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IRS Expands Preventative Care Benefits Permitted to be Provided under a High Deductible Health Plan

Generally, in order to qualify as a high deductible health plan (HDHP), the plan may not provide any benefits for a year until the minimum deductible for that year is satisfied. However, section 223(c) (2)(C) providers a safe harbor, allowing plans to provide preventative care benefits without the participant meeting their deductible. To be considered preventative care under this safe harbor, the benefit must be described as preventive care for purposes of section [86] of the Social Security Act (SSA) or be preventive care in guidance issued by the Treasury Department and the IRS.

In prior guidance the Treasury Department and the IRS have stated that preventive care generally does not include any service or benefit intended to treat an existing illness, injury, or condition. However, the IRS is revisiting this guidance following the Administration's June 2019 Executive Order (EO 13877), which directed federal agencies to, among other things, expand the ability of patients to select HDHPs that cover low-cost preventive care before the deductible and that helps maintain health status for individuals with chronic conditions.

In this notice, the Treasury Department and the IRS, in consultation with HHS, determined that certain medical care services received and items purchased, including prescription drugs, for certain chronic conditions should be classified as preventive care for someone with that chronic condition. Using agency-determined criteria, the notice sets out a list of the list of preventive care services and items that will now be considered preventative care under the HDHP preventative care safe harbor provision. The specified services and items are treated as preventive care only when prescribed to treat an individual diagnosed with the associated chronic condition, and only when prescribed for the purpose of preventing the exacerbation of the condition or the development of a secondary condition.

This change does not mean these services will be considered as preventive care required to be provided without cost sharing under the Affordable Care Act. This expansion does not impact the ACA's definition of preventative care.

The list of added benefits are as follows:

Preventive Care for Specified Conditions - For individuals Diagnosed with: Angiotensin Converting Enzyme (ACE) inhibitors - congestive heart failure, diabetes, and/or coronary artery disease; anti-resorptive therapy - osteoporosis and/or osteopenia; beta-blockers - congestive heart failure and/or coronary artery disease; blood pressure monitor - hypertension; inhaled corticosteroids - asthma; insulin and other glucose lowering agents - diabetes; retinopathy screening – diabetes; peak flow meter – asthma; glucometer – diabetes; hemoglobin A l e testing – diabetes; International Normalized Ratio (INR) testing – living disease and/or bleeding disorders; Low-density Lipoprotein (LDL) testing – heart disease; Selective Serotonin Reuptake Inhibitors (SSRIs) – depression; statins – heart disease and/or diabetes.

Adopting the Expansion

How and when HDHPs plan may adopt this expansion will depend on how their plan documents currently incorporate IRS guidance on what falls under the preventative care safe harbor. If all IRS guidance is incorporated by reference, the plan may be able to adopt the expansion automatically without changing plan documents.

However, if the pre-existing list of preventative care safe harbor benefits are spelled out in the SBC documents, then a change to the documents is required if the plan wants to add the expanded list. Under

the ACA, this would count as a material change and so would require 60 days notice before becoming effective.

If the list is NOT in the SBC, but is in the plan documents, then ERISA rules for plan document modification would apply.

Source: www.spbatpa.org

(This information is no way intended to be legal advice.) Please consult with your proper legal representative from your firm.

HSA Contribution Limits for 2020

Every year, the IRS announces new inflation-adjusted contribution limits for health savings accounts (HSAs). The 2020 contribution limit for HSAs linked to family coverage is $7,100. The contribution limit for self-only coverage is $3,550, according to IRS Rev Proc. 2019-25.

Generally, excess contributions are not deductible and must be included in gross income. They are also generally subject to a 6% excise tax, which applies to each tax year the excess contribution remains in the account.

Source: www.spbatpa.org

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Medicare Secondary Payer Rules and Incentivizing Plan Participants to Join Medicare

Employers occasionally seek ways to incentivize employees who are eligible for Medicare to sign up and leave their group health plan. This is not permitted under Medicare Secondary Payer (MSP) rules.

