Health Care Issues and Planning for Tax Professionals

HPTP/21/W1

Today's Presenter

Michael J. Tucker, CPA
Mike, an employee of Surgent McCoy CPE, LLC, has authored many professional articles and is a veteran TV and live seminar presenter. He currently heads up Surgent McCoy's webinar efforts, where he writes and hosts many of the webinars Surgent McCoy sponsors and presents.

Today's Presenter

Erica Dumpel, CLU

Erica is president of Czajkowski Dumpel & Associates, Inc. (CDA Inc.), an agency she founded in August of 1975. CDA Inc. is a boutique benefits firm in the metro Atlanta area that specializes in employee benefits, particularly health insurance. As many employees continue to work beyond their normal retirement age, coordination of employer-based plans and Medicare has become increasingly important. Erica consults with individuals and companies to help determine what decisions relative to Medicare are the most advantageous for the employees and provide the best protection for them and their families. Additionally, Erica works nationally with individuals advising on Medicare decisions in both a consulting and a brokerage capacity.

Today's Presenter

Bob Lickwar, CPA, MST

Bob has more than 30 years of experience as a practicing CPA and has worked exclusively with privately held businesses and owners to provide compliance services and sophisticated tax planning strategies including like-kind exchanges, tax efficient workouts and restructurings, reorganizations and estate planning services. He has assisted clients in the development of tax-favored and other retirement plans and has worked with firm partners in developing tax efficient succession transitions, including acquisitions and sales of businesses. He also has extensive experience in dealing with tax authorities at both the federal and state levels.

Today's Presenter

Lida Bayne, SPHR

Lida, an HR and Benefits Consultant for Czajkowski Dumpel & Associates, Inc., advises companies in the small to mid-size benefits market. She focuses on regulatory compliance in the administration of health and welfare plans. Lida conducts reviews of benefits policy and procedure and provides guidance for the employer regarding best practices, as well as supporting broker efforts to place and maintain the highest quality plans with each client company.

Proposed Legislation

FY 2022 Budget Resolution Agreement Framework

- House Democrats on Ways and Means Committee trying to find money to pay for President Biden's $3.5 trillion in budget priorities, including expenditures related to:
  - Expanded child tax credit
  - National paid-leave program
  - Renewable energy tax breaks

FY 2022 Budget Resolution Agreement Framework

- The budget resolution calls for the following health care-related investments
  - Paid Family and Medical Leave
  - Affordable Care Act (ACT) expansion
  - Extending and filling the Medicaid Coverage Gap
  - Expanding Medicare to include dental, vision, and hearing benefits, and lowering the eligibility age
  - Addressing health care provider shortages (Graduate Medical Education)
  - Child Tax Credit/EITC/CDCTC extension
  - Long-term care for seniors and persons with disabilities (HCBS)
  - Health equity (maternal, behavioral, and racial justice health investments)
  - Reducing prescription drug prices
- How many of these proposed changes will be enacted, if any, is an open question

New Developments Related to Long-Term Care Insurance

Background to Crisis Dealing With Long-Term Care Insurance

- In 2018, 52.4 million Americans were 65 years of age or older and 6.5 million were 85 years of age or older
- By 2040, 80.9 million will be age 65 or older and 14.4 million will be age 85 or older
- From 2021 until 2030 an average of 10,000 baby boomers will turn age 65
- Demand for long-term care much greater than supply
- For example, the Medicaid waiting list for home-based care has a three-year wait
- Half of US households are led by someone age 55 or older who has no retirement savings

Background to Crisis Dealing With Long-Term Care Insurance

- Insurance carriers for LTCI have had many more claims than expected
- Lower interest rates than expected
- Fewer lapse rates than expected
- Mortality lower than expected

The Result!

Very high premium rate increases**…100%, 200%, 300% and distrust of the insurance industry**

Fewer stand-alone insurers selling traditional long-term care policies

In 2000, over 125 carriers selling; in 2019, about 12

Fewer consumers buying –

Stand-alone policy sales:

2002: 750,000

2008: 400,000

2018: 56,000

Source: NAIC – Long-Term Care Insurance update 3-5-2019

Background to Crisis Dealing With Long-Term Care Insurance

- Average retirement payment from Social Security is about $18,500
- Average price of a semi-private room in a nursing home in excess of $93,000 annually
- Cost of home-health aid around $50,000 annually
- Most seniors will need some form of long-term care
  - 70% of Americans who turn age 65 today will need extended health-related services and support at some point in their lives
  - Medicare does not handle routine living assistance or custodial care
  - Purchasing Long-term care insurance has proven problematic for many due to the very great premium increases

New Washington State Employee Payroll Tax Law for LTCI Benefits

- Most insurers have abandoned the sale of long-term care insurance
- Those insurance companies with outstanding long-term care insurance policies have substantially raised the annual premiums on their policies
- In 2019, Washington State passed the nation's first state-run long-term insurance program
- The program is funded by a 0.58 payroll tax on employees
- Starting in 2025, eligible Washington State residents can receive benefits from the program of $100 per day, with a lifetime cap of $36,500

New Washington State Employee Payroll Tax Law for LTCI Benefits

- Starting January 1, 2022, a 0.58% premium assessment will be imposed on all State of Washington employee wages
- *There are no specific exemptions for hospital or health system employees*
- An employee has a one-time opportunity to opt-out if they have comparable private long-term care insurance
- Starting January 1, 2025, proceeds of this premium assessment will be used to provide long-term services and support benefits to Washington State residents who have paid into the LTSS Program for a specific amount of time and who need a certain amount of assistance with activities of daily living
- Starting January 1, 2022, all Washington employee wages (those employees who work in Washington, receive wages reported on a Form W-2, and work at least 500 hours per year) are subject to a **0.58% premium assessment** (for example, $0.58 premium assessment on every $100 of eligible wages)

New Washington State Employee Payroll Tax Law for Long-Term Care Benefits

- The 0.58% premium assessment is not a tax on employers, but employers are required to collect premiums through employee payroll deductions and remit proceeds to the State of Washington Employment Security Department (EDS), which will deposit the funds in a trust for the individual until they qualify for the long-term care benefit
- All qualifying employees are subject to the premium assessment, with an exception for individuals who have private long-term care insurance and have opted-out

New Washington State Employee Payroll Tax Law for Long-Term Care Benefits

- Any employee who attests that they have *comparable* long-term care insurance purchased before November 1, 2021 may apply to the ESD for an exemption from the premium assessment
- The employee must provide proof of their ESD exemption to their employer before the employer can waive collecting the premium assessment from the employee's wages
- The employee must apply for the opt-out exemption to ESD between October 1, 2021 through December 31, 2022
- Starting on January 1, 2022, any self-employed individuals (non-W-2 wage employees) may choose to participate
- They may elect this option by January 1, 2025, or within three years of becoming self-employed for the first time

State-Based Public Health Insurance Options

Options in the States of Washington, Colorado, and Nevada

- National out-of-pocket spending on health care grew 4.6% in 2019 to $406.5 billion—3.1% growth in 2018
- A public option generally involves a government-run health insurance agency that is lower-priced than commercial health insurance policies and competes with commercial insurers
- The states of Washington and Colorado have adopted a public health insurance option
- Nevada's public option has private insurers offering lower-priced health plans and requires some insurers to bid to offer plans starting in 2026 on the public option

Options in Nevada

- The goal in Nevada is to have the public option health insurance plans priced 5% less than other popular, mid-priced plans that comply with the Affordable Care Act (ACA) so that public-option plans would be priced at 15% less than commercial options over four years
- Insurers that administer Nevada's Medicaid contracts would be required to bid to offer plans through the public option to many individuals whose income is low enough to qualify for ACA subsidies as well as small businesses
- Uninsured people in Nevada currently have Medicaid, which they may qualify for based on income
- The public option is intended for those earning too much to qualify for Medicaid and is not available to Medicaid recipients

New Developments

Increase in Medicaid Enrollments

- The number of Americans relying on Medicaid to pay for health care expenses increased to an all-time high during the coronavirus pandemic
- Nearly 80 million Americans are currently covered through Medicaid
- Some people signed up in 2020 as the pandemic's economic fallout took away their jobs, income and health benefits
- Much of the increase is due to the first coronavirus relief law adopted by Congress in 2020 which gave states extra federal money to help cover what were anticipated to be ballooning Medicaid costs
- In exchange, states were required to promise that they would not remove anyone from their Medicaid rolls until the federal government ended the coronavirus public health emergency
- 63 million Americans were covered under Medicare in 2020

Texas v. California

- In Texas v. California, the United States Supreme Court dismissed a challenge to the ACA from Republican-led states and the former Trump administration, which urged the justices to invalidate the entire ACA on the grounds that the challengers of the ACA did not have standing to bring such a lawsuit
- Some taxpayers had filed protective refund claims in anticipation that the Supreme Court would invalidate the taxes included in the ACA—the 0.9% additional Medicare tax on earned income and the 3.8% tax on net investment income
- It appears unlikely that the Supreme Court will overturn part or all of the ACA

Biden Executive Order, July 2021

- By executive order, President Biden has taken a series of steps to lower prices for prescription drugs, including taking legal steps against companies that cooperate to keep generic medicines off the market and allowing states and Indian tribes to import drugs from Canada
- President Biden also called for measures to increase the use of generic drugs and other medicines known as biosimilars, which are essentially generic versions of expensive biological drugs already on the market
- President Biden called on the Department of Health and Human Services to issue proposed rules within 120 days to allow high-priced hearing aids to be sold over-the-counter in drug stores

Biden Executive Order, July 2021

- President Biden also called for curbing “pay for delay” deals between brand-name drugmakers and generic companies
- These are contracts in which a generic company receives compensation for keeping their lower cost drugs off the market

