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Insider

Departments finalize regulations on individual coverage and excepted benefit HRAs

By Anu Gogna and Ben Lupin

On June 13, 2019, the Departments of Labor (DOL), Treasury, and Health and Human Services (HHS) released final regulations allowing employers to offer health reimbursement arrangements (HRAs) that can be integrated with individual health insurance coverage, referred to as individual coverage HRAs (ICHRAs). The individual health insurance coverage may be purchased on or off an Affordable Care Act (ACA) public exchange. The final rules take effect January 1, 2020.

The regulations also cover the requirements for an HRA to be considered a limited excepted benefit exempt from ACA insurance market reforms, including the prohibition on annual and lifetime dollar limits on essential health benefits, and the preventive services mandate. Finally, they address 1) premium tax credit eligibility for ICHRA participants, 2) whether the individual health insurance coverage purchased using ICHRA credits becomes part of an ERISA plan, and 3) the special enrollment period (SEP) in the individual market for those newly eligible for an ICHRA.

Integration rules for ICHRAs

The final regulations include the following five basic requirements to integrate an HRA with individual health insurance coverage:

1. ICHRA participants must also be enrolled in individual health insurance and show proof of coverage.
2. Employers may not offer both an ICHRA and a traditional group health plan to the same class of employees.
3. ICHRAs must be offered on the same terms to all employees in the same class.
4. Employees must be provided an opportunity to opt out of the ICHRA at least annually and upon termination of employment.
5. When offering an ICHRA, employers must provide an explanatory notice to all eligible employees.

The final regulations make several changes to the proposed regulations that were issued in 2018 (proposed rule) and provide clarifications on open issues, including the following:

- *Coverage that can be integrated with an ICHRA.* ICHRAs may be integrated with individual coverage, including catastrophic plans, grandmothered[1] plans and Medicare, but not with: 1) plans that only provide excepted benefits, 2) short-term limited duration insurance, 3) other group health plan coverage such as spousal employer coverage, and 4) TRICARE.
- *ACA annual/lifetime dollar limit prohibition and preventive services mandate compliance.* As with the proposed rule, the final regulations treat individual coverage integrated with an ICHRA (except coverage solely for excepted benefits) as compliant with the ACA's annual/lifetime dollar limit prohibition on essential health benefits and the preventive services mandate. As a result, participants will not have to prove separately that their individual policy is compliant; however, to receive reimbursements from

In This Issue

1 Departments finalize regulations on individual coverage and excepted benefit HRAs
4 CMS issues guidance on out-of-pocket maximum limits and drug coupons
5 Changes to 162(m) prompt revisiting pay plans and proxy disclosures

News in Brief

7 DOL requires top hat statements to be filed electronically

[1] Grandmothered plans are small group and individual market health plans that do not fully comply with the ACA and that were established from March 23, 2010 — the date of the ACA's enactment — through 2013.

If a participant no longer has individual health insurance coverage, claims incurred after the coverage ceases may not be reimbursed by the ICHRA.

an ICHRA, they do need to meet annual and ongoing substantiation requirements (see details below).

- *Forfeiture of ICHRA and COBRA.* Consistent with the proposed rule, if a participant no longer has individual health insurance coverage, claims incurred after the coverage ceases may not be reimbursed by the ICHRA, subject to any coverage continuation requirements such as COBRA. Failing to maintain individual coverage and thus becoming ineligible for an ICHRA itself does not constitute a qualifying event for COBRA purposes. Similarly, an employee moving from an ICHRA-eligible class to a noneligible class is not a COBRA-qualifying event unless the change in classification is a result of a termination of employment or reduction in hours.
- *Same terms requirement.* Under the proposed rule, employers were required to offer ICHRAs on the same terms to each class of employees subject to exceptions for a participant's age and number of dependents. Under the final regulations, maximum dollar amounts may vary by age but amounts for the oldest participants may not exceed three times the amounts for the youngest participants. The final regulations also allow amounts credited to the ICHRA to vary by number of dependents.
- *Classes of employees.* The final regulations made changes to the permissible classes of employees and permit employers to make distinctions based on the following employee groups:

