Subject: 1) On-going ACA Litigation; 2) Impact of Coronavirus on Employer Shared Responsibility Provisions; 3) Transparency in Health Coverage Rules; 4) State Individual Mandate Reporting Update; 5) Year-end Reminders

Date: November 20, 2020

For so many reasons, 2020 has been a year like no other. Court challenges, regulatory changes, and coronavirus notwithstanding, employers must continue to attend to their ACA responsibilities. This edition also discusses the transparency in health plan coverage rules, state-required individual mandate reporting, and a pronouncement relating to the preventive services mandate. And finally, we've included some year-end reminders to ensure on-going compliance with the ACA.

On-going ACA Litigation

Despite the fact that the Affordable Care Act continues to be the law of the land, its provisions continue to be litigated. Most recently, the United State Supreme Court heard oral arguments on November 10, 2020 in a consolidated case (*California v. Texas*, No. 19-840 and *Texas v. California*, No. 19-1019). The primary issues argued before the Court were whether the provision in the Tax Cuts and Jobs Act in 2017 that reduced the individual mandate penalty amount to zero for failure to maintain minimum essential coverage (MEC) renders the provision unconstitutional, and if so, whether the MEC provision is severable from the rest of the ACA, and whether the challengers have a standing to sue. A ruling is expected sometime in the spring of 2021.

Impact of Coronavirus on Employer Shared Responsibility Provisions

As with most everything in 2020, compliance with the employer shared responsibility requirements of the ACA cannot escape untouched by the coronavirus. Employers subject to the employer shared responsibility rules (employs 50 or more full-time employees) must determine who are 'full-time' employees.

The law provides two methods for defining full-time employee; they are: a monthly measurement method, or a lookback method. If a lookback method is used, as typically, it is the most commonly used method, an individual's hours worked are calculated over a measurement period, and based on those hours worked, the individual is deemed full-time for a corresponding stability period. As you know, in 2020, many employees experienced a reduction in hours due to furloughs, layoffs and the like. These reductions in hours will impact full-time determination, and there is potentially both a positive and a negative implication, depending on one's point of view.

The positive impact may be that when the applicable large employer files its 2022 employer shared responsibility statements with the IRS reflecting the 2021 stability period, it may have significantly fewer full-time employees, resulting from individuals not achieving full-time status during the 2020 measurement period.

The downside is that those individuals who do not qualify as full-time may not be eligible for health coverage. As a reminder, the ACA does not define eligibility for health coverage; it simply defines who is a full-time employee. Many health plans have adopted a health plan eligibility standard that mirrors its definition of full-time employee for ACA purposes. If your health plan has adopted this type of eligibility language, you may discover that certain individuals may no longer meet the definition. As a result, employers may want to modify their health plan's definition of eligibility in order to provide coverage for these individuals in 2021.

If a health plan uses a more traditional definition of eligibility, such as 'an individual who is regularly scheduled to work 30 hours or more per week', and assuming that this definition is not tied to an ACA measurement period, then the determination of health plan eligibility will not likely be impacted.

In summary, employers will want to be very careful that they make their full-time employee determination for the 2020 measurement period impacting the 2021 stability period. Further, employers will want to carefully review the eligibility language in their health plan(s), and make changes as appropriate to be consistent with the employer's intent.

Final Transparency in Health Coverage Rules

On November 11, 2020, the tri-governing ACA agencies (Departments of Health and Human Services, Labor and Treasury) released final rules, together with a Fact Sheet, that require extensive disclosure obligations upon group health plans and insurers. The final rules mirror the proposed regulations issued last year (see CBIZ *Health Reform Bulletin 148*). Following is a very brief summary of the requirements.

Applicability. The transparency in coverage regulations apply to both individual and group health plans, whether insured or self-funded. Certain plans are not subject to these rules including grandfathered plans, excepted benefit type plans, account-based plans such as health reimbursement arrangements and medical flexible spending account plans, and short-term limited duration plans.

Effective Dates. These rules adopt a three-year, phased-in approach as follows:

- Beginning in January 2022, disclosures to insureds must be made available in a searchable online format, which would include data points such as billing codes, names of providers, and other cost-sharing characteristics. Further, the information must be made available in paper upon request. Effectively, these disclosures are an advanced explanation of benefits, providing detailed information such as:
  - ✓ Negotiated rates for covered items and services, both in and out of network and including prescription drug information;
  - ✓ An estimate of the insured's cost-sharing responsibility;
  - ✓ The amount the individual has already paid or incurred for the deductible and out-of-pocket expenses;
  - ✓ If the items or services are bundled, a list of that which is included in the bundle; and
  - ✓ An explanatory notice of the insured's obligations prior to items or services being provided.
- For plan years beginning on or after January 1, 2023, price and cost sharing estimates must be provided for a specifically delineated list of 500 items and services.
- For plan years beginning on or after January 1, 2024, price and cost sharing estimates must be disclosed for all items and services.