Leyh, 157 TC No. 7

- In 2014, the taxpayer, while his divorce was pending, entered into a separation agreement with his spouse according to which the taxpayer agreed to pay for the spouse’s health and vision insurance through a cafeteria plan provided by his employer (“insurance payments”) until their final decree of divorce was granted
- The payments were made via pretax reductions to his salary so that he did not pay income tax on that portion of the wages used to pay for the insurance
- The taxpayer, on his separately-filed 2015 return, excluded from his gross income the insurance payments and also claimed an alimony deduction for the portion of the insurance payments covering his spouse
- The IRS disallowed the alimony deduction on the grounds that the alimony deduction was an impermissible double deduction as the insurance payments made to the cafeteria plan were excluded from his income

Leyh, 157 TC No. 7

- The Tax Court held that a married couple awaiting a final decree of divorce could have chosen to file a joint return for 2015
- If they had done so, they would have had
  - (1) An exclusion from gross income equal to the insurance payments made by the cafeteria plan,
  - (2) No alimony deduction for that amount, and
  - (3) No alimony income inclusion for that amount
- Because the couple chose to file separately and treat the insurance payments as alimony, the spouse was required to include the insurance payments attributable to her insurance premiums in her gross income as alimony
- Since the spouse was required to include the alimony payments in her income, then the husband was permitted a corresponding deduction for those payments because the husband's alimony deduction was properly viewed as being matched against his spouse's alimony income, not against the cafeteria plan amounts excluded from his income

Interim Final Regulations Relating to Surprise Medical Bills

Interim Final Regulations Relating to Surprise Medical Bills

- On September 30, 2021, the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (collectively, the Departments), and the Office of Personnel Management (OPM), released an interim final rule with comment period, entitled "Requirements Related to Surprise Billing; Part II"
- This rule is related to Title I (the No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021, and establishes new protections from surprise billing and excessive cost sharing for consumers receiving health care items and services
- The interim final rule implements additional protections against surprise medical bills under the No Surprises Act, including provisions related to the independent dispute resolution process, good faith estimates for uninsured or self-pay individuals, the patient-provider dispute resolution process, and expanded rights to external review

Interim Final Regulations Relating to Surprise Medical Bills

- In conjunction with the release of this interim final rule, the Departments and OPM launched a website focused primarily on providing general information about No Surprises Act provisions that will include a federal portal for organizations to apply to become certified independent dispute resolution entities and for providers and payers to participate in the federal independent dispute resolution process: https://www.cms.gov/nosurprises/Help-resolve-payment-disputes
- The Departments and OPM intend to post additional information over the next several months, including information about how to initiate an independent dispute resolution process in the federal portal, and plan to highlight different provisions as they become more relevant to different stakeholders and audiences

Surprise Billing and the Need for Greater Protections

- Most group health plans and health insurance issuers that offer group or individual health insurance coverage have a network of providers and health care facilities, in-network providers, that agree to accept a specific payment amount for their services
- Providers and facilities that are not part of a plan or issuer network, out-of-network or “OON” providers, usually charge higher amounts than the contracted rates the plans or issuers pay to in-network providers
- When a person with health coverage gets care from an OON provider, their health plan or issuer usually does not cover the entire OON cost, leaving the person with higher costs than if they had been seen by an in-network provider
- In many cases, the OON provider may bill the individual for the difference between the charge and the amount paid by their plan or insurance, unless prohibited by state law, a practice known as “balance billing”

Surprise Billing

- A surprise bill is an unexpected bill from a health care provider or facility that can occur when a person with health insurance unknowingly gets medical care from a provider, facility, or provider of air ambulance services outside their health plan’s network
- Surprise billing can happen in both emergency and non-emergency care settings

Emergency Medical Care

- In an emergency, an individual usually gets care at the nearest emergency department
- Even if a person goes to an in-network hospital for emergency care, they might get care from OON provider at that facility
- For non-emergency care, an individual might choose an in-network facility or an in-network provider, but not know that a provider involved in their care, for example, an anesthesiologist or radiologist, is an OON provider
- In some cases, a person can receive a surprise bill from an OON provider that is higher than the amount they would otherwise pay or had planned to pay for their in-network care
- The No Surprises Act protects individuals from large and unexpected surprise bills

Costs for Out-of-Network Care

- When individuals do not have an opportunity to select in-network providers or are given care by an OON provider involved in their in-network care, their health care costs go up overall
- Surprise billing is often used as leverage by health care providers to get higher in-network payments
- The result is higher premiums, higher cost sharing for consumers, and increased health care spending overall

Surprise Billing and the Need for Greater Protections

- A recent study found that payments made to providers/facilities by people who got a surprise bill for emergency care were more than 10 times higher than those made by other individuals for the same care*
- OON cost sharing and surprise bills usually do not count toward a person's deductible and maximum out-of-pocket limit
- Individuals with surprise bills may have to spend more out-of-pocket because they must pay their OON cost sharing and surprise billing amounts regardless of whether they have met their deductible and maximum out-of-pocket limits
- Studies have shown that in the period from 2010-2016, more than 39% of emergency department visits to in-network hospitals resulted in surprise bills, increasing to 42.8% in 2016
- During the same period, the average amount of a surprise medical bill also increased from $220 to $628**
- *Biener, A. et al., Emergency Physicians Recover a Higher Share of Charges from Out-of-network Care than from In-network Care, Health Affairs 40.4 (2021): 622-628.
- **Sun, E.C., et al. "Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-network Hospitals." JAMA Internal Medicine, 179.11 (2019): 1543-1550. Doi:10.1001/jamainternmed.2019.3451.

American Rescue Plan Act Health Care-Related Provisions

- The July 2021 interim final rules contain provisions to protect consumers from surprise medical bills for emergency services, nonemergency services furnished by nonparticipating providers at participating facilities in certain circumstances, and air ambulance services furnished by nonparticipating providers of air ambulance services
- These interim final rules require plans and issuers that provide or cover any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department to cover emergency services without any prior authorization; without regard to whether the health care provider furnishing the emergency services is a participating provider or the services are provided in a participating emergency facility; and without regard to any other term or condition of the plan or coverage other than the exclusion or coordination of benefits or a permitted affiliation or waiting period

American Rescue Plan Act Health Care-Related Provisions

- With respect to emergency services furnished by nonparticipating providers or facilities, nonemergency services furnished by nonparticipating providers at certain participating facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services, the July 2021 interim final rules generally limit cost sharing for out-of network services to in-network levels, require such cost sharing to count toward any in-network deductibles and out-of-pocket maximums, and prohibit balance billing

American Rescue Plan Act Health Care-Related Provisions

- The July 2021 interim final rules also specify that consumer cost-sharing amounts for emergency services furnished by nonparticipating providers or facilities, and for nonemergency services furnished by nonparticipating providers at certain participating facilities, must be calculated based on one of the following amounts:
  - (1) An amount determined by an applicable All-Payer Model Agreement under Social Security Act section 1115A;
  - (2) If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law; or
  - (3) If there is no such applicable All-Payer Model Agreement or specified state law, the lesser of the billed charge or the plan's or issuer's median contracted rate, the latter referred to as the qualifying payment amount (QPA)
- Cost-sharing amounts for air ambulance services provided by nonparticipating providers of air ambulance services must meet the same standards as would apply if the services were provided by a participating provider of air ambulance services and must be calculated using the lesser of the billed charges or the QPA

Limitations on Balance Billing

- Balance billing is a billing practice where a provider bills the patient for the difference between the provider's charge and the allowed amount
- For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill the patient for the remaining $30
- Under the July 2021 interim final rules, balance billing for services subject to the requirements in those interim final rules generally is prohibited
- In general, the protections in the July 2021 interim final rules that limit cost sharing and prohibit balance billing do not apply to certain post-stabilization services, or to certain nonemergency services performed by nonparticipating providers at participating health care facilities if the provider makes certain disclosures to the participant, beneficiary, or enrollee, and obtains the individual's consent to waive balance billing protections
- However, this exception to the prohibition on balance billing is narrow

Limitations on Balance Billing

- In particular, it is not available in certain circumstances where surprise bills are likely to occur, such as for ancillary services provided by nonparticipating providers in connection with nonemergency care in a participating health care facility
- The July 2021 interim final rules also include a number of other specific requirements regarding notice and consent that must be met in order for a provider or facility to be permitted to balance bill a participant, beneficiary, or enrollee for items and services that would otherwise be subject to the prohibition on balance billing

Required Estimated Billings

- The No Surprises Act requires health care providers, providers of air ambulance services, and health care facilities to furnish a good faith estimate of expected charges upon request or upon scheduling an item or service
- Providers and facilities are required to inquire if an individual is enrolled in a group health plan, group or individual health insurance coverage, an FEHB plan, or a Federal health care program, and, if enrolled in a group health plan, or group or individual health insurance coverage, or a health benefits plan, whether the individual is seeking to have a claim for such item or service submitted to such plan or coverage
- In the case that the individual is enrolled in such a plan or coverage (and is seeking to have a claim for such an item or services submitted to such plan or coverage), the provider or facility must furnish a good faith estimate to the individual's plan or issuer of such coverage to inform the advanced explanation of benefits that plans and issuers are required to provide a participant, beneficiary, or enrollee
- In the case that the individual requesting a good faith estimate for an item or service or seeking to schedule an item or service to be furnished is not enrolled in a plan or coverage, or is not seeking to file a claim with such plan or coverage (self-pay), the interim final rules require providers and facilities to furnish a good faith estimate to the individual

Good Faith Estimates for Uninsured or Self-Pay Individuals – Requirements for Providers and Facilities

- When scheduling an item or service or if requested by an individual, providers and facilities are required to inquire about the individual's health insurance status or whether an individual is seeking to have a claim submitted to their health insurance coverage for the care they are seeking
- The provider or facility must provide a good faith estimate of expected charges for items and services to an uninsured (or self-pay) individual, meaning an individual that:
  - Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal health care program or a health benefits plan under chapter 89 of title 5, United States Code; or
  - Has benefits for such items/services under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code, but does not seek to have a claim submitted to their plan, issuer, or carrier for the item or service