Medicare secondary payer regulations at 42 CFR 411.103 explicitly prohibit employers or other entities (i.e. an insurer) from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in, or to terminate enrollment in, a group health plan that is, or would be, primary to Medicare. This prohibition precludes offering to Medicare beneficiaries an alternative to the employer primary plan (for example, coverage of prescription drugs) unless the beneficiary has primary coverage other than Medicare.

The Centers for Medicare and Medicaid Services MSP Manual further explains that employers are required to offer to their employees age 65 or over and to the age 65 or over spouses of employees of any age the same coverage that they offer to employees and employees spouses under age 65.

For Example, a plan may not provide benefits that are less for individuals age 65 or over or charge policyholders premiums that are higher for individuals age 65 or over since this would create an incentive for these individuals to reject the group health plan coverage and make Medicare the primary payor. This provision applies whether or not the individual age 65 or over is entitled to Medicare. This equal benefit rule applies to coverage offered to full-time and part-time employees.

Source: www.spbatpa.org

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Is a Spouse Entitled to COBRA when the Covered Employee Drops Coverage after Enrolling in Medicare?

Although uncommon, covered employees will occasionally choose to drop coverage in the employer's group health plan upon enrolling in Medicare. However, when the employee's spouse is covered under that plan, the question of whether that spouse is entitled to COBRA coverage emerges.

The Department of Labor does list the covered employee becoming entitled to Medicare as a qualifying event that would entitle the spouse or dependent child to COBRA coverage, if it causes the spouse or

dependent to lose coverage. However, the IRS has not viewed becoming eligible for Medicare and then dropping group health plan coverage as causing a loss of coverage.

SPBA has discussed this issue with IRS officials. The key question is whether Medicare enrollment *on its own* would have caused a loss of coverage, if the employee had not dropped the group health plan. Due to Medicare Secondary Payer rules, a plan cannot provide that plan coverage terminates when a covered employee enrolls in Medicare.

The IRS examined these issues in a 2004 ruling, IRS Revenue Ruling 2004-22. The IRS found Medicare enrollment was not considered a qualifying event because if the employee had been enrolled in the plan, the Medicare enrollment would not have caused the spouse to lose coverage on its own.

Source: www.spbatpa.org

Are ALEs Required to hold Open Enrollment Periods?

Following the enactment of the Affordable Care Act (ACA) and its Employer Shared Responsibility (ESR) provisions, employers who previously did not offer annual enrollment periods for employees should consider offering one.

Under the ACA< Applicable Large Employers (ALEs) – employers with an average of at least 50 full-time employees or “full-time equivalents” – must offer affordable minimum essential coverage that provides minimum value to its full-time employees, or face possible penalties under ESR provisions of the ACA>

It is important to note that Treas. §54.4980H-4(b)(1) states that “An applicable large employer member will not be treated as having made an offer of coverage to a full-time employee for a plan year if the employee does not have an effective opportunity to elect to enroll in the coverage at least once with respect to the plan year, or does not have an effective opportunity to decline to enroll…”

The IRS further discusses the meaning of an offer of coverage on its ACA Employer section on its website: “If an employer fails to offer an employee an effective opportunity to elect to enroll in the coverage at least once for the plan year, or to decline to enroll if the coverage offered does not provide minimum value or is not affordable, that employee is not treated as having been offered the coverage.”

So, while the ACA does not specifically mandate an open enrollment period for ALEs, those ALEs who do not provide an annual opportunity for employees to either enroll or decline coverage could face ESR penalties.

Who must be included in Open Enrollment?

ESR regulations state that ALEs must offer coverage to full time employees and their dependents. However, ESR regulations also contain a specific definition for who constitutes a dependent. Under the ESR definition, a dependent means a child under the age of 26. It does not include the spouse of the employee.