In addition, insured plans can take credit in their medical loss ratio (MLR) calculations if their insureds chose cost-effective care. Insurers can begin to include this in their MLR calculations for the 2020 reporting year.

Plan sponsors should begin working closely with their insurers and third party administrators (TPAs) to achieve compliance with these rules. Self-funded plan sponsors should also be aware that while the plan sponsor can contractually obligate a TPA to satisfy these obligations, the plan sponsor ultimately remains liable if the TPA fails to comply with these disclosures.

Updates: State-required Individual Mandate Reporting

A handful of states enacted individual mandate laws that require residents to be covered by minimum essential coverage (MEC) or pay a state tax (see our *Benefit Beat* articles from May, 2020 and September, 2019). These states are California, District of Columbia, Massachusetts, New Jersey, Rhode Island and Vermont. Further, certain states require entities who provide MEC to file information returns to the relevant state revenue departments. Most of these states accept the Form 1094 and 1095 series used for federal MEC filing purposes. Recently, several state revenue departments have issued updates relating to these reporting obligations, as reflected in the charts below.

Notably, unlike many other employment laws, these state individual mandates are not based on place of employment; rather, the applicability of the state individual mandate laws is based on state of residence.

Individual State Mandate Reporting				
State	*Covered entities*	*Applicable form(s)*	*Report due*	*Resources*
California	• Self-funded plan sponsors, health insurers • Employers required to report the information if insurer does not	Same forms used for federal purposes (Form 1094/1095)	• File annually by March 31 • Provide written statement annually by January 31 to individuals	California Franchise Tax Board **Reporting Information**
District of Columbia	• Self-insured health plans, fully insured health plans covering min. 50 full-time employees, health insurers • Third party service providers may file forms for applicable entities	Same forms used for federal purposes (Form 1094/1095)	• File 30 days after IRS deadline for submitting 1095-B/C forms, including any extensions • Form 1095-B/C satisfies DC obligation; no further benefit statement to individuals required	District of Columbia Office of Tax and Revenue **Updated Guidance**
Massachusetts	• Employers, health insurers and other entities that provide health coverage • Employers may contract with TPA to fulfill this obligation	Form MA 1099-HC	Provide annually by January 31 to primary subscriber, and file with Department of Revenue	Massachusetts Department of Revenue **Health Care Reform for Employers**
	• Employers with six or more employees	Health Insurance Responsibility Disclosure (HIRD) form	Annual HIRD filing period: begins Nov. 15 and ends Dec. 15	Massachusetts Department of Revenue **HIRD FAQs**

Individual State Mandate Reporting, cont'd				
State	*Covered entities*	*Applicable form(s)*	*Report due*	*Resources*
New Jersey	◆ Employers, health insurers and other entities that provide health coverage ◆ Employers must submit the forms if the insurer does not	◆ Forms 1095-B/C ◆ Form NJ-1095	◆ File report annually by March 31 ◆ For tax year 2020, provide Form 1095-B to each primary enrollee by March 2, 2021	New Jersey Division of Taxation **Guidance**
Rhode Island	◆ Employer/plan sponsors, licensed insurers ◆ Employers may contract with a third party for reporting and disclosure obligations	Forms 1094/1095	◆ File report annually by January 31 (for tax year 2020, deadline extended to March 31, 2021) ◆ Provide written statement annually by January 31 to individuals (for tax year 2020, deadline extended to March 2, 2021)	Rhode Island Division of Taxation **Health Coverage Mandate**
Vermont	As of January 1, 2020, Vermont residents must maintain a minimum level of health coverage. The law requires residents to self-report compliance when filing his/her taxes. There is no penalty for failure to have health coverage.			

Year-end Reminders

❑ Preventive Health Services

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

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

With regard to a **COVID-19 vaccine**, the tri-governing agencies (DOL/IRS/HHS) issued final regulations on November 6, 2020 to clarify how coverage will be provided. As a reminder, the CARES Act enacted in March, 2020 expedited the timeframe in which a coronavirus vaccine will be covered as a preventive service to 15 days from the date a vaccine is sanctioned as a preventive service. The final regulations provide that the cost of a recommended COVID-19 vaccine and its administration, whether obtained in-network or out-of-network, is covered as a preventive service, with no cost share. To meet the requirements of a *qualifying coronavirus preventive service*, including a vaccine, the regulations clarify that such service be FDA-approved, with an A or B rating by the USPSTF, or recommendation by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

❑ Employer Shared Responsibility Provisions

- ***Applicability.*** For purposes of the ACA's employer shared responsibility requirement as well as the reporting and disclosure requirements, applicable large employer (ALE) status is determined each calendar year, based on the average size of the employer's workforce during the prior year. Thus, if you averaged at least 50 full-time employees, including full-time equivalent employees during 2020, you are most likely an ALE for 2021, and are subject to the reporting and disclosure requirements due in early 2022.

