized during the Obama administration;

- May be renewed for a total coverage duration of up to 36 months (inclusive of the initial coverage term), which is an increase from the prohibition on renewals under the Obama-era rules and the one-year maximum initially proposed by the Trump Administration; and
- Contains one of two versions of required notices, depending on whether the coverage start date is before January 1, 2019 (when the penalty for failing to comply with the ACA's individual mandate is zeroed out), which warn consumers that the policies are not required to comply with various federal health insurance mandates.

The final regulations do not prevent an individual from "stacking" separate short-term, limited-duration policies that run consecutively, so long as each policy is separate and its duration does not last longer than 36 months. In addition, the final rules allow carriers to sell guaranteed renewal riders to their short-term, limited-duration policies to make it easier for an individual to maintain his or her coverage under a given policy for the full 36-month duration period.

Limited Impact on Employers

Short-term, limited-duration insurance is not an employer-provided product, but is sold directly to individuals. Thus, these new regulations should not have any direct impact on employers, aside from possibly certain small employers who, in lieu of offering employer-sponsored coverage, could encourage their employees to purchase short-term, limited-duration coverage. However, there are some concerns that broadening access to short-term, limited-duration insurance could weaken the individual and small group insurance risk pools. If so, there is the potential for an indirect impact on the cost of coverage in the large group market if healthcare providers shift more of their cost for uncompensated care to the employer-provided coverage.

Unclear Future Outlook

The preamble to short-term, limited-duration insurance final regulations confirms that states can apply or adopt standards that are more restrictive than those in the final federal rules. In turn, due to concerns about deceptive marketing confusing consumers as to the limited scope of the coverage provided under these policies as well as the potential impact on their state health insurance markets, over 20 states already have in place more stringent initial policy term and maximum coverage duration limitations. Three states (Massachusetts, New York and New Jersey) go further and prohibit medical underwriting of such policies, making them effectively unavailable in those states because medical underwriting is a key plan design feature in most short-term, limited-duration policies. In addition, several additional states (including California, Illinois, Minnesota, Virginia, and Washington) are quickly moving to reconsider their regulation of short-term, limited-duration insurance. Thus, even after these new federal regulations become effective on October 2, 2018, their impact will be uneven across the U.S.

Coverage of Emergency Room Services Under Scrutiny

In brief:

- The Federal government has declined to require insurers to use a Federal or third-party database of medical payments and charges in determining usual, customary and reasonable (UCR) charges for paying out-of-network providers for emergency services under the Affordable Care Act.
- Anthem's strategy in certain states of denying benefits for non-emergency treatment at an emergency room has been criticized for requiring patients to self-diagnose whether their medical condition constitutes an emergency, possibly leading to aggravated medical conditions and even death.

Hospital emergency room services can result in big medical bills, so it is not surprising that two recent cases address the financial liability facing group health plans for these services. The first case concerns a lawsuit filed by the American College of Emergency Physicians (ACEP), challenging the Federal government's formula under the Affordable Care Act (ACA) for a group health plan's payment for emergency services by an out-of-network physician. The second case concerns Anthem Blue Cross Blue Shield, which denied coverage in certain states for non-emergencies treated in a hospital emergency room. Both cases provide useful instruction for group health plans attempting to control high cost emergency room services.

Background

The ACA's "patient protections" include a requirement that non-grandfathered group health plans covering emergency room services must comply with the following:

- Emergency room services must be covered without the need for a prior authorization determination;

- The services must be covered whether the health care provider is in-network or out-of-network; and
- If the services are provided out-of-network, the patient's cost-sharing requirement (expressed as a copayment amount or coinsurance rate) must be the same as the amount that would apply if the services were provided in-network.

In its regulations, the Federal government acknowledged that the ACA does not prohibit balance billing by an out-of-network provider of emergency room services, nor does the ACA require group health plans to cover the balance billing amount. But it expressed concern that the ACA patient protections would be defeated if a plan paid an unreasonably low amount to an out-of-network provider for these services, while limiting the copayment or coinsurance to the in-network amount, because the patient could end up paying for most of the emergency room costs through balance billing. The Federal government concluded that the plan must pay a reasonable amount for these services under an objective standard, which has been dubbed the "Greatest of Three" or "GOT" rule.