Good Faith Estimates of Health Care Costs

- The good faith estimate must include expected charges for the items or services that are reasonably expected to be provided together with the primary item or service, including items or services that may be provided by other providers and facilities
- For example, for a surgery, the good faith estimate might include the cost of the surgery, any labs or tests, and the anesthesia that might be used during the operation
- If an item or service is something that is not scheduled separately from the surgery itself, it will generally be included in the good faith estimate
- Other items or services related to the surgery that might be scheduled separately, like pre-surgery appointments or physical therapy in the weeks after the surgery, will not be included in the good faith estimate

Good Faith Estimates of Health Care Costs

- HHS understands that it may take time for providers and facilities to develop systems and processes for providing and receiving the required information from others
- Therefore, for good faith estimates provided to uninsured or self-pay individuals from January 1, 2022 through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured or self-pay individual does not include expected charges from other providers and facilities that are involved in the individual's care

Patient-Health Care Provider Dispute Resolution

- In a situation where an uninsured or self-pay individual receives a good faith estimate and then is billed for an amount substantially in excess of the good faith estimate, HHS establishes in the September 30, 2021 rule a patient-provider dispute resolution process to determine a payment amount
- The September 30, 2021 rule provides eligibility details for this dispute resolution process, a definition of "substantially in excess," and further information on the selection process for select dispute resolution (SDR) entities that will resolve disputes through the patient-provider dispute resolution process

External Review of Health Care Provider Billings

- The September 30, 2021 rule amends final rules issued by the Departments in 2015 related to external review
- The September 30, 2021 rule expands the scope of adverse benefit determinations eligible for external review to include determinations that involve whether a plan or issuer is complying with the surprise billing and cost-sharing protections under the No Surprises Act and its implementing regulations
- In addition, under these interim final rules, grandfathered plans that are not otherwise subject to external review requirements will be subject to external review requirements for coverage decisions that involve whether a plan or issuer is complying with the surprise billing and cost-sharing protections under the No Surprises Act

American Rescue Plan Act
Health Care-Related Provisions

American Rescue Plan Act
Health Care-Related Provisions

- On March 10, 2021, US Congress passed the American Rescue Plan Act of 2021 (ARP), the latest COVID-19 relief package that made several important health policy-related changes, including funding for vaccine distribution and testing to combat the COVID-19 pandemic, making policy adjustments to the Medicaid program, facilitating health insurance coverage and providing more money for healthcare providers
- The ARP included funding for COVID-19 vaccine distribution, testing and contact tracing, and support for healthcare workforce expansion and public health initiatives
- The ARP requires state Medicaid programs and the Children's Health Insurance Program (CHIP) to provide coverage, without cost sharing, for treatment or prevention of COVID-19 for one year after the end of the public health emergency (PHE), while raising to 100% payments to states for administering vaccines for the same period

American Rescue Plan Act Health Care-Related Provisions

- If a state chooses to implement an option under Medicaid to provide COVID-19 testing for uninsured individuals, the ARP also extended the requirement to provide treatment and prevention to those individuals without requiring cost sharing for one year after the end of the PHE
- The Secretary of the Department of Health and Human Services (HHS) may under the Public Health Service (PHS) Act determine that:
  - a) A disease or disorder presents a public health emergency; or
  - b) A public health emergency, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists

Marketplace Advanced Premium Tax Credit

- The ACA established tax subsidies for health insurance purchased through insurance exchange marketplaces, known as advanced premium tax credits (APTCs), which are available to individuals earning between 100% and 400% of the Federal Poverty Level (FPL)
- For 2021 and 2022, the ARP expanded the availability of marketplace APTCs to eligible individuals whose income is above 400% of the FPL based on a sliding scale
- On one end of the sliding scale, individuals whose income is between 100% and 150% of the FPL are eligible for full coverage of their premiums
- On the other end of the scale, individuals with incomes above 400% of the FPL will have their premiums capped at 8.5% of their income

ACA Signups Extended by 30 Days

- The Centers for Medicare & Medicaid Services (CMS) is taking a number of steps that will make it easier for eligible individuals to sign up for the ACA by extending enrollments by 30 days
- Beginning in 2021, consumers will have an extra 30 days to review and choose health plans through Open Enrollment, which will run from November 1, 2021 through January 15, 2022, on HealthCare.gov
- CMS is also expanding services provided by Federally-facilitated Marketplace (FFM) Navigators—experts who help consumers, especially those in underserved communities, understand their benefits and rights, review options, and enroll in Marketplace coverage

COBRA Continuation Coverage

COBRA Continuation Coverage for Employees and Their Families

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) entitles an individual and their covered dependents, if any, to elect to continue coverage under the health insurance plan the individual was enrolled in as an active member
- Health insurance premium assistance is available to certain individuals who are eligible for COBRA continuation coverage due to a qualifying event that is:
  - A reduction in hours; or
  - An involuntary termination of employment

COBRA Continuation Coverage for Employees and Their Families

- If an individual qualifies for premium assistance, the individual does not need to pay any of the COBRA premium otherwise due to the plan for the months when the individual is eligible for the premium assistance
- This premium assistance was available for six months, from April 1, 2021 through September 30, 2021
- If the individual chose to continue the COBRA continuation coverage beyond September 30, 2021, they may have to pay the full Cobra premium amount due, though such an individual may qualify for a special enrollment period to enroll in coverage through the ACA's Health Insurance Marketplace

Requirements to Qualify for COBRA Continuation Coverage

- To qualify for COBRA premium assistance, the individual must meet all of the following requirements:
  - Must have a COBRA qualifying event that is a reduction in hours or an involuntary termination of the covered employee's employment
  - Must elect to be enrolled in COBRA continuation coverage
  - Must not be eligible for Medicare
  - Must not be eligible for coverage under any other group health plan, such as a plan sponsored by a new employer or a spouse's employer

Additional Opportunity to Enroll in COBRA

- The ARP provided that individuals who may have experienced a reduction in hours or an involuntary termination of employment and did not elect COBRA when it was first offered or who did elect COBRA but are no longer enrolled had a new election opportunity and were eligible for the premium assistance
- If the employer identified an individual as having experienced a reduction in hours or an involuntary termination of employment, the individual will have an AEI 2021 2nd COBRA CONTINUATION COVERAGE ELECTION FORM sent to them
- See: https://forms.benefitresource.com/cobra/ARPA_QB_FAQ.pdf

How to Elect COBRA Coverage

- The ARP provided that an individual had a limited number of days to elect COBRA coverage under the extended election period
- An individual's election window is determined by the plan and is calculated from the date of the enactment of the ARP or the date a notice of the individual's election rights is sent to them, whichever is later
- To elect COBRA coverage, the individual must have completed and submitted the election form to COBRAComplete no later than the election period end date

Enrolling in Medicare Instead of COBRA

- If an individual did not enroll in Medicare Part A or B when the individual was first eligible because they were still employed and covered by employer-provided health insurance after the initial enrollment period for Medicare Part A or B, the individual has an eight-month special enrollment period to sign up, beginning on the earlier of:
  - The month after the individual's employment ends

    or
  - The month after group health plan coverage based on current employment ends

Enrolling in Medicare Instead of COBRA

- If the individual does not enroll in Medicare Part B and elects COBRA continuation coverage instead, the individual may have to pay a Part B late enrollment penalty and may have a gap in coverage if the individual decides they want Part B later
- If the individual elects COBRA continuation coverage and then enrolls in Medicare Part A or B before the COBRA continuation coverage ends, the plan may terminate the individual's COBRA continuation coverage
- However, if Medicare Part A or B is in effect on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if the individual enrolls in the other part of Medicare after the date of the election of COBRA coverage

Enrolling in Medicare Instead of COBRA Continuation Coverage After the Individual's Group Health Plan Coverage Ends

- If the individual is enrolled in both COBRA continuation coverage and Medicare, Medicare will be the primary payer and COBRA will pay second
- Certain COBRA continuation coverage plans may pay as if secondary to Medicare even if the individual is not enrolled in Medicare

Early Termination of COBRA Coverage

- COBRA coverage may terminate if:
  - The required premium coverage is not paid when due
  - After the date of the COBRA election, the individual and his or her spouse or dependent children, if any, become covered under another group health plan that does not contain any exclusion or limitation for any of the individual's pre-existing conditions
  - After the date of the individual's COBRA election, the individual, spouse or dependent children, if any, become entitled to Medicare benefits
  - IF coverage is extended an additional 11 months due to disability, a determination that the individual is no longer disabled
  - COBRA coverage may also be terminated for any reason the plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage, such as fraud

Sick Pay and Family Leave Pay

When an Employer Must Provide Sick Pay and Family Leave Pay

- In 2020, an employee was entitled to 80 hours of Emergency Paid Sick Leave if an employee was:
  1. Subject to a quarantine or isolation order
  2. Advised by a health care provider to self-quarantine
  3. Experiencing symptoms of COVID-19 and seeking a medical diagnosis
  4. Caring for an individual who is subject to a quarantine or isolation, or has been advised by a health care provider to self-quarantine
  5. Caring for the child of such employee if the school or place of care of the child has been closed, or the childcare provider of such child is unavailable due to COVID-19
  6. Experiencing any other substantially similar condition specified by the U.S. Department of Health and Human Services
- For qualifying reasons Nos. 1, 2, 3, employers are required to pay employee's regular rate or applicable federal minimum wage (if higher) subject to a cap of $511 per day or $5,110 in the aggregate
- For qualifying reasons Nos. 4, 5, 6, paid sick leave is paid at 2/3 of the employee's rate, up to $200 per day or $2,000 in the aggregate

When an Employer Must Pay Family and Medical Leave Pay

- In addition to the paid sick leave credit, an eligible employer was required to provide up to an additional 10 weeks of expanded paid family and medical leave at two-thirds of the employee's regular pay if the employee is unable to work (including telework) due to a need to care for a child whose school was closed or whose childcare provider was unavailable for reasons related to COVID-19