- ***Affordability Standard.*** For purposes of determining affordability, coverage under an employer-sponsored plan is deemed affordable if the employee's required contribution to the plan does not exceed 9.83% (indexed for 2021; up from 9.78% in 2020) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

- ***Increase in Excise Tax Penalties.*** The chart below reflects the amount of penalties for purposes of calculating the 'no coverage' excise tax pursuant to Code Section 4980H(a), and the 'inadequate or unaffordable' excise tax pursuant to Code Section 4980H(b) for 2019 to 2021. These are the excise taxes that could apply if an applicable large employer is found not to have offered health coverage to a full-time employee. These amounts are based on the HHS inflationary percentage contained in its annual benefit and payment parameter standards for the relevant year, and as officially released by the Internal Revenue Service.

'No Coverage' Excise Tax IRC Section 4980H(a)		*'Inadequate or Unaffordable' Excise Tax IRC Section 4980H(b)*	
2019	$2,500	**2019**	$3,750
2020	$2,570	**2020**	$3,860
2021	$2,700	**2021**	$4,060

❑ **Small Business Tax Credit (SBTC).** Small businesses and tax-exempt employers who provide health care coverage to their employees under a qualified health care arrangement are entitled to a tax credit, known as the small business tax credit (SBTC). To be eligible for the SBTC, the employer must employ fewer than 25 full-time equivalent employees, whose average annual wages are less than $55,600 (indexed for 2021; the wage ceiling in 2020 is $55,200).

The tax credit phases out for eligible small employers when the number of its full-time employees (FTEs) exceeds 10; or, when the average annual wages for the FTEs exceeds $27,800 in the 2021 tax year (the phase-out wage limit in 2020 is $27,600). As a reminder, only qualified health plan coverage purchased through a SHOP marketplace is available for the tax credit, and only for a 2-consecutive year period.

For purposes of calculating the SBTC, the Form 8941 is filed annually on the employer's tax return as a general business credit; tax exempt entities would file the Form 8941 with its Form 990-T.

❑ Additional ACA-related Fees

Patient-Centered Outcomes Research Institute (PCORI) Fees

The PCORI fee is assessed on the average number of lives covered under the policy or plan. While the PCORI fee was set to expire for policy/plan years ending on or after October 1, 2019, the *Further Consolidated Appropriations Act, 2020* (enacted on December 20, 2019) extends the PCORI fee obligations for ten years. Thus, the fee will continue to be assessed through 2029.

For policy and plan years ending between October 1, 2018 and September 30, 2019, the fee was $2.45 per covered life. The fee increases to $2.54 per covered life for policy and plan years ending between October 1, 2019 and before October 1, 2020, according to IRS Notice 2020-44. Affected entities are required to pay the fees and file the Form 720 by July 31 of each year.

ACA Cost Share Restrictions

The chart below reflects the 2021 and 2020 inflationary adjustments applicable to out-of-pocket (OOP) limits including deductibles, co-insurance and co-payments in ACA plans. These cost-share restrictions apply to insured plans offered via the marketplace, and insured and self-funded plans offered outside marketplace. These amounts differ from the OOP limits applicable to high deductible health plans used in conjunction with a health savings account (HSA).

	2021		2020	
	Self-only	*Family*	*Self-only*	*Family*
ACA Plans - Out-of-Pocket (OOP) Limits	$8,550	$17,100	$8,150	$16,300
Health Savings Accounts	*Individual*	*Family*	*Individual*	*Family*
HDHP Annual Deductible	$1,400	$2,800	$1,400	$2,800
HDHP Annual Out-of-Pocket Limit	$7,000	$14,000	$6,900	$13,800
Contribution Limit	$3,600	$7,200	$3,550	$7,100

Highlights of ACA-related Reporting and Disclosure Reminders

The two tables below reflect certain reporting and disclosure requirements. Of particular note:

- **Clarifications to revised SBC Template for 2021.** As mentioned in *CBIZ Health Reform Bulletin 148*, the DOL and HHS issued a revised summary of benefits and coverage (SBC) template and related materials to be used by plan sponsors and insurers for policy/plan years beginning on or after January 1, 2021 relating to coverage for plan years beginning on or after that date. These documents are available on the DOL-EBSA and/or HHS-CCIIO webpages.

