Milliman

Health & Group Benefits

AN EMPLOYER BENEFITS UPDATE

APRIL 2020

Milliman's perspective on today's issues for employers and other plan sponsors

COVID-19 has rapidly become an everyday reality for all of us, different in so many ways from what we have experienced historically. As we have seen with COVID-19, changes to our healthcare landscape can be dramatic and occur very quickly. As a result, Milliman's Health and Group Benefits practice will be releasing timely market updates offering brief summaries to make sure our employer clients stay informed and ahead of the curve. We plan to release these updates electronically and on a more frequent basis.

Please keep a look out for this information and make sure to reach out if there are any additional questions.

Please note: Milliman continues to publish new information as the response to the global pandemic evolves. For complete and up-to-date thought leadership from Milliman on COVID-19, we encourage you to visit milliman.com/coronavirus.

The new life of the HRA: Expanded options allow employees to use funds on the individual marketplace

Stephanie Peterson

Health reimbursement accounts (HRAs) are a type of tax-preferred, account-based health arrangement that employers use to reimburse employees for their healthcare expenses. Historically, employers were effectively prevented from offering standalone HRAs to their employees to purchase separate coverage within the individual insurance market (outside of the traditional employer-sponsored coverage). A new regulation introduced in June of 2019 now allows these standalone HRAs specifically for the purpose of purchasing coverage within the individual insurance market.

This new regulation released by the Department of Labor (DOL), Health and Human Services (HHS), and the Treasury permits employers to offer a new individual coverage HRA (ICHRA) as an alternative to traditional group health coverage (subject to certain conditions) and a new excepted benefit HRA (EBHRA) to fund expenses associated with benefits other than medical. In other words, these new regulations will not only allow and permit the continuation of the traditional HRAs (such as HRAs integrated with group health plans and retiree-only HRAs) but would also recognize two new types of HRAs as described below.

1. **Individual coverage HRA (ICHRA)**

   This HRA is designed for employers (typically small to mid-sized) who either do not offer a group medical plan at all or do not offer a group medical plan to certain employee segments (such as retail or part-time employees). Essentially, ICHRAs extend the tax advantages of a traditional employer-sponsored group health plan (i.e., exclusion of premiums and benefits received from federal taxes and payroll taxes) to HRA reimbursements of individual insurance market premiums.

   To receive the HRA reimbursements, an employee must be enrolled in an individual insurance market plan. This plan can be one that is offered either on or off the public exchange (HealthCare marketplace). An ICHRA

reimburses employees for their medical care expenses/premiums up to a maximum dollar amount that the employer makes available each year.

2. **Excepted benefit HRA (EBHRA)**

   This new type of HRA is very distinct from both a traditional HRA and the ICHRA. With this account, employers can offer an EBHRA to employees who are eligible for group coverage, though enrollment in a group plan isn't necessary. This does not apply to medical insurance premiums. An EBHRA can be used to fund and reimburse expenses or premiums for excepted benefits only, such as dental, vision, or short-term insurance. The initial 2020 funding limit for this type of account will be $1,800 per year (indexed for inflation starting in 2021).

Considerations

Though the Internal Revenue Servie (IRS) has finalized this ruling effective January 1, 2020, there are still many considerations an employer should explore before implementing one of these new types of accounts.