Employer Credits

- Eligible employers are entitled to receive a credit in the full amount of the qualified sick leave wages and qualified family leave wages, plus allocable qualified health plan expenses and the employer's share of Medicare tax (the eligible employer is not subject to the employer portion of Social Security tax imposed on those wages) paid for leave during the period beginning April 1, 2020 and ending Dec. 31, 2020
- The credit was allowed against the employer portion of Social Security taxes on all wages and compensation paid to all employees
- If the amount of the credit exceeded the employer portion of these federal employment taxes, then the excess was treated as an overpayment and refunded to the employer

Employer Credits

- Eligible employers that paid qualified leave wages were able to retain an amount of all federal employment taxes equal to the amount of the qualified leave wages paid, plus the allocable qualified health plan expenses and the amount of the employer's share of Medicare tax imposed on those wages, rather than depositing them with the IRS
- The federal employment taxes that were available for retention by eligible employers included federal income taxes withheld from employees, the employee's share of Social Security and Medicare taxes, and the employer's share of Social Security and Medicare taxes with respect to all employees

Sick Pay and Family Leave Pay Credits Claimed on Form 941

- Eligible employers claim the sick pay and family leave pay credits on Form 941, *Employer's Quarterly Federal Tax Return*, but they can benefit more quickly from the credits by reducing their federal employment tax deposits
- An eligible employer is not be subject to a penalty under Section 6656 for failing to deposit federal employment taxes relating to qualified leave wages in a calendar quarter if:
  - The eligible employer paid qualified leave wages to its employees in the calendar quarter before the required deposit;
  - The amount of federal employment taxes that the eligible employer does not timely deposit is less than or equal to the amount of the eligible employer's anticipated tax credits for these qualified leave wages for the calendar quarter as of the time of the required deposit; and
  - The eligible employer did not seek payment of an advance credit by filing Form 7200 with respect to any portion of the anticipated credits it relied upon to reduce its deposits
- If the federal employment taxes that would otherwise be deposited by an eligible employer are less than the available tax credits for qualified sick and qualified family leave, an eligible employer may request an advance payment of the excess credits from the IRS by submitting a Form 7200

2021 Changes Relating to Sick Leave and Family Leave Pay

- As of January 2021, providing sick leave and family leave pay became optional with the employer
- Employers that voluntarily provide sick leave and family leave pay to their employees could receive a payroll tax credit to cover the wages paid through September 30, 2021, subject to applicable caps

ARP's 2021 Additional Bases for Employee Eligibility for Emergency Paid Sick Leave

The ARP added additional qualifying reasons for an employer to pay sick leave to its employees:

- Obtaining a COVID-19 vaccine
- Recovering from any injury, disability, illness, or condition related to such vaccine
- Seeking or awaiting the results of a COVID-19 test when the employee has been exposed to COVID-19 or the employer requested the test

Employees who used these qualifying reasons are to be paid at their full regular rate of pay, subject to the $511 per day or $5,110 aggregate cap

The ARP's Reset of Emergency Paid Sick Leave

- Employees received a new allotment of 80 emergency paid sick leave hours on April 1, 2021
- If an employer voluntarily provides paid sick leave coverage to its employees in 2021, those employees who previously exhausted the 80 hours of emergency paid sick leave became eligible again for another 80 hours after April 1, 2021
- Unused leave from before March 31, 2021 did not roll over into the new period

Emergency Family Medical Leave and Expansion

- Under prior law, employers could receive tax credits for Emergency Family Medical Leave if the employee was unable to work due to caring for the employee's child because of closure of the child's school or place of care or if childcare was unavailable due to COVID-19
- Employees could take this leave, which ran concurrently with regular Family Medical Leave Act (FMLA) entitlements
- The first two weeks of Emergency FMLA were unpaid, with the remaining (up to) 10 weeks paid at 2/3 the employee's regular rate, up to $200 per day and a total maximum of $10,000
- The ARP deleted the unpaid two-week provision so that the employee was entitled to up to 12 paid weeks of Emergency FMLA in addition to the 80 hours of Emergency Paid Sick Leave if the employee qualifies
- The ARP increased the amount of wages for which an employer may claim the tax credit for paid expanded FMLA leave from $10,000 to $12,000 annually per employee
- As noted, the ARP expanded the qualifying reasons for expanded FMLA to include all of the reasons that would support Emergency Paid Sick Leave — not just limited to childcare reasons

Self-Employed Individuals May Claim Sick and Family Leave Credits

- Eligible self-employed individuals will determine their qualified sick and family leave equivalent tax credits with Form 7202
- Taxpayers claimed the credits on their 2020 Form 1040 for leave taken between April 1 and Dec. 31, 2020, and on their 2021 Form 1040 for leave taken between January 1 and March 31, 2021

When an Employer Must Offer ACA Compliant Medical Coverage

Applicable Large Employers

- The ACA requires Applicable Large Employers (ALEs) to either offer minimum, affordable essential health insurance coverage that provides "minimum value" to full-time employees and their dependents or make an employer shared responsibility payment to the IRS
- ALEs have information reporting responsibilities regarding the minimum essential health insurance coverage they offer to employees
- ALEs are required to send reports to employees and to the IRS
- An employer that sponsors self-insured health insurance coverage has insurer information reporting responsibilities as a provider of minimum essential coverage whether or not the employer is an ALE

Section 4980H Penalties on Non-Compliant ALEs

The Section 4980H(a) penalty applies to an ALE which fails to offer an eligible employer-sponsored plan to at least 95% of its full-time employees (FTEs) and their dependents and at least one FTE skips the group plan and purchases an exchange plan with a premium tax credit for the month

The Section 4980H(b) penalty applies if at least one FTE is allowed to benefit from the premium tax credit (PTC), which may occur if the eligible employer-sponsored plan is not affordable or does not provide Minimum Value or if the employee was not offered employer-sponsored health insurance coverage

What is an ALE?

- Whether an employer is an ALE and is therefore subject to the employer shared responsibility provisions depends on the size of its workforce
- An ALE is an employer that employs at least 50 full-time or full-time equivalent employees
- For the purposes of the ACA, a full-time employee is someone who works at least 30 hours a week
- A full-time equivalent employee (FTE) is a combination of part-time employees that together count as one FTE
- An FTE is any collection of two or more employees whose hours, when taken together, add up to a full-time workload of 30 hours a week
- Two employees who each work 15 hours/week would represent one full-time equivalent, as would three 10-hour-a-week workers (3 x 10 = 30 hours = 1 FTE)

ALE Reporting Responsibilities

- ALEs are required to report information about whether they offered coverage to employees and information about the offer of coverage
- ALEs are required to send this information to the IRS on Forms 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*, and 1095-C, *Employer-Provided Health Insurance Offer and Coverage*
- ALEs are also required to send the Form 1095-C for each employee to that employee
- The information on these forms is used to determine whether an ALE is subject to a penalty under Sections 4980H(a) or 4980H(b)

Reporting Responsibilities in the Case of Self-Insured Health Coverage

- An employer that offers self-insured health coverage—whether or not the employer is an ALE—has information reporting responsibilities as a provider of minimum essential coverage
- In general, an ALE that sponsors self-insured health coverage will use the same form it uses to report about offers of coverage (Form 1095-C) to satisfy this requirement by filling out Part III of Form 1095-C for employees and family members who enroll in the coverage

Section 4980H

- Section 4980H provides that ALEs are required to offer qualifying health coverage to their FTE employees and their dependents or potentially be liable for an assessable payment if at least one FTE receives a premium tax credit for coverage in the Marketplace
- An ALE may be a single entity or may consist of a group of related entities (such as parent and subsidiary entities or other related/affiliated entities) referred to as an aggregated ALE Group
- In either case, the reporting requirements apply to each separate entity and each separate entity is referred to as an ALE Member

ALE's Obligation to Offer Minimum Essential Health Insurance Coverage

- Part III of Form 1094-C asks the employer to indicate yes or no, for each month in the year, if it offered minimum essential coverage to 95% or more of its full-time employees
- The IRS treats a blank response as the answer "no"
- An employer should be able to track its compliance with the requirement to offer minimal essential health insurance coverage by generating monthly reports that calculate the percentage of coverage
- This information provides the employer with an opportunity to make adjustments during the year to ensure the accuracy of the yes or no answer
- Most employers who receive Letter 226-J from the IRS are unable to produce this type of report and submit it as evidence that supports a formal IRS response

IRS Letter 226J

- IRS Letter 226J notifies an ALE of a proposed ACA Employer Shared Responsibility Payment (ESRP) assessment under Section 4980H(a) or (b)
- ALEs have 30 days to respond using Form 14764 to indicate their agreement or disagreement with the IRS's proposed penalty assessment

IRS Letter 227

- IRS Letter 227 acknowledges the ALE's response to Letter 226J and explains the outcome of the IRS's review and how the ESRP can be resolved
- Applicable IRS webpage can be accessed at www.irs.gov/individuals/understanding-your-letter-227

Calculating Whether an Employer is an ALE

- Whether an employer is an ALE in a particular calendar year depends on the size of the employer's workforce in the preceding calendar year
- Thus, an employer will use information about the size of its workforce during 2021 to determine if it is an ALE for 2022
- To be an ALE for a calendar year, an employer must have employed an average of at least 50 full-time employees, including full-time equivalent employees, during the preceding calendar year
- To determine its workforce size for a calendar year, an employer adds its total number of FTE employees for each month of the prior calendar year to the total number of FTE employees for each calendar month of the prior calendar year and divides by 12

Calculating Whether an Employer is an ALE

- An employer determines its number of FTE employees for a month by counting individuals employed on average for at least 30 hours of service per week during the month or at least 130 hours of service during the month
- An employer determines its number of FTE employees for a month by combining the number of hours of service of all non-FTE employees for the month, but not including more than 120 hours of service per employee and dividing the total by 120

Example

- An employer employing 40 full-time employees and 20 employees each with 60 hours of service in a month has the equivalent of 50 full-time employees in the month (40 full-time employees plus 10 full-time equivalent employees (20 X 60 = 1200 and 1200/120 =10))
- For section 4980H purposes, the number of an employer's FTE employees is relevant only to determine if the employer is an ALE
- FTE employees are not taken into account in determining the amount of employer shared responsibility payment, if any, that an ALE may owe