Source: www.spbatpa.org

Industry Groups Celebrate Cadillac Tax Repeal

After President Trump signed the $1.4 trillion spending bill on December 20, 2019, a broad range of stakeholders celebrated the long-awaited repeal of the so-called "Cadillac tax." Under the new law, the Patient Protection and Affordable Care Act's (ACA) excise tax on high-cost health plans, which was scheduled to go into effect January 1, 2022, will never take effect.

The new law, the Further Consolidated Appropriations Act, 2020, contains several other provisions impacting health and welfare plans. These include the repeal of the medical device tax, the repeal of the health insurance providers fee, a 10-year extension of annual employer fees to fund the Patient-Centered Outcomes Research Institute (PCORI), and an extension of the employer credit for paid family and medical leave.

Cadillac tax. The unpopular Cadillac tax was originally designed to curtail the preferred treatment of employer-sponsored plans and reduce excess health spending. The tax would have required plan sponsors and insurers to pay a 40 percent excise tax on the excess cost of employer-sponsored health coverage for employees - amounts over $11,100 for employee-only and $29,750 for family coverage, adjusted for inflation annually. The Cadillac tax had been delayed several times, most recently to 2022. A recent Kaiser Family Foundation study had found that the Cadillac tax would have affected 21 percent of employers when it was scheduled to take effect in 2022.

The excise tax on high-cost health plans was designed to help pay for the ACA. The Congressional Budget Office (CBO) has projected that the real of the Cadillac tax will cost nearly $200 billion over 10 years. However, many organizations lobbied for several years to have Congress repeal the Cadillac tax. These groups include the Employers Council for Flexible Compensation (ECFC) and the ERISA Industry Committee.

"Repeal of the Cadillac Tax was one of our highest legislative priorities," said Martin Trussell, ECFC executive director. "We want to thank Congress and the Administration for recognizing the deleterious effect that the Cadillac Tax would have on employer sponsorship of health care plans, especially consumer-directed health plans, and for repealing the tax."

According to Annette Guarisco Fildes, president and CEO of ERIC, "America's large employers, and the tens of millions of Americans with employer-sponsored health coverage, can finally breathe easy, thanks to [the] repeal of the Cadillac tax. The tax was never going to generate massive amounts of money as the budget scorekeepers assumed. Instead, the existence of the tax forced employers to scale back their benefit offerings, and increasingly shift rising health care costs to employees as the only way to avoid the tax. Now, employers will be able to focus on the future with certainty, while they continue to champion innovation in the health care system to bring down costs and improve health care quality,in order to provide the high-value benefits employees and their families have come to rely on."

Other provisions. The new law contains several other provisions impacting health and welfare plans. These include:

- ***Medical device tax repealed.*** The 2.3 percent excise tax on the value of medical devices sold domestically went into effect in 2013 but was suspended by Congress twice, and was not in effect during the period beginning on January 1, 2016 through December 31, 2019. Earlier estimates from the CBO said repeal of the medical device tax would cost about $24 billion over a decade, while the IRS estimated earlier this year that repeal of the health insurance tax would amount to revenue losses of $15.5 billion just in 2020.

- ***Health insurance providers fee repealed.*** The ACA annual fee on health insurance providers also was repealed. The fee imposed a fee on each covered entity engaged in the business of providing health insurance for United States health risks. The fee was divided among health insurers based on their market share and their premiums written. The fee was effective beginning in 2015 but was under a moratorium for 2017 and 2019. CBO estimates that the repeal of the fee will cost almost $151 billion over 10 years.

- ***PCORI fees extended.*** The PCORI fee on health insurance policies and self-funded health plans was set to expire for plan years ending after September 30, 2019, but now has been extended for another 10 years. The law also makes several program changes sough by employers.

- ***Employer credit for paid family and medical leave.*** The law provides a one-year expension of the federal tax credit for employers providing paid family and medical leave through 2020, which was originally enacted as a two-year pilot program under the Tax Cuts and Jobs Act of 2017, CBO projects the extension of the credit will cost $2.2 billion over 10 years.

Source: Spencer's Research

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