1. **How does this affect the employer mandate?** As outlined within the ACA, those employers with more than 50 full-time employees are subject to the employer mandate. An offer of an ICHRA can potentially count as an offer of coverage and thus comply with the employer mandate. The affordability test will still need to be performed to determine whether the ICHRA contributions comply. In general, an employer will need to contribute a sufficient amount for the offer of an ICHRA to be considered affordable.
2. **Who is eligible for the ICHRA offering?**
   a. If an employer offers an ICHRA, it must make this offer to all individuals within a class of employees. There are two exceptions to this rule: (a) employers can offer older workers within a class of employees a higher HRA dollar amount, and (b) employers can offer workers with dependents an additional amount to account for the number of participants they are intending to cover, given that premiums within the individual market vary by age.
   b. Employers cannot offer an ICHRA to any employee to whom they offer their traditional employer-sponsored coverage (i.e., group health plan). However, an employer can decide to offer an ICHRA to certain classes of employees and a traditional group health plan to other classes of employees. The rule outlines the classes of employees that can be used, and includes minimum class size requirements that vary based on employer size.
   c. The IRS has provided guidance on defining classes of employees and the applicable minimum class sizes.
3. **How much can an employer contribute to an ICHRA?** Employers can contribute as little or as much as they want. However, the ICHRA must be offered with the same terms to each class of employees considered above. In addition, there must be some consideration given toward the employer mandate, if applicable.
4. **What is an EBHRA and what are the benefits for offering?** Traditional account-based plans do not work well for excepted benefits such as dental and vision due to the federal healthcare requirements. The EBHRA cannot be used to reimburse for individual health insurance premiums (medical/Rx), group health plan premiums (medical/Rx) (other than COBRA), or Medicare premiums. The EBHRA was created to reimburse for premiums associated with excepted benefits such as dental and vision. The EBHRA must be offered in conjunction with a traditional group health plan. However, an employee is allowed to use an EBHRA even if they choose not to enroll in the traditional group health plan.
5. **When does this new regulation go into effect?** Employers are able to offer either an ICHRA or EBHRA for plan years beginning on or after January 1, 2020.

Expected outcomes

With access to care as a significant barrier for many uninsured employees, the new HRA rulings expand coverage choices and provide employers—particularly small employers where it is cost prohibitive to offer group insurance—the opportunity to take an active role in improving access to care for their employees, potentially providing a competitive benefit offering while limiting their exposure to the complexities of traditional group health plan.

The DOL expects the new ruling to have the following effects:

- Benefit 800,000 employers, primarily small and mid-sized businesses
- Benefit 11 million members, including approximately 800,000 previously uninsured

When considering those potential impacts, it is important to reflect on the trajectory of HRAs as a benefit offering. According to the Society for Human Resource Management, in 2018 only 19% of employers offered HRAs, just a 2% increase since 2014. By comparison, 56% of employers offered health saving accounts (HSAs), an 11% increase since 2014. Furthermore, the number of HSA participants increased dramatically from 2017 to 2018, rising from 50% to 81% participation where the employer offers an HSA-eligible plan. Overall, the previous limitations and regulatory hurdles that have accompanied HRAs may have limited their appeal to employees and employers. However, the expanded use of HRAs may ultimately increase their appeal and result in wider adoption in the coming years.

Conclusion

The new HRA options should not obviate the employer responsibility for educating members on health literacy. Employers play a critical role in the healthcare ecosystem. While the expansion of HRAs is a step in the direction of providing additional coverage options, it is a single piece in the broader healthcare puzzle. Employers should continue to explore additional and complementary strategies to improve member health and emphasize consumerism and health risk mitigation.

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Sources:

IRS (June 13, 2019). FAQs on new health coverage options for employers and employees. Available at: https://www.irs.gov/pub/irs-utl/health_reimbursement_arrangements_faqs.pdf

Miller, S. (June 14, 2019). New final rule lets employees use HRAs to buy health insurance. Society for Human Resource Management. Available at: https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/new-final-rule-lets-employees-use-hras-to-buy-health-insurance.aspx

Otto, N. (June 14, 2019). New rule may greatly expand HRA usage. Employee Benefit News. Available at: https://www.benefitnews.com/news/irs-final-rule-expands-hra-usage

ConnectYourCare.com. Benefits by the numbers: Companies offering HSAs, FSAs, and HRAs in 2018. Available at: https://www.connectyourcare.com/blog/benefits-numbers-companies-offering-cdhp-hsa-fsa-hra-2018/

Society for Human Resource Management (June 19, 2019). 2018 employee benefits: The evolution of benefits, synopsis. Available at: https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/pages/2018-employee-benefits.aspx

Society for Human Resource Management (June 19, 2019). 2018 employee benefits: The evolution of benefits, full report. Available at: https://www.shrm.org/hr-today/trends-and-forecasting/research-and-surveys/Documents/2018%20Employee%20Benefits%20Report.pdf

Retiree health cost estimates for 2020

Robert Schmidt

The potential cost of healthcare as a retiree is important to consider well before an employee decides to retire. These costs can change as a result of regulations, inflation, new drugs, health risks, etc. Each year, Milliman develops estimates of retiree health costs in order to educate employees and retirees about the potential cost of healthcare over the course of retirement. In this article, Milliman has outlined four different scenarios of projected costs to help prospective retirees plan appropriately.