1. Full-time employees
2. Part-time employees
3. Employees working in the same geographic location (generally, the same insurance rating area, state or multistate region)
4. Seasonal employees
5. Employees in a unit covered by a particular collective bargaining agreement
6. Employees who have not satisfied a waiting period
7. Nonresident aliens with no U.S.-based income
8. Salaried workers
9. Non-salaried workers (such as hourly workers)
10. Temporary employees of staffing firms
11. Any group of employees formed by combining two or more of these classes

- *Minimum class size requirement.* The final regulations include a minimum class size requirement based on employer size[2] that applies only to employee classes most at risk of adverse selection, including salaried, non-salaried, full time, part time and those whose primary site of employment is in the same rating area (unless the geographic area is a state or a combination of two or more entire states).
- *Rules for newly hired employees.* Under the final rules, employers that offer a traditional group health plan to one employee class can prospectively offer an ICHRA to employees in that class who are hired on or after a future date while continuing to offer the traditional group health plan to employees hired before such date.
- *Opt-out requirement.* The final regulations make some clarifications to the requirement that ICHRA participants be allowed to opt out and waive future reimbursements from the ICHRA at least annually and upon employment termination.
- *Substantiation of individual health insurance coverage.* The final regulations generally adopt the annual and ongoing coverage substantiation requirement from the proposed rule, with minor clarifications and included model attestation forms.[3] The annual substantiation is due by the first day of the ICHRA plan year. ICHRAs can set a reasonable timeframe for new dependent coverage effective retroactively, but it must be completed before reimbursing expenses. An employee's attestation,

[2] The applicable class size minimum is 10 for an employer with fewer than 100 employees, 10% of the total number of employees for an employer with 100 to 200 employees, and 20 for an employer with more than 200 employees.

[3] Individual Coverage HRA Model Attestations

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The final regulations recognize certain HRAs as limited excepted benefits and make some changes from the proposed rules to address concerns about adverse selection and confusion.

if inaccurate, will not prevent the ICHRA from being integrated with individual coverage unless the employer has actual knowledge of the inaccuracy.

- *Notice requirement.* The final regulations retain but revise the requirement that employers must notify eligible participants of the interaction between the ICHRA and the premium tax credit, and also include a model notice.[4] Employers are not required to include in the notice whether the ICHRA is affordable for a particular participant; however, HHS is expected to provide resources later this year to help individuals determine their premium tax credit eligibility.
- *Interaction between ICHRAs and health savings accounts (HSAs).* An ICHRA participant can contribute to an HSA-qualified high-deductible health plan if the ICHRA only reimburses individual health insurance premiums (and meets Internal Revenue Code requirements).

Excepted benefit HRAs

The final regulations recognize certain HRAs as limited excepted benefits and make some changes from the proposed rules to address concerns about adverse selection and confusion. To be considered an excepted benefit, an HRA must meet the following four conditions:

1. The employer must offer other group health plan coverage that is not account-based and does not consist solely of excepted benefits.
2. The benefit amount must be limited (i.e., $1,800 for plan years after December 31, 2020, indexed for inflation).
3. An excepted benefit HRA cannot reimburse premiums for Medicare Part B or D, individual health coverage or coverage under a group health plan (other than COBRA).
4. The HRA must be available under the same terms to all similarly situated individuals regardless of any health factor.

Consistent with the proposed rule, an excepted benefit HRA may reimburse premiums for short-term limited-duration insurance. The final regulations also clarify that employers may not make enrollment in an excepted benefit HRA conditional on the employee's declining to enroll in the traditional group health plan.

Premium tax credit eligibility and affordability

The final regulations retain the rule that employees who opt out of an ICHRA that meets the affordability requirements are ineligible for premium tax credits.

ACA employer mandate

Future guidance will address how to apply the ACA employer mandate to an ICHRA. This guidance will be important because employers could satisfy the employer mandate by offering an ICHRA to at least 95% of their full-time employees (and dependents). Furthermore, an employer could avoid the employer mandate penalty by offering full-time employees an ICHRA that is affordable (which would meet the minimum value requirement), regardless of whether the employee enrolls in the ICHRA.