- The IRS issued final versions of the **Forms 1094 and 1095 series** (see *CBIZ Health Reform Bulletin 154*). Paper versions of the forms must be submitted to the IRS by March 1, 2021, or sent electronically by March 31, 2021. The deadline for furnishing benefit statements (Form 1095-B and Form 1095-C) to individuals has been extended from January 31, 2021 to March 2, 2021.

ACA-required Reporting Reminders

Form	*To Whom*	*Due Date*
Form W-2 *ACA-required reporting includes*: ◆ Aggregate cost of health coverage (Box 12, using Code DD). *Note: employers filing <250 Form W-2s per year remain exempt from reporting the aggregate cost of health coverage on the Form W-2 until future IRS guidance is issued.*	Internal Revenue Service (IRS) http://www.irs.gov/ Form W-2 Instructions (2020)	January 31, 2021

ACA-required Reporting Reminders, cont'd

Form	To Whom	Due Date
Form W-2 reporting, cont'd ◆ Total amount of permitted benefits received under a qualified small employer health reimbursement arrangement (QSEHRA) (Box 12 - Code FF) ◆ Additional Medicare tax withholding on earnings exceeding $200,000 per calendar year (Box 6)	Internal Revenue Service (IRS) http://www.irs.gov/ Form W-2 Instructions (2020)	January 31, 2021
Form 1094/1095 *See* CBIZ HRB 154 *for discussion of final 2020 Forms and Instructions* ◆ File Forms 1094/1095	IRS	◆ By paper: March 1, 2021 ◆ Efile: March 31, 2021
◆ Furnish Form 1095; or, certain Form 1095-B reporting entities can utilize simplified posting method	Individuals listed in Forms 1094 and 1095	March 2, 2021
Form 720 Used for purposes of Patient Centered Outcome Research Institute (PCORI) fee	IRS	July 31 of each year

Additional ACA-Related Disclosure Reminders

Note: Below are select ACA-required disclosures. For a more descriptive list of notice obligations relating to the ACA and other welfare benefit plans, ask your CBIZ representative for a Chart of Notice Obligations.

Form	To Whom	Due Date
Summary of Benefits and Coverage (SBC) SBC template and related materials available from **DOL-EBSA** and/or **HHS-CCIIO** ***Important Note:*** Two versions of these materials available: ◆ One set for plan years beginning on or after Jan. 1, 2021; or, ◆ One set for use on or after April 1, 2017	All plan participants	From Plan Sponsor to Plan Participants: 1. Upon application 2. By the first day of coverage 3. Within 90 days of enrollment by special enrollees 4. Upon contract renewal 5. Upon request
Advanced 60-day Notice of Material Change in Benefits	All plan participants	No later than 60 days prior to any material change in any terms of plan affecting Summary of Benefits and Coverage (SBC) content not reflected in the most recently-provided SBC (other than in connection with renewal or reissuance of coverage)

Additional ACA-Related Disclosure Reminders, cont'd

Form	*To Whom*	*Due Date*
Notice of Marketplace Options ◆ Model notice for use by employers **who offer coverage** to some or all employees: ▪ English (**PDF** or **Word**) ▪ Spanish (**PDF** or **Word**) ◆ Model notice for employers who **do not offer health coverage:** ▪ English (**PDF** or **Word**) ▪ Spanish (**PDF** or **Word**)	All new hires including full-time and part-time employees, without regard to eligibility status for the health plan	Within 14 days of date of hire

Increased Penalties for Certain Compliance Violations

Federal government agencies who enforce the ACA, including the Departments of Labor, Treasury and Health and Human Services, have authority to adjust civil penalties attributable to compliance failures.

Failure to provide Summary of Benefits and Coverage (SBC)	Up to $1,176 per failure *(indexed for 2020)*
Failure to file a correct information return *Example: Form 1094/1095 and W-2*	▪ Avg. annual receipts/3 years ≥$5M: $280 per return (cap of $3,426,000 per calendar year) ▪ Avg. annual receipts/3 years ≤$5M: $280 per return (cap of $1,142,000 per calendar year) *(indexed for 2021)*
Failure to provide correct payee statement *Example: Forms 1094/1095 and W-2*	▪ Avg. annual receipts/3 years ≥$5M: $280 per return (cap of $3,426,000 per calendar year) ▪ Avg. annual receipts/3 years ≤$5M: $280 per return (cap of $1,142,000 per calendar year) *(indexed for 2021)*

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