Employee Defined

- Generally, all employees working in the United States are counted either as full-time employees or full-time equivalent employees when an employer is determining whether it is an ALE
- One exception is for seasonal workers, which applies under the following two conditions:
  - (1) The employer's workforce exceeds 50 full-time employees, including full-time equivalent employees, for 120 days or fewer during the preceding calendar year, and
  - (2) All of the employees in excess of 50 employed during that period of no more than 120 days are seasonal workers

Seasonal Workers

- Seasonal workers are workers who perform labor or services on a seasonal basis as defined by the Department of Labor (DoL) and retail workers employed exclusively during holiday seasons
- For this purpose, employers may apply a reasonable, good faith interpretation of the term “seasonal worker” and a reasonable, good faith interpretation of the DoL’s definition of seasonal worker

Attribution Rules That Apply in Determining Common Ownership

- If two or more businesses have a certain level of common or related ownership using the attribution rules of Section 414(b), (c), (m) or (o), they are treated as a single employer and are combined for purposes of determining whether or not they collectively employ at least 50 full-time employees (including full-time equivalent employees)
- If the combined total meets the ALE threshold, then each separate business is considered to be part of an ALE and is therefore subject to the employer shared responsibility provisions
- This includes any business that does not employ enough employees to meet the ALE threshold on its own

Example

- If an individual owns 80% or more of two businesses that are separate legal entities, the total number of full-time employees of that employer is based on the full-time employees (including full-time equivalent employees) in both businesses combined together
- If the employees in the combined businesses add up to fewer than 50 full-time employees (including full-time equivalent employees) in a calendar year, the employer shared responsibility provisions will not apply to those businesses for the following calendar year

Employee Defined

- For purposes of the employer shared responsibility provisions, an employee is an individual who is an employee under the common-law standard for determining employer-employee relationships
- An employee does not include a sole proprietor, a partner in a partnership, an S corporation shareholder who owns at least 2% of the S corporation, a leased employee, or a worker that is a qualified real estate agent or direct seller

How an ALE Should Report Whether It Made an Offer of Health Insurance Coverage to an Employee

- The ALE uses line 14, Offer of Coverage, in Part II of Form 1095-C to report whether an offer of coverage was made to an employee for each month of the year
- An offer of coverage is considered to have been made for a month only if the coverage offered would provide coverage for every day of that month
- The ALE should enter the applicable indicator code to report whether coverage was offered and, if so, the type of coverage that was offered to the employee for that month (for example, employee-only coverage, employee and dependents coverage, employee, spouse and dependents coverage, etc.)

Reporting the Employee's Required Contribution

- An amount is entered on line 15 of Form 1095-C only if the Offer of Coverage reported on line 14 of Form 1095-C includes an offer of minimum value coverage to the employee
- In that case, the Employee Required Contribution is the employee's share of the monthly cost for the lowest-cost self-only minimum essential coverage providing minimum value that is offered to the employee by the ALE
- The Employee Required Contribution may not be the same amount as the premium the employee pays for coverage if, for example, the employee chooses to enroll in more expensive coverage, such as family coverage

Reporting the Employee's Required Contribution

- The Employee Required Contribution may not be the same amount as the premium the employee pays for coverage if the employer, in addition to or in conjunction with the coverage, offers other arrangements that could affect the employee's cost of coverage, including certain HRA contributions, wellness program incentives, flex credits, and opt-out payments
- Form 1095-C is not required for the following employees unless the employee or the employee's family member was enrolled in a self-insured plan sponsored by an ALE Member:
  - An employee who was not a full-time employee in any month of the year; or
  - An employee who was in a limited non-assessment period for all 12 months of the year (for example, a new variable hour employee still in an initial measurement period)

Defining an "Offer of Coverage"

- An ALE makes an offer of coverage to an employee if it provides the employee an effective opportunity to enroll in health insurance coverage, or to decline that coverage, at least once for each plan year
- Whether an employee has an effective opportunity to enroll is based on all the relevant facts and circumstances
- An ALE offers coverage for a month only if the coverage would be provided for every day of that calendar month
- For purposes of the employer shared responsibility provisions, "coverage" refers to minimum essential coverage that is health coverage under an eligible employer-sponsored health insurance plan

Defining an "Offer of Coverage"

- Mandatory coverage that an ALE provides to employees only counts as an offer of coverage if that coverage meets certain requirements
- If an ALE provides mandatory coverage and does not provide the employee an effective opportunity to waive or otherwise decline the coverage, the ALE is treated as having made an offer of coverage to the employee only if that mandatory coverage:
  - Provides minimum value; and
  - Does not require an employee contribution for any calendar month of more than 9.83%, as adjusted for 2021, of a monthly amount determined as the mainland federal poverty line for a single individual for the applicable calendar year, divided by 12

Defining an "Offer of Coverage"

- An ALE is not considered to have made an offer of coverage to a full-time employee unless it provides the employee an effective opportunity to enroll in the coverage or to decline that coverage at least once for each plan year
- Whether an employee has an effective opportunity to enroll is based on all the relevant facts and circumstances
- If an ALE would terminate a full-time employee's employment if the employee attempted to enroll in the coverage, the employee would not have an effective opportunity to enroll in the coverage

Defining an "Offer of Coverage"

- The employer shared responsibility provisions apply to ALEs regardless of whether their full-time employees have coverage from another source such as Medicare, Medicaid, or a spouse's employer
- If an ALE does not offer coverage to its full-time employees (and their dependents) or offers coverage to less than 95% of its full-time employees (and their dependents) and one or more of its full-time employees receives a premium tax credit, the ALE may be liable for an employer shared responsibility payment

Affordability and Minimum Value

- Employer-provided coverage is considered affordable for an employee if the employee required contribution is no more than 9.83% (in 2021) of that employee's household income
- In general, the employee required contribution is the employee's cost of enrolling in the least expensive coverage offered by the employer that provides minimum value
- The employee required contribution includes amounts paid through salary reduction or otherwise and takes into account the effects of employer arrangements such as health reimbursement arrangements (HRAs), wellness incentives, flex credits, and opt-out payments

Affordability and Minimum Value

- Because ALEs generally do not know their employees' household incomes, there are three affordability safe harbors employers can take advantage of that are based on information the employer does have available:
  - The Form W-2 wages safe harbor
  - The rate of pay safe harbor
  - The federal poverty line safe harbor
- If an ALE's offer of coverage is affordable using any of these safe harbors, then the offer of coverage is deemed affordable for purposes of the employer shared responsibility provisions regardless of whether it was affordable based on the employee's household income, which is the test that applies for purposes of the premium tax credit

When Employer Coverage Provides Minimum Value

- An employer health insurance plan provides minimum value if it covers at least 60% of the total allowed cost of benefits that are expected to be incurred under the plan and provides substantial coverage of inpatient hospitalization services and physician services
- The U.S. Department of Health & Human Services has developed a minimum value calculator that can be used to determine if a plan provides minimum value—see https://goo.gl/4lVFbe

Calculating the Employer Penalty When Employer Fails to Offer Coverage

- Employers subject to the employer mandate are required to offer coverage that provides “minimum value” and is “affordable,” or be subject to penalties
- An ALE that does not offer coverage is subject to a $2,700 (in 2021) penalty per full-time employee (minus the first 30)
- This penalty applies if one full-time employee receives a federal premium subsidy for marketplace coverage

Example

- Assume that in 2021 an employer has 1,000 full-time employees and does not offer health insurance coverage to any full-time employee
- One employee purchases coverage on the marketplace and is eligible for a federal premium subsidy
- The employer penalty is computed as follows:
  - $2,700 per full-time employee, minus the first 30 employees
  - 1,000 – 30 = 970 employees
  - 970 x $2,700 = $2,619,000 = penalty

Calculating the Employer Penalty When Employer Fails to Provide Minimum Value or Is Not Affordable

- If the plan does not provide minimum value (60% of total allowed costs) or does not provide affordable coverage (9.83% in 2021), the penalty is the lesser of:
  - $4,060 (in 2021) per full-time employee receiving subsidy or
  - $2,700 per full-time employee (minus first 30)

Example

- Assume 1,000 full-time employees
- Assume employer offers coverage, but coverage is not affordable and/or does not provide minimum value
- The penalty is triggered if one employee purchases coverage on the marketplace and receives a federal premium subsidy
- Assume 250 employees purchase coverage on the marketplace and are eligible for a subsidy
- Lesser of $2,700 per full-time employee, minus the first 30 employees, OR $4,060 per full-time employee receiving a federal premium subsidy
- 970 x $2,700 = $2,619,000 penalty
- 250 x $4,060 = $1,015,000 penalty (the lesser penalty applies)

Employee Eligible for Medicare and Also Covered by Their Employer's Health Insurance

Dual Coverage: Medicare and Employer Health Insurance

- Whether an individual needs to enroll in Medicare at 65 depends on:
  - Whether the individual continues to work and have health insurance provided through the individual's job

    and
  - The size of the individual's employer
- The same rules apply if an individual's health insurance coverage comes from the spouse's employer

Medicare Coverage When Individual Covered by Employer Health Insurance

- As long as an individual has group health insurance from an employer for which the employer or his or her spouse actively works after turning 65, the individual can delay enrolling in Medicare until the employment ends or the health insurance coverage stops, whichever happens first, without incurring any late penalties if the individual enrolls after turning age 65
- When the employer-provided health insurance coverage ends, the individual is entitled to a special enrollment period of up to eight months to sign up for Medicare
- An individual may not delay Medicare enrollment without penalty if the individual's employer-sponsored coverage comes from retiree benefits or COBRA as these do not count as active employment

Medicare Coverage When Individual Covered by Employer Health Insurance

- An individual who works beyond age 65 but relies on health insurance from a former employer is not considered to be covered by an employer
- The individual or spouse must be actively working for the employer that currently provides the individual's health insurance in order to delay Medicare enrollment and qualify for a special enrollment period later in time
- A large employer — one with at least 20 employees — must offer the individual and his or her spouse the same benefits that it offers to younger employees and their dependents
- It is entirely up to the individual, not the employer, whether to:
  - Accept the employer health plan and delay Medicare enrollment
  - Decline the employer coverage and rely wholly on Medicare
  - Have both employer health insurance coverage and Medicare apply at the same time