Under the GOT rule, a group health plan must pay the out-of-network provider whichever of the following is the highest amount for the emergency room services:

- The in-network rate, which is the amount negotiated with in-network providers for emergency services.
- The out-of-network rate, which is the amount for the emergency service calculated using the same method that the plan generally uses to determine payments for out-of-network services (such as the usual, customary and reasonable – or UCR– charge), but substituting the in-network copayment, coinsurance, or other cost-sharing provisions for the out-of-network cost-sharing provisions.
- The Medicare rate, which is the amount that would be paid under Medicare for the emergency services.

The Federal government subsequently released a frequently asked question (FAQ) (Q/A-4 of ACA FAQs Part 31), which explains that a group health plan is required to disclose how it calculates the amounts under the GOT rule, including the UCR amount, within 30 days of a request by a covered individual or that person's authorized representative.

ACEP Case

The American College of Emergency Physicians filed a lawsuit against the Federal government, criticizing the second prong of the GOT rule (which concerns the out-of-network rate) to the extent that it referenced UCR charges as a possible method for calculating a reasonable payment for emergency services. ACEP argued that the manner in which UCR charges are calculated is "often not transparent and may be inaccurate." It suggested that an independent database, such as one then being created by an entity called FAIR Health, should be used instead.

The U.S. District Court for the District of Columbia issued a memorandum opinion on the case on August 31, 2017, which focused on procedural matters (rather than on the merits of the GOT rule). The Court concluded that the Federal government had not complied with the Administrative Procedure Act, because its regulations did not specifically address ACEP's concerns about the GOT rule. The Court ordered the Federal government to respond to these concerns as part of its rule-making authority, and to exercise its discretion to reach the same or a different conclusion about the GOT rule as it deems appropriate.

The Federal government responded to the Court order on May 3, 2018, by publishing a "clarification" of the regulations. On the issue of transparency, the "clarification" stated that the GOT rule is sufficiently transparent because it takes into account other Federal laws that require disclosure to the claimant or his/her authorized representative (as discussed in the FAQ cited above). On the issue of accuracy, it stated that replacing UCR charges with a Federal or third-party database would be costly and time-consuming to monitor for accuracy, and "there is no indication that such a database would be a better barometer of UCR amounts than the current methodology used by group health plans." Based on these factors, the Federal government concluded that the regulations provide a reasonable methodology for determining appropriate payments by group health plans for out-of-network emergency services, and that no change is necessary to the GOT rule.

Anthem Case

Beginning in 2015, Anthem Blue Cross Blue Shield ("Anthem") began notifying individual policyholders in Kentucky (later extended to Missouri, Georgia, Indiana, Ohio, and New Hampshire) that it would deny benefits if the individual used an emergency room ("ER") for non-

emergency care, and that the individual would be responsible for paying for these services. More specifically, Anthem selected ER claims for review (and possible denial) if the claim contained a primary medical diagnosis code that was not associated with emergency care. Anthem's emergency room initiative resulted in the denial of benefits for 12,200 emergency room claims in Kentucky, Missouri and Georgia from July 2017 through December 2017, representing 5.8% of total emergency room claims submitted from these states during that period (although up to 73% of these denials were subsequently overturned by Anthem upon appeal by the policyholders).

The office of U.S. Senator Claire McCaskill subsequently published a report, expressing concern about Anthem's emergency room initiative. The report stated that Anthem essentially required patients to act as medical professionals when they experienced medical events, and to self-diagnose whether the medical event constituted an emergency under the Anthem policy. According to the report, the American Medical Association expressed concern that "[t]he impact of this policy is that very ill and vulnerable patients will not seek needed emergency medical care while, bluntly, their conditions worsen or they die."