(1) Projected costs for a healthy 65-year-old couple retiring in 2020

A healthy 65-year-old couple retiring in 2020 is projected to spend approximately $351,000 in today's dollars ($535,000 in future dollars) on healthcare over their lifetime. Expenses at age 85 are estimated to be 234% higher than that at age 65.

(2) Projected costs for a healthy 45-year-old couple

A healthy 45-year-old couple is projected to spend approximately $505,000 in today's dollars ($1.4 million in future dollars) on healthcare over their lifetime.

Both scenarios (1) and (2) above have calculated these projected costs using the following assumptions:

- The health statuses of the retiree and spouse are assumed to be average for their entire life span.
- The retiree and spouse are assumed to be male and female with life spans of 88 and 90, respectively.
- Nationwide average premiums and out-of-pocket expenses from a retirement age of 65 through life span for a Medicare Supplement Plan G and a standard Medicare Part D plan are used.

- Future medical trend is assumed to be 4.9% per year. This assumption is based on long-term estimates from a Society of Actuaries model,[1] supplemented with Milliman research and converted to an annual equivalent rate.
- For calculations of present values in today's dollars, investment return of 3.0% per year is used.

(3) Average premium plus out-of-pocket cost at age 65

The estimated 2020 annual premium plus out-of-pocket cost for a healthy 65-year-old is $4,700.

Scenario (3) has calculated the out-of-pocket cost using the following assumptions:

- The health status of the retiree is assumed to be average. The average is based on a typical commercially insured population based on the Milliman Health Cost Guidelines™.
- A male or female age 65 is assumed.
- 2020 nationwide average premiums and out-of-pocket expenses at age 65 for a Medicare Supplement Plan G, Medicare Part B, and a standard Medicare Part D plan are used, based on the Milliman Health Cost Guidelines and premium information obtained from the Centers for Medicare and Medicaid Services (CMS).

(4) Portion of Social Security benefit spent on healthcare

A healthy 67-year-old couple is projected to spend 34% of their Social Security benefit on healthcare in 2020.

Scenario (4) calculations are based on the following assumptions:

- The health statuses of the retiree and spouse are assumed to be average. These averages are based on a typical commercially insured population based on the Milliman Health Cost Guidelines.
- The retiree and spouse are assumed to be male and female.
- 2020 nationwide average premiums and out-of-pocket expenses at age 67 for a Medicare Supplement Plan G, Medicare Part B, and a standard Medicare Part D plan are used, based on the Milliman Health Cost Guidelines and premium information obtained from the CMS.
- The December 2018 average monthly Social Security benefit at age 65-69 of $1,432.02 for retirees and $849.81 for spouses is used, with adjustments to 2019.[2] Social Security cost of living adjustments of 2.8% in 2019 and 1.6% in 2020 are used.[3]

Conclusion

The healthcare marketplace is volatile, partially due to legislative and regulatory changes, as well as the state of the drug pipeline, among other factors. Actuarially derived health cost estimates can help employees plan for the future and ensure that their retirement account is funded appropriately to reach the healthcare needs of the future.

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1 Society of Actuaries. Getzen model of long-run medical cost trends update for 2020–2029+. Available at: https://www.soa.org/resources/research-reports/2019/getzen-model-update/
Source: Milliman Health Cost Guidelines

2 Social Security Administration. OASDI current-pay benefits: Summary, Table 5.A10, Number and average monthly benefit for beneficiaries aged 60 or older, by sex, type of benefit, and age, December 2018. Available at: https://www.ssa.gov/policy/docs/statcomps/supplement/2019/5a.pdf

3 Social Security Administration. Cost-of-living adjustments. Available at: https://www.ssa.gov/OACT/COLA/colaseries.html