Medicare Coverage When Individual Covered by Employer Health Insurance

- If an individual enrolls in both the employer's group plan and Medicare Part B, the employer plan is always primary
  - In such a case, the employer's health insurance plan settles medical bills first and Medicare only pays for services that it covers but the employer plan does not
  - Primary coverage refers to the policy that responds first to an insured loss, either on a first dollar basis or after allowing for a deductible
  - When the primary coverage limits are paid, any remaining loss is covered by whatever excess layer of insurance may be **in** place
- Unless the employer coverage is very poor, the insured would be paying monthly premiums for Medicare with little or no return

Medicare Coverage When Individual Covered by Employer Health Insurance

- By signing up for Part B while still having employer coverage, the individual could be forfeiting the right to buy Medicare supplemental insurance (Medigap) with full federal protections after this employment ends
- Insurance companies are prohibited from refusing to sell a Medigap policy or charge higher premiums based on health or preexisting medical conditions *if* the individual buys the policy within six months of enrolling in Medicare Part B
- Outside of that six-month window, except in very limited circumstances, they can do both

Medicare Coverage When an Employer Has Fewer Than 20 Employees

- The laws that prohibit large insurers from requiring or even persuading Medicare-eligible employees to drop the employer plan and sign up for Medicare do not apply to companies and organizations that employ fewer than 20 people
- With an employer with fewer than 20 employees, the employer decides which policy has primary coverage
- If the employer does require an individual to enroll in Medicare, then Medicare automatically becomes primary, and the employer plan provides secondary coverage
- In such a case, Medicare settles the individual's medical bills first, and the group plan only pays for services that it covers but Medicare does not
- Thus, if the individual fails to sign up for Medicare when required, the individual will essentially be left with no or marginal health insurance coverage

An Employer With Fewer Than 20 Employees

- It is very important to ask the employer whether an individual is required to sign up for Medicare when the individual turns age 65 or receives Medicare on the basis of disability
- If so, the individual should find out exactly how the employer plan will fit in with Medicare and get the employer's response in writing
- Signing up for Medicare Part B when an individual has employer insurance will not jeopardize the individual's chances of buying Medigap supplemental insurance after the employment ends
- When Medicare is primary to the employer plan, an individual has the right to buy Medigap with full federal protections if he or she does so within 63 days of the employer coverage ending

2021 Special Enrollment Period

- As a result of the APP, additional savings were available for consumers through HealthCare.gov starting April 1, 2021
- These savings decreased premiums for many, on average, by $50 per person per month and $85 per policy per month
- On average, one out of four enrollees on HeathCare.gov will be able to upgrade to a higher plan category that offers better out-of-pocket costs at the same or lower premium compared to what they were formerly paying

2021 Special Enrollment Period

- Consumers who were eligible and enroll under the Special Enrollment Period can select a plan with coverage that could start as soon as the first month after plan selection
- Current enrollees will be able to change to any plan available to them in their area
- To take advantage of the SEP, current enrollees should review their application and make changes, if needed, to their current information and submit their application in order to receive an updated eligibility result
- Additionally, beginning in early July 2021, on HealthCare.gov, consumers who received or have been determined eligible to receive unemployment compensation for any week during 2021 may be able to get another increase in savings when enrolling in new Marketplace coverage or updating their existing Marketplace application and enrollment
- These savings to be made available starting in early July for eligible consumers are in addition to the increased savings available to consumers on HealthCare.gov starting April 1

2021 Special Enrollment Period (SEP) Access Was Extended to August 15 on HealthCare.gov for Marketplace Coverage

- The SEP was available to consumers in the 36 states that use the HealthCare.gov platform
- Consumers served by state-based Marketplaces that use their own platform can check their state's website to find out more information on Special Enrollment Periods in their state

Pass-Through Entities Providing Health Insurance Coverage to Owners

Partners and Health Insurance

- Premiums for health insurance paid by a partnership on behalf of a partner for services as a partner are treated as guaranteed payments
- As such, the partnership can deduct the payments as a business expense and the partner must include them in gross income
- However, if the partnership accounts for insurance paid for a partner as a distribution to the partner, the partnership cannot deduct the premiums

Partners and Health Insurance

- A partner who qualifies can deduct 100% of the health insurance premiums paid by the partnership on his or her behalf as an adjustment to income
- The partner cannot deduct the premiums for any calendar month, or part of a month in which the partner is eligible to participate in any subsidized health plan maintained by any employer of the partner, the partner's spouse, the partner's dependents, or any children under age 27 who are not dependents

Health Insurance and S Corporation Shareholders

- S corporations can provide health insurance as a tax-free fringe benefit to their non-owner employees
- In this case, the S corporation offers a group health insurance policy to employees and deducts the cost as a business expense, paying no tax on the insurance premiums
- Section 707(c) provides that greater than 2% shareholders must include the cost of their health insurance as income, a rule that subjects S corporation owners to income tax but not to Social Security and Medicare tax
- The 2% shareholder deducts the health insurance

Health Insurance and S Corporation Shareholders

- S corporation owners cannot avoid this rule by employing their spouse and getting covered through the spouse's participation in the health insurance plan
- For health insurance purposes, spouses and other family members of an S corp owner are treated as though they were an S corp owner themselves even if the family member does not own any stock in the S corporation
- HRAs are only available to W-2 employees
- S corporation shareholders and their families are not treated as employees and therefore are not eligible to participate in an HRA

Chief Counsel Advice 201912001

- Section 1372 provides that individuals holding 2% or more of the stock of an S corporation are treated as if they were partners for purposes of applying the employee fringe benefit income tax rules
- Section 1372(b) expands the definition of shareholders for purposes of this rule to include those who would be deemed to hold such shares by attribution under Section 318
- Section 106 provides that employees are permitted to exclude the value of employer-provided health insurance from their income

Chief Counsel Advice 201912001

- The IRS held that family members, while not directly holding shares in an S corporation, who are deemed to be 2% shareholders under the rules of Section 318 are allowed to claim the self-employed health insurance deduction under Section 162(l) if they otherwise qualify
- Under Section 318(a), a*n individual shall be considered as owning the stock owned, directly or indirectly, by or for—*
  - *(i) his spouse (other than a spouse who is legally separated from the individual under a decree of divorce or separate maintenance), and*
  - *(ii) his children, grandchildren, and parents*

Chief Counsel Advice 201912001

- The question raised in the advice was whether such family members, if employed by the S corporation and covered by a qualifying medical plan of the S corporation meeting the provisions of Notice 2008-1, could claim the self-employed health insurance deduction found at Section 162(l)
- Partners treat the value of such insurance paid by the partnership as a guaranteed payment
- IRS Announcement 92-16 provides that an S corporation shareholder treats this amount that would have been a guaranteed payment as wages for income tax purposes
- Because Section 1372 only applies to income tax provisions, these deemed wages are not subject to FICA, Medicare, or FUTA taxes

Chief Counsel Advice 201912001

- CCA 201912001 concluded that family members, if employed by the S corporation and covered by a qualifying medical plan of the S corporation, meeting the provisions of Notice 2008-1 can claim the self-employed health insurance deduction found at Section 162(l)
- Section 162(l) allows a deduction in computing adjusted gross income for health insurance for self-employed individuals that meet certain conditions
- For an S corporation, the provision of the insurance must meet the requirements found in Notice 2008-1
- For all covered taxpayers, the taxpayer cannot be eligible to participate in a subsidized health plan maintained by an employer of the taxpayer or taxpayer's spouse

Chief Counsel Advice 201912001

- CCA 201912001 held that the deemed shareholder(s) by attribution receives the same treatment as someone directly holding the S corporation stock
- Thus, an individual who is a 2% shareholder of an S corporation pursuant to the attribution of ownership rules under Section 318 is entitled to the deduction under Section 162(l) for amounts that are paid by the S corporation under a group health plan for all employees and included in the individual's gross income if the individual otherwise meets the requirements of Section 162(l)

Health Savings Accounts

Health Savings Accounts

- A taxpayer may contribute to a Health Savings Account (HSA) only if he or she has a High Deductible Health Plan (HDHP)
- A HDHP is a health plan, including a Marketplace plan, that only covers preventive services before the deductible

Health Savings Account
2021-2022 HSA Contribution Limits and Guidelines

Minimum deductible amount	2021	2022
• Single plan	$1,400	$1,400
• Family plan	$2,800	$2,800
Maximum out-of-pocket limits		
• Single plan	$7,000	$7,050
• Family plan	$14,000	$14,100

Health Savings Account
2021-2022 HSA Contribution Limits and Guidelines

HSA contribution limits	2021	2022
• Single coverage	$3,600	$3,650
• Family coverage	$7,200	$7,300
Catch-up contributions		
• Single coverage	$4,600	$4,650
• Family coverage	$8,200	$8,300

IRS Notice 2019-45

- Generally, a HDHP may not provide benefits for any year until the minimum deductible for that year is satisfied
- However, a HDHP may provide preventive care benefits without a deductible plan
- The IRS added various items that qualify as preventive—see: https://www.irs.gov/newsroom/irs-expands-list-of-preventive-care-for-hsa-participants-to-include-certain-care-for-chronic-conditions

HSA Payments for Health Insurance, Including COBRA

- HSA funds can be used to pay for health insurance premiums, including COBRA
- HSAs can pay for testing and treating coronavirus if the insured has not reached his or her deductible
- The HSA can cover the costs without having the health insurance policy lose its status as a high-deductible health insurance plan

HSA Payments Can Cover Many Different Items

- HSA-qualified plans can be used to temporarily cover telehealth or other remote-care services below the deductible
- Over-the-counter drugs and medicine can now be purchased using an HSA without a prescription
- Items such as vaccines, therapies for stress and anxiety, thermometers, batteries for medical devices, contact lenses and solution, prescription glasses, cold and allergy medicine, and first aid items like bandages, gloves and cleansing wipes are all covered