In January 2018, Anthem made what it called "enhancements" to its process for evaluating emergency room claims, including automatic payments whenever one of the following conditions is met:

- The patient was directed to the emergency room by a health care provider.
- The patient was under the age of 15.
- The patient's home address was more than 15 miles from an urgent care center.
- The emergency room visit occurred during certain weekend hours or on a major holiday.
- The patient was traveling out of state.
- The patient received any kind of surgery.
- The patient received intravenous fluids or intravenous medications.
- The patient received an MRI or CT scan.
- The emergency room visit was billed as urgent care.
- The emergency room visit was associated with an outpatient or inpatient admission.

Because of these enhancements, claim denials by Anthem for non-emergency use of emergency room visits declined significantly, to lower than 0.1% of total emergency room claims for Kentucky, Missouri and Georgia. Senator McCaskill's report stated that these enhancements support the conclusion that the original initiative was overly restrictive in its review of ER claims. The report also stated "[a]s legislators in Missouri and other states consider further responses to insurer ER policies, the challenges outlined above should inform their efforts to prevent patients from unfairly bearing the costs of emergency medical services."

Marketplace Availability Notice "Updated"

The Department of Labor (DOL) recently issued new versions of their model notices to inform newly hired employees of the availability of health coverage options through the Marketplace exchanges. One version is for employers who offer a health plan to some or all of its employees, and the other version is for employers who do not offer a health plan. While these new versions of the "New Health Insurance Marketplace Coverage Options and Your Health Coverage" update the expiration date of the Office of Management & Budget's approval of the model forms through March 31, 2020, there are no substantive changes to the body of the forms. This is somewhat surprising as both versions still reflect Marketplace open enrollment that "begins in October 2013 for coverage starting as early as January 1, 2014," when more recently open enrollment generally begins November 1st. Additionally, they still reflect that employer coverage is "unaffordable" if the cost exceeds 9.5% of annual household income. That percentage is 9.56% for 2018 and rises to 9.86% for 2019.

In any event, employers are reminded that the Fair Labor Standards Act (FLSA), as amended by the Affordable Care Act, requires employers subject to the FLSA to distribute a written notice to all new hires within 14 days of each employee's start date. In turn, employers may but are not required to use the model forms to satisfy this notice requirement. In addition, even though there is no penalty for failure to provide the notices, it is generally considered a best practice to provide the notices to minimize confusion by employees who may attempt to obtain subsidized Marketplace coverage when they are also eligible for employer-provided coverage.

FAQ: What are the Key Concepts, Features, and Differences of a Health and Welfare "Wrap" Plan Document, a "Wrap" SPD, and a Cafeteria Plan Document?

Wrap Plan Document and Wrap SPD

The Employee Retirement Income Security Act (ERISA) requires most health and welfare benefit plans of non-governmental and non-church employers to have both a written formal plan document and a written "summary plan description" (SPD). ERISA lists numerous provisions that must be included in a written plan document, such as claims procedures and COBRA rules. For insured plans, carriers typically provide some documentation, such as "plan booklets" or "certificates of coverage," which contains many of the ERISA-required provisions such as a detailed description of the benefits provided. For self-insured plans, third party administrators (TPAs) often provide such documentation. However, it is not unusual for such documentation to not fully comply with ERISA. A "wrap" plan document is a separate document that will incorporate by reference the plan booklet or certificate of coverage, then supplement that with any additional provisions needed to fully comply with ERISA, in order to meet the written formal plan document requirement. The plan document need not be automatically provided to plan participants, but it must be provided on request.