ERISA plan status

Like the proposed regulations, the final regulations reiterate that ICHRAs are group health plans subject to ERISA. However, ERISA does not apply when an employee can use a cafeteria plan to make salary reductions on a pretax basis to pay the portion of the premium not covered by the ICHRA.

The final regulations adopt but clarify a safe harbor provision under which the individual health insurance coverage purchased using the ICHRA is exempt from ERISA.

The following conditions meet the safe harbor requirements:

1. An employee's purchase of any individual health insurance must be completely voluntarily.
2. The employer does not select or endorse any particular insurance carrier or insurance coverage.
3. Reimbursement for non-group health insurance premiums is limited solely to individual health insurance coverage.
4. The employer does not receive any cash, gifts or other consideration in connection with an employee's selection or renewal of any individual health insurance.
5. Each plan participant is notified annually that the individual health insurance coverage is not subject to Title I of ERISA.

Special enrollment period

Employees and dependents may qualify for a new one-time SEP in the individual market regardless of whether they have individual health coverage. All those with newly gained access

[4] Individual Coverage HRA Model Notice

to an ICHRA can take this into account when choosing an individual health insurance plan.

The SEP is available for coverage offered both on and off the ACA public marketplace. After becoming eligible for an ICHRA, individuals have 60 days to enroll in individual coverage or change the plan. Later this year, HHS plans to provide resources to help individuals offered an ICHRA determine whether they qualify for a SEP.

Going forward

Employers that are considering offering ICHRAs or excepted benefit HRAs to employees will need to consider the administrative and compliance obligations involved, such as substantiation, attestation, notification and ERISA concerns. Large employers subject to the ACA's employer mandate that are interested should await further guidance from the IRS on satisfying the affordability requirements.

Later this year, HHS plans to provide resources to help individuals offered an ICHRA determine whether they qualify for a SEP.

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CMS issues guidance on out-of-pocket maximum limits and drug coupons

By Anu Gogna and Ben Lupin

The Centers for Medicare & Medicaid Services (CMS) issued the final Notice of Benefit and Payment Parameters for 2020 (Notice) and accompanying Fact Sheet addressing a variety of Affordable Care Act (ACA) benefit provisions affecting both the group and individual health plan markets. The changes take effect January 1, 2020.

Two items of note apply directly to sponsors of large self-insured and fully insured group health plans:

1. **2020 annual limits on cost sharing.** The maximum annual out-of-pocket limit for 2020 is $8,150 for individual coverage and $16,300 for family coverage (compared with $7,900 and $15,800 for 2019). These limits differ from those for health savings account (HSA)-qualified high-deductible health plans (HDHPs) for 2020.
2. **Cost sharing with drug coupons.** Drug manufacturers often provide coupons to patients to reduce their out-of-pocket costs, and some insurers and pharmacy benefit managers (PBMs) have responded by adopting accumulator adjustment programs, also known as copay accumulators or variable copay programs. These programs omit the value of a drug coupon from payments that count toward the health plan's cost-sharing limits. Under the guidance in the Notice, group health plans may disregard amounts paid using drug manufacturer coupons for prescription brand drugs only if a generic equivalent was available and medically appropriate. Otherwise, the drug coupon must count toward the cost-sharing limits.

States can adopt a different rule for fully insured plans, meaning they could require drug coupons/financial assistance to be counted toward the annual cost-sharing limits in all circumstances. Several states are considering legislation on accumulator programs. Virginia and West Virginia have already passed laws requiring health plans to include "any amounts paid by the employee or paid on behalf of the employee by another person" when calculating an employee's cost-sharing contributions. Arizona now requires inclusion only if a drug does not have a generic equivalent or the patient has obtained access to the drug through prior authorization, step therapy, or the plan's exceptions and appeals process. More states are expected to weigh in on this issue.