Flexible Spending Arrangements (FSAs)

Flexible Spending Arrangements (Accounts) (FSAs)

- A health care Flexible Spending Arrangement (FSA) allows employees to be reimbursed for medical expenses
- FSA contributions are deducted from an employee's paycheck on a pre-tax basis and no employment or federal income taxes are deducted from the contribution
- FSAs are usually funded through voluntary salary reduction agreements with an employer, but the employer may also contribute to the FSA
- FSA contributions lower an employee's taxable income, but they do not lower the amount of salary used to calculate an employee's other tax benefits such as retirement plan contributions

Flexible Spending Arrangements (Accounts) (FSAs)

- An individual cannot take a medical expense deduction for expenses that are reimbursed to the taxpayer through a FSA
- Throughout the year, employees can use FSA funds for qualified medical expenses not covered by their health plan
- These can include co-pays, deductibles, and a variety of medical products
- Also covered are services ranging from dental and vision care to eyeglasses and hearing aids
- Eligible health care expenses can be incurred until March 15 in order to file claims against unused balances from the previous plan year

Flexible Spending Arrangements (Accounts) (FSAs)

- For calendar year 2021, salary reduction contributions to a health care FSA cannot be more than $2,750 a year or any lower amount set by the plan
- If employers provide health care FSA contributions, this amount is in addition to the amount that employees can elect
- Health care FSA contribution limits work on an individual basis so that each spouse in the household may *contribute* up to the *FSA limit* in the plan year
- Under the FSA use-or-lose provision, participating employees normally must incur eligible expenses by the end of the plan year or forfeit any unspent amounts
- However, if they choose to, employers can offer an option for participating employees to have more time to use FSA money

Flexible Spending Arrangements (Accounts) (FSAs)

- Under the *carryover option*, an employee can carry over up to $500 of unused funds to the following plan year
- For example, an employee with unspent funds at the end of 2021 would still have those funds available to use in 2022
- Under the *grace period option*, an employee has until two and a half months after the end of the plan year to incur eligible expenses
- For example, 3/15/2022 for a plan year ending on 12/31/2021
- Employers can offer either option, but not both, or no option

Health Reimbursement Arrangements

Health Reimbursement Arrangements (HRA) TD 9867

- An HRA is an arrangement that is funded solely by an employer and that reimburses an employee for medical care expenses (as defined under Section 213(d)) incurred by the employee, or their spouse, dependents and any children who, as of the end of the taxable year, have not attained age 27, up to a maximum dollar amount for a coverage period
- No salary reduction contributions or other contributions by employees
- The HRA reimbursements are excludable from the employee's income and wages for federal income tax and employment tax purposes
- Amounts that remain at the end of the year can be used to reimburse expenses incurred in later years, depending on the terms of the HRA

Individual Enrolled in Both an HRA and Employer's Other Self-Insured Major Medical Group Plan

- An HRA is a self-insured group health plan that is minimum essential coverage
- Therefore, enrollment in an HRA must be reported in the same manner as enrollment in other minimum essential coverage, unless an exception applies
- Under an exception, if an individual is covered by two or more plans or programs that are minimum essential coverage and that are provided by the same reporting entity, reporting is required for only one of them for that month

Individual Enrolled in Both an HRA and Employer's Other Self-Insured Major Medical Group Plan

- Thus, if, for a month, an individual is enrolled in an employer's self-insured major medical group health plan and also has an HRA from the same ALE Member, the ALE Member is not required to report enrollment in coverage under the HRA (Form 1095-C, Part III or Form 1095-B, as applicable) for the individual
- If an employee is covered under both arrangements for some months of the year but drops coverage under the non-HRA group health plan and is covered only under the HRA, the employer must report coverage under the HRA for the months after the employee drops the non-HRA coverage

Disposition of Excess HRA Funds

- All HRAs, including the new Individual Coverage HRA (ICHRA) (discussed shortly), are exclusively employer-funded
- When employees leave the employer, their HRA funds return to the employer
- This rule differs from HSAs, which are employee-owned and portable when employees leave

Individual Coverage HRAs (ICHRAs)

- In 2019, the U.S. Departments of Health and Human Services, Labor, and the Treasury issued a final rule allowing employers of all sizes that do not offer a group coverage plan to fund a new kind of HRA known as an individual coverage HRA (ICHRA)
- These rules removed the prohibition on integration of an HRA with individual health insurance coverage if certain conditions were satisfied
- Starting January 1, 2020, employees have been able to use employer-funded ICHRAs to buy individual-market insurance, including insurance purchased on the public exchanges formed under the ACA

Individual Coverage HRAs (ICHRAs)

- HRAs and other account-based group health plans may be integrated with individual health insurance coverage or Medicare if certain conditions are satisfied
- Certain HRAs and other account-based group health plans will be recognized as limited excepted benefits (an excepted benefit HRA)

21st Century Cures Act

- Before the ACA, HRAs were used with group health plans to reimburse employees for individual health insurance
- IRS Notice 2013-54 held that a group health plan, including an HRA, used to purchase coverage on the individual market, was not integrated with that individual market coverage for purposes of the annual dollar limit prohibition
- Accordingly, an HRA used to purchase coverage on the individual market failed to comply with the ACA's annual dollar limit prohibition
- The penalty for paying for individual insurance policies for employees on a pre-tax basis is $100 daily ($36,500 for each employee annually)

QSEHRAs

QSEHRAs

- The 21st Century Cures Act created the Qualified Small Employer Health Reimbursement Arrangement (QSEHRA), which made it permissible for small employers to reimburse employees for individual insurance as long as the employers and employees meet the statutory guidelines
- A **QSEHRA** is a health cost reimbursement plan that can be offered by small business employers
- The costs reimbursed are tax-deductible by businesses and tax-free for employees

QSEHRAs

- A QSEHRA can be used to offset health insurance coverage or repay uncovered medical expenses
- A QSEHRA allows small employers to set aside a fixed amount of money each month that employees can use to purchase individual health insurance or use on medical expenses, tax-free
- The money stays with the employer until an employee makes a claim that qualifies for reimbursement
- If employees never make claims or do not claim the full amount, the employer keeps the money

QSEHRAs

- The employer must have fewer than 50 full-time employees and cannot offer a group health plan to any of its employees—the minimum number of employees needed to participate is one
- If a group health plan is provided, the employer will have to cancel it before QSEHRA can start
- Employees must have a health insurance plan that meets minimum essential coverage (MEC) in order to participate
- Short-term plans, indemnity, and faith-based sharing plans do not qualify as MEC

QSEHRAs

- A QSEHRA is designed to work with tax credits employees may have received from the marketplace to purchase their insurance. Any tax credits the employee receives on their premiums will be reduced dollar for dollar by the QSEHRA.
- There are no minimum contribution limits
- The IRS sets the maximum contribution limits each year for QSEHRA
- The 2021 QSEHRA limits are as follows:
  - Individual $5,300 ($441.67/month)
  - Family $10,700 or ($891.67/month)

QSEHRAs

- QSEHRA is funded solely by the employer and the employee cannot contribute to the fund
- The reimbursement amounts must be offered fairly to all employees—the rates can vary by family size, or all employees can be offered the same rate
- Employers can exclude part-time, seasonal employees under 26 years and employees on a spouse's group plan
- Employers can choose to reimburse premiums only or premiums and medical expenses

Individual Coverage HRAs

- By using an Individual Coverage HRA, (ICHRA), employers can provide workers and their families with tax-preferred funds to pay all or a portion of the cost of coverage that workers purchase in the individual market
- An ICHRA can be offered as a stand-alone benefit or as another option in a business's health benefits program, alongside group health insurance
- An ICHRA reimburses employees for their medical care expenses (and sometimes their family members' medical care expenses), up to a maximum dollar amount that the employer makes available each year

ICHRAs

- All employers with at least one W-2 employee can offer an ICHRA, including businesses, nonprofits, government entities, and religious organizations
- Unused amounts in any year to roll over from year to year
- Employees must enroll in individual health insurance or Medicare for each month the employee or the employee's family member is covered by the ICHRA
- This can be individual health insurance offered on or off an Exchange
- However, it cannot be short-term, limited-duration insurance (STLDI) or coverage consisting solely of dental, vision, or similar "excepted benefits"

ICHRA Reimbursements to Employees

- With an ICHRA, employers can choose how to structure reimbursements to employees:
  - Give all employees the same amount of money
  - Vary reimbursements by family size using a reasonable method
  - Example: an employer can offer $150 for single employees, $300 for married employees, and $450 for employees with children or the employer could offer $200 for each additional dependent
  - Vary reimbursements by employee age
  - Vary reimbursements by both family size and employee age

ICHRA Classes of Employees

- Employers may either offer an ICHRA or a traditional group health plan but cannot offer employees a choice between the two
- Employers can choose to create different reimbursement rules for different employee classes
- Employers can create classes of employees around certain employment distinctions, such as:
  - Salaried workers versus hourly workers
  - Full-time workers versus part-time workers
  - Workers in certain geographic areas
- and then offer an ICHRA on a class-by-class basis

ICHRA Minimum Class Sizes

- Minimum employee class sizes vary by employer size and are as follows:
  - 10 employees for employers with fewer than 100 employees
  - 10% of the total number of employees for employers with between 100 and 200 employees
  - 20 employees for employers with more than 200 employees

Potential ICHRA Classes

- Full-Time Employees
- Part-Time Employees
- Seasonal Employees
- Employees covered by a collective bargaining agreement
- Employees who have not satisfied a waiting period for coverage
- Salaried Employees
- Non-Salaried Employees
- Temporary Employees of staffing firms
- Non-Resident aliens with no US-based income
- Employees in the same geographic rating area
- Any combination of two or more classes from above

ICHRAs

- Employers that offer an ICHRA must do so on the same terms for all employees in a class of employees
- Employers may increase the ICHRA amount for older workers and for workers with more dependents
- Employers may offer both the ICHRA and group health insurance
- Employers can maintain their traditional group health plan for existing enrollees and offer an ICHRA to newly hired employees