Trending in parental and family leave benefits

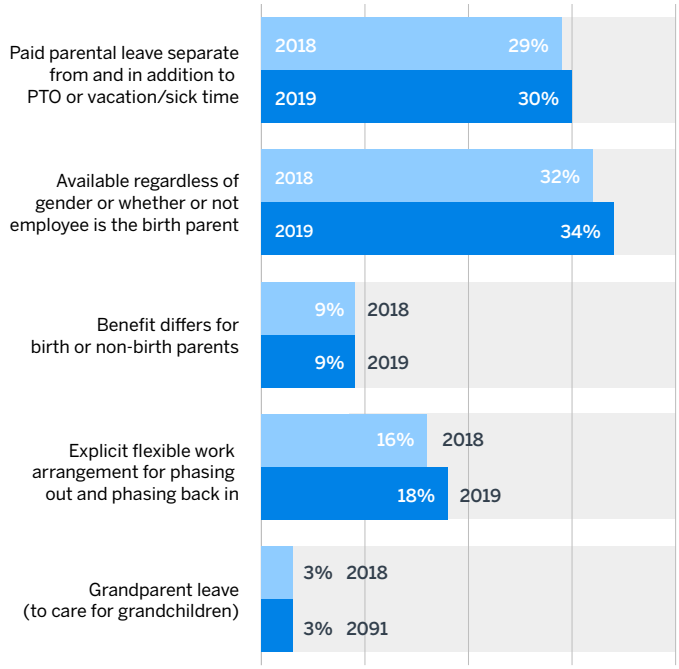
Ryan Hart

With an increasingly competitive talent market and changing employee demographics, employers are taking a closer look at their total benefits packages to understand what is driving prospective employees' wants and needs, particularly relating to parental leave. State and local laws are also changing quickly, creating a regulatory maze that can be difficult to navigate. Milliman conducted a What's Trending benefits pulse survey specific to parental leave benefits to get a sense of what employers are currently doing and considering in this space.

Parental leave benefits: Results

The results of a 2019 Milliman pulse survey confirmed that many employers are experiencing the issues of complex compliance as a result of changing laws and a competitive talent market demanding more robust leave benefits. Despite these pressures, there was little change in action from 2018 to 2019. Similar proportions of employers to those shown in Figure 1 are considering changes in 2020. Both parental leave benefits that are available regardless of employee gender or birth parent status and paid parental leave separate from vacation/sick time are popular for a significant minority among responding organizations.

FIGURE 1:

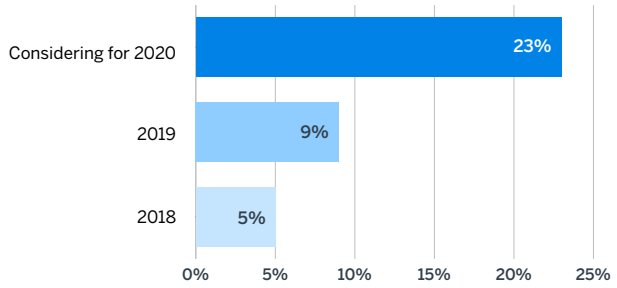


For those that responded, the number of weeks of available leave increased for both birth and non-birth parents from 2018 to 2019 for the 6-11 weeks and 12+ weeks categories. Yet the percentage of pay decreased slightly.

Family leave benefits

More employers are considering paid family leave benefits in 2020 that are separate from, and in addition to, PTO or vacation/sick time, and above and beyond the care for newborns/newly adopted children. While only 9% of respondents in 2019 (5% in 2018) said they currently offer this benefit, 23% of respondents said they were considering offering it for 2020. Similar to parental leave, the number of weeks offered is trending up while the percentage of pay is trending down.

FIGURE 2:



Conclusion

With competitive and regulatory pressures on employers to shore up parental leave programs, relatively few are taking definitive action. Of those that are, mitigating the potentially significant cost increases by lowering the percentage of pay while increasing the number of weeks of leave is a common strategy. As state and local laws continue to evolve, employers will need to pay special attention in order to ensure compliance.

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Regulatory Roundup

Compliance topic summaries

April 2020 H&GB Newsletter

Families First Coronavirus Response Act

Summary: On March 18, 2020, the president signed the Families First Coronavirus Act in response to the coronavirus pandemic. The Act includes:

- No participant cost sharing for COVID-19 testing or the provider visit related to