2020 plan-year considerations

- **Self-insured non-HDHP plans.** Employers sponsoring these plans can adopt an accumulator program following CMS guidelines. When a generic equivalent drug is not available or not medically appropriate, or an individual obtains an exception, the plan must count the coupon value toward cost sharing; if a generic equivalent drug is available and medically appropriate, the plan can decide whether to count the value.
- **Fully insured non-HDHP plans.** Under these plans, an accumulator program may count the value of the drug coupon toward cost sharing following CMS guidelines *and if allowed by state law.*

- **HSA-eligible HDHPs (fully insured and self-insured).** Existing IRS guidance is unclear as to whether these plans must adopt an accumulator program to remain HSA-eligible. Notably, the IRS prohibits a HDHP from covering benefits before the deductible is satisfied (with certain exceptions, such as for preventive care). The concern is that crediting the coupon's value toward the HDHP's deductible/out-of-pocket maximum could result in the deductible/out-of-pocket maximum being satisfied without any payment from a participant.

Going forward

Employers should review the terms of their group health plans as well as agreements with PBMs to determine what, if any, changes may be needed for 2020. Employers with HSA-qualified HDHPs will need to determine with legal counsel how to comply with IRS and CMS guidance moving forward.

Existing IRS guidance is unclear as to whether [HSA-eligible HDHPs] must adopt an accumulator program to remain HSA-eligible.

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Changes to 162(m) prompt revisiting pay plans and proxy disclosures

By Ryan Beger and Steve Seelig

While it has been over a year since the Tax Cuts and Jobs Act of 2017 eliminated the performance-based compensation exception to section 162(m) of the tax code, relatively few companies have revamped their pay programs to take advantage of its repeal. This likely reflects the short time frame companies had for making changes entering 2018, as well as a desire to preserve the deductibility of grandfathered awards. Companies are also unsure of how shareholders might react if they recraft their programs to preserve most performance-based design elements.

To provide more clarity about those issues of concern to some shareholders, proxy advisor Institutional Shareholder Services (ISS) issued a set of **frequently asked questions** (FAQs)[1] reflecting its view on the direction pay plans should take. We share our insights on ISS's suggested approach below.

Shareholder approval and use of performance-based pay

The 162(m) shareholder approval process in place for over 20 years reasonably assured shareholders that at least some portion of executive pay would be performance-based. Despite concern following the rule's repeal that companies might make greater use of non-performance-based compensation or fully discretionary programs, there have not been many changes to senior executive pay programs. In fact, ISS considers shifts away from performance-based compensation to discretionary or fixed-pay elements to be a problematic pay practice, including "changes made in light of the removal of 162(m) deductions."

While shifting away from performance-based compensation won't necessarily generate an automatic negative say-on-pay vote recommendation, companies would be well advised to clearly indicate their intention to continue with performance-based plans. This also would enable companies to move away from existing "negative discretion" designs to those that permit upward discretion, without raising concerns.

Fortunately, the ISS FAQs offer more details on the 162(m) shareholder approval process. Although references to 162(m) can be removed from a plan, ISS notes that the section's requirements "included items that are recognized by investors as good or best practices," and "their removal may be viewed as a negative change in a plan amendment evaluation." Going further, ISS cites removing individual award limits from the plan document as an example of a negative change.

Most companies appear to be maintaining or creating individual limits for non-employee directors when they seek

Companies would be well advised to clearly indicate their intention to continue with performance-based plans.

[1] Institutional Shareholder Services, U.S. Equity Compensation Plans Frequently Asked Questions, updated December 19, 2018

Many of the requirements under 162(m) represent good governance practices honed during the say-on-pay era.

new share authorizations, in reaction to recent court cases; however, practices are mixed for maintaining individual limits for employees. An ISS analysis found that at least 7% of these proposals sought to remove certain 162(m) plan provisions, including 1) reference to the exception for qualified performance-based compensation, 2) individual grant limits, and 3) references to performance cash awards.

Many of the requirements under 162(m) represent good governance practices honed during the say-on-pay era, and companies should consider taking the following steps:

- Continue to establish maximum amounts/shares payable to covered employees (per the plan document).
- Agree upon extraordinary items and rules around financial metrics exclusions at the beginning of the period (not after the fact at year-end).
- Establish performance goals within 90 days after the performance period begins.
- Ensure performance goal outcomes are substantially uncertain when adopted.
- Limit the use of "upward" discretion outside of individual performance goals (which should generally be measurable and objective).

Retaining these provisions in the shareholder-approved plan document can reduce the need for expanded disclosure; however, if the plan must be stripped of such 162(m)-related provisions (for example, when a company is seeking approval of a new equity plan), it is recommended that the company reassure shareholders that it will maintain its existing approach.