ICHRAs

- ICHRAs must include a disclosure provision to help ensure that employees understand the type of HRA being offered by their employer and how the ICHRA offer may make them ineligible for a premium tax credit or subsidy when buying an ACA exchange-based plan
- At least once a year, employees must be given the option to opt-out of ICHRAs
- If employees do opt out, they forfeit the ability to claim reimbursements for the year

ICHRAs

- Large employers that are subject to the corporate mandate to provide health insurance to their full-time employees (typically employers with over 50 full-time or full-time equivalent employees) can design their ICHRA to satisfy the large employer mandate and avoid the Section 4980H(a) and (b) penalties
- Currently, there is no guidance from the Departments of Labor, Treasury, or Health and Human Services regarding how large employers (ALEs) who are held to the corporate mandate determine what their minimum HRA contributions will have to be in order to satisfy the employer shared responsibility mandate

Excepted-Benefit HRA

Excepted Benefit HRA

- An excepted benefit HRA lets employers that offer traditional group health plans provide an additional pretax $1,800 annually for 2021 to reimburse employees for certain qualified medical expenses, including premiums for vision, dental, and short-term, limited-duration insurance that does not comply with the ACA
- An excepted benefit HRA must not be an integral part of the employer's group health plan
- To satisfy this requirement, the employer must offer a separate group health plan to any employees who are offered the excepted benefit HRA in a given plan year

Excepted Benefit HRA

- Excepted benefit HRAs may not reimburse for the following premiums:
  - Individual coverage (if the insurance covers more than just excepted benefits)
  - Group health plan coverage (if the group health plan covers more than just excepted benefits)
  - Medicare Parts A, B, C and D
  - Cost sharing for any of these types of coverage are still reimbursable through an excepted-benefit HRA
- The eligible employee is not actually required to enroll in the group health plan to receive coverage under the excepted benefit HRA
- The excepted benefit HRA can be used by employees whether or not they enroll in a traditional group health plan and can be used to reimburse employees' COBRA continuation coverage premiums and short-term insurance coverage plan premiums

Health Care Sharing Ministry

Conditions Related to Participation in a Health Care Sharing Ministry

- The Affordable Care Act (ACA) required that beginning in 2014 each individual must maintain minimum essential health insurance coverage (MEC) or pay a penalty*
- A health care sharing ministry (HCSM) is an arrangement where members, who typically share religious beliefs, make monthly payments that are pooled together to cover the medical expenses of other members
- The ACA provided for an exemption from the ACA's penalty for failure to carry health insurance coverage for a HCSM to which all of the following conditions apply:
  - The HCSM has been in existence at all times since December 31, 1999
  - The HCSM is a Section 501(c)(3) organization whose members share a common set of ethical or religious beliefs
  - The HCSM members share medical expenses among its members
  - The HCSM conducts an annual audit available to the public
- *Since 2019, the penalty for failure to carry health insurance no longer applies

Operation of a HCSM

- HCSMs generally:
  - Never guarantee payment of claims
  - State they are "not insurance"
  - Provide fewer protections than ACA-compliant health insurance
- HCSMs generally have dollar limits on coverage ranging between $125,000 and $250,000 per health care incident, though it may be possible to purchase additional health care coverage for an additional fee
- Prescription drugs are usually excluded from HCSM coverage though drugs for certain short-term health episodes may be covered
- Medications for chronic illnesses such as diabetes or high blood pressure are generally not covered

Operation of a HCSM

- HCSMs do not cover preventive services such as immunizations for children, mammograms, and colonoscopies
- HCSMs generally apply pre-existing condition exclusions and may refuse to accept individuals who are already sick

Claims Excluded by Coverage by a HCSM

- HCSMs generally do not cover claims for mental illness and the use of illegal substances
- HCSMs may refuse to cover any medical claim that it determines is a violation of moral guidelines established by the HCSM's board of directors
- Claims excluded on moral grounds include those for treatment of diseases related to pre-marital sex, pregnancy outside of marriage, and diseases that may be related to drug or alcohol use
- There is no formal appeal process when a claim is denied

Payment and Coverage Issues

- HCSMs generally operate under a self-pay arrangement
- HCSM members must pay their medical providers up-front and wait for the HCSM to reimburse them
- HCSMs often advise their members to negotiate payment discounts with their medical providers and to avoid paying the full amount of their invoice for medical services provided
- Customarily, health care providers require proof of insurance or some other proof of guaranteed payment before they will agree to perform a medical procedure
- HCSMs cannot provide such proof because HCSM plans expressly state that they do not guarantee payment

IR-2020-116, June 8, 2020

- The IRS has released proposed regulations which provide that payments to a HCSM are expenses for medical care under Section 213
- The IRS's proposed regulations are in response to Executive Order 13877, which directed the Treasury to propose regulations to treat expenses related to certain types of arrangements, potentially including direct primary care arrangements and HCSMs, as eligible medical expenses under Section 213(d)

Impact of the IRS's Proposed Section 213 Regulations

- The IRS's proposed regulations are a beneficial change for HCSMs and their members because an individual HCSM member may deduct payments to the HCSM as a medical expense provided the individual itemizes deductions
- If the individual is self-employed, the payments will now be deductible as Self-Employed Health Insurance regardless of whether the individual itemizes
- Where the member is a more than 2% shareholder in an S Corporation, the payments are deductible without itemizing if the amounts are paid or reimbursed by the S corporation and reported on the shareholder's W-2
- A similar treatment is available for partners in a partnership who receive self-employment income from the partnership

IRS FAQs Dealing With Loss of Employer-Provided Health Insurance

- COVID-19 FAQs for Participants and Beneficiaries
- https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/covid-19.pdf

If My Place of Employment Temporarily Closes Because of the COVID-19 Outbreak, Am I Still Covered by My Employer's Group Health Plan?

- As long as the employer exists, continues to sponsor a health plan, and employs you, and you continue to meet your employer's eligibility requirements, you would generally remain covered under your existing health plan, even if the employer's physical location closes

I Think I May Be Losing My Health Coverage as a Result of the COVID-19 Outbreak. What Can I Do To Obtain Other Health Coverage?

- Options:
  - Special Enrollment in Another Group Health Plan
  - Special Enrollment in Individual Market Insurance Coverage
  - Health Coverage through a Government Program (CHIP)
  - COBRA Continuation Coverage
    - If an individual is Medicare-eligible, but has not enrolled in Medicare, and chooses to enroll in COBRA, they may incur unexpected out-of-pocket costs for benefits paid under COBRA, as well as penalties for late enrollment in Medicare once enrolled

Can My Employer Terminate or Reduce My Health Benefits at Any Time?

- Employers offer health benefits on a voluntary basis. Federal law does not require employers to offer health coverage to their employees, nor does it generally prevent employers from cutting or reducing benefits. However, employers may have to take certain steps (such as providing advance notice) before reducing health benefits.
- If an employer terminates your health benefits, depending on the reason for termination, you and your family may have a right to continuation coverage under COBRA if the plan still exists or a related employer still has a plan. You may also have a contractual right to coverage if, for example, benefits are required under a collective bargaining agreement.
- In addition, a plan cannot deny eligibility or continued eligibility based on an individual's health status

My Employer Did Not Pay the Insurance Premium for My Group Coverage. May I Pay the Premium to Continue My Coverage?

- You should contact your employer to determine whether the employer intends to pay the premium. You may also wish to contact your state insurance commissioner regarding any rights you may have under state law to pay premiums directly to the insurance company or convert your health coverage to an individual policy.

FAQs Regarding Implementation of the CARES Act, HIPAA, and the ACA

How Does the Dec. 12, 2020 ACIP Recommendation Impact When Plans and Issuers Must Provide Coverage Without Cost Sharing for COVID-19 Vaccines Under Section 3203 of the CARES Act and Its Implementing Regulations?

- Plans and issuers must now cover COVID-19 vaccines and their administration, without cost sharing, immediately once the particular vaccine becomes authorized under an EUA or approved under a BLA, and according to the scope of the applicable EUA or BLA

May a Group Health Plan (or Health Insurance Issuer Offering Coverage in Connection With a Group Health Plan) Offer Participants in the Plan a Premium Discount for Receiving a COVID-19 Vaccination?

- Yes, if the premium discount complies with the final wellness program regulations
- A premium discount that requires an individual to perform or complete an activity related to a health factor, in this case obtaining a COVID-19 vaccination, to obtain a reward would be considered a wellness program that must comply with the five criteria for activity-only wellness programs described in paragraph (f)(3) of the final wellness program regulations
- To satisfy these criteria, a wellness program that provides a premium discount to individuals who obtain a COVID-19 vaccination must be reasonably designed to promote health or prevent disease and must provide a reasonable alternative standard to qualify for the discount

May a Group Health Plan or Health Insurance Issuer Condition Eligibility for Benefits or Coverage for Otherwise Covered Items or Services to Treat COVID-19 on Participants, Beneficiaries, or Enrollees Being Vaccinated?

- No. PHS Act section 2705, ERISA section 702, section 9802 and the Departments' implementing regulations generally prohibit plans and issuers from discriminating against participants, beneficiaries, and enrollees in eligibility, premiums, or contributions based on a health factor.

How Are Premium Discounts and Surcharges for Receiving or Not Receiving the COVID-19 Vaccination, Respectively, Treated for Purposes of Determining Affordability of Coverage With Respect to the Employer Shared Responsibility Payment Under Section 4980H(b)?

- Wellness incentives that relate to the receipt of COVID-19 vaccinations are treated as not earned for purposes of determining whether employer-sponsored health coverage is affordable
- Although premium incentives are permissible as part of a nondiscriminatory wellness program, premium incentives other than incentives relating exclusively to tobacco use, including wellness programs encouraging vaccinations for COVID-19, are treated as not earned when determining the employee's required contribution for an offer of health coverage

Q&A

We will now answer viewer questions that have come in during the webinar

Thank You!