An SPD is a document intended to be a "summary" of the formal plan document. Thus, it is generally intended to be a document separate and apart from the plan document. However, for health and welfare plans, many practitioners will combine the plan document and SPD into a single document. ERISA and related DOL regulations set forth numerous items that must be included in an SPD, including plan eligibility provisions, a description of plan benefits, and plan subrogation and reimbursement provisions. These required SPD items differ to some extent from the items required in the written plan document, and, as with the plan document requirements, plan booklets or certificates of coverage often provide some, but not all, of the required SPD items. A "wrap" SPD is also a separate document that will incorporate by reference the plan booklet or certificate of coverage, then supplement that with any additional provisions needed to fully comply with SPD requirements, such as the sponsor's Employer Identification Number, 3-digit plan number, and plan year, in order to meet the SPD requirements. SPDs must be distributed to plan participants (see our September 2017 Update for an article on electronic SPD distribution).

Besides supplementing other documentation to satisfy ERISA and related DOL regulations, "wrap" plan documents and "wrap" SPDs are also used to combine multiple benefits into a single "plan," primarily for Form 5500 filing purposes. Absent wrap documentation, plan sponsors of separate benefits (e.g., a medical benefit, dental benefit, and vision benefit) subject to Form 5500 filing requirements should file a separate Form 5500 for each. Thus, the wrap document can reduce complexity and expense of such filings. This single "plan" will often have some name such as the ABC, Inc. Health and Welfare Plan, the ABC, Inc. Omnibus Welfare Plan, or the like.

Note that there are no direct penalties on employers for not having a plan document or SPD. However, penalties may be assessed if an employer does not timely respond to certain requests for the plan document and/or SPD. Regardless, it is important that those covered under health and welfare benefit plans understand their benefits. Absent documentation, participants may be left to guess what their benefits are, and disagreements may be settled through lawsuits, with courts tending to give participants the benefit of any doubt. For those maintaining a plan document and SPD separately, it is important that they are each reviewed for consistency. Further, it is important that wrap plan documents and wrap SPDs be reviewed for consistency against plan booklets or certificates of coverage provided by carriers or TPAs.

Cafeteria Plan Document

A cafeteria plan is generally not a benefit, but is essentially a benefit funding arrangement that allows for employees to pay their share of the cost of certain qualified benefits on a pre-tax basis. Cafeteria plans are sometimes referred to as premium-only plans (POP), premium conversion plans (PCP), flex plans, etc. For most employee benefits, employee contributions cannot be treated as pre-tax without a cafeteria plan document. Absent such a plan document, whenever an employee is given an option to pay for and receive a tax-free benefit, such as medical plan coverage, versus waiving such benefit and keeping the additional taxable wages, the "constructive receipt" tax doctrine dictates that the employee

be taxed on the employee contribution amount regardless of whether the employee elected and paid for the benefit. Typically, a cafeteria plan document will list the benefits for which employees can make contributions pre-tax, including medical, dental, and vision benefits, and make contributions pre-tax to health savings accounts (HSAs), health flexible spending accounts (FSAs), and dependent care FSAs.

A key feature of a cafeteria plan is that employee elections for how much is taken pre-tax from their pay (generally determined by the cost of benefits they elect) cannot be changed within a plan year except in limited circumstances specified in regulations, and only if the cafeteria plan document expressly allows for those changes. Most cafeteria plan documents contain language allowing changes for all permissible situations, though such situations can be limited as the sponsor chooses in drafting the document. Note that the underlying benefit plans being funded through the cafeteria plan will often have mid-year election change language in their plan documents and/or SPDs that mirrors what is allowed under the cafeteria plan rules, though not necessarily. For example, when a sponsor of a single insured plan chooses to substantially increase employees' share of premiums (even though premiums charged by the carrier do not change) a cafeteria plan document might allow a mid-year election change to revoke coverage, but the underlying insurance policy may not allow dropping of coverage in that situation.

In most cases, plan sponsors of health and welfare plans will maintain plan documents separate from the cafeteria plan document. However, note that health FSAs and dependent care FSAs are actual "benefit plans" themselves. Though they generally require plan documents, documentation of those benefits is often included within a cafeteria plan document.

Contact your USI representative for further information on benefit plan and cafeteria plan documentation requirements.

How can we help?

To learn more about current compliance issues, please contact your local USI Benefits Consultant, or visit us at www.usi.com.