Proxy disclosure of 162(m)-related issues

A company that continues to pay performance-based compensation should disclose this prominently in the Compensation Discussion and Analysis (CD&A), such as in the executive summary. Details can be presented in the CD&A's stand-alone section on "the impact of accounting and tax treatments of a particular form of compensation," where references are traditionally made to the potential application of the performance-based exception to 162(m). In the recent past, 162(m) compliance has prompted shareholder suits, with companies responding by having counsel carefully word their proxy disclosures. As processes change, new disclosures should be crafted with equal care.

Companies must also consider whether to continue using "negative discretion," as well as how to disclose the plan in the proxy — specifically, whether this would alter the Summary Compensation Table (SCT) disclosure.

The Securities and Exchange Commission staff guidance (**Compensation and Disclosure Interpretations 119.02**) permits companies to disclose 162(m)-compliant plan payouts using negative discretion in the Non-Equity Plan Compensation column. If positive discretion is applied instead, more compensation would be shown in the SCT's Bonus column due to discretionary adjustments; however, as suddenly moving disclosed values to the Bonus column might attract scrutiny from proxy advisors and shareholders, companies are encouraged to clearly describe the reasoning prominently in the proxy. Additionally, more detailed disclosure of actual performance thresholds, targets and maximums in the Grants of Plan Based Awards table might be required.[2]

Frequency of share requests

Some companies opt to include the 162(m)-compliant plan provisions in an omnibus plan along with their request for new share authorizations, while others have a stand-alone plan approved separately for 162(m) approval purposes. ISS found that equity plan proposals decreased by 40% in 2018, and only about 2% were submitted solely for the purposes of 162(m) reapproval, down from 13% in 2017. It isn't clear whether companies that needed the five-year approval simply decided it was no longer necessary or were waiting to see how shareholders viewed the process.

The ISS FAQs disclosed an increase in the weighting of the plan duration factor of the Equity Plan Scorecard (EPSC) in light of 162(m) changes "to encourage plan resubmission to shareholders more often than listing exchanges require." So far this change has marginally impacted the EPSC score, possibly because institutional investors already preferred more regular requests. Frequent requests, however, have their downsides — more time, effort, and printing and professional fees — and some companies actually make larger share requests than ISS would otherwise support (while still generally obtaining shareholder approval).

How often should companies resubmit their shareholder-approved plans? Requesting shareholder approval every three to five years is considered best practice and will largely remain the norm, even with the changes to 162(m) and the ISS model.

[2] **"162(m) changes will affect your proxy disclosure, but not in the manner some suggest,"** *Executive Pay Matters,* December 21, 2017.

Going forward

Companies have much to consider as they approach the new 162(m) world, particularly as most large institutional shareholders have not made policy changes to their published proxy voting policies.

Proxy advisors are not likely to use 162(m)-related changes when issuing voting recommendations on new equity requests. They are more likely to express the views in the say-on-pay analysis, particularly in case of a pay-for-performance disconnect or poor responsiveness to shareholder feedback. While proxy advisors have expressed their initial views, it remains to be seen how this will manifest as they prepare vote recommendations, and how shareholders will ultimately vote.

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News in Brief

DOL requires top hat statements to be filed electronically

By Stephen Douglas and Bill Kalten

The Department of Labor (DOL) recently issued a final regulation requiring "top hat" plan statements to be filed electronically rather than by mail or personal delivery, effective August 16, 2019. Top hat plans are unfunded or insured pension plans that provide deferred compensation for a select group of management or highly compensated employees. Filing the one-time statement satisfies ERISA's reporting and disclosure requirements.

The electronic top hat filing system can be accessed now. Once a statement is filed, it becomes available to the general public on the DOL's website.

Employers that establish new top hat plans will need to use the electronic filing system going forward. Employers with existing top hat plans may want to verify that required filings have been made. Employers can use the DOL's Delinquent Filer Voluntary Compliance Program to pay reduced penalties for any late filings. Instructions are available in the DOL's Frequently Asked Questions about the Delinquent Filer Voluntary Correction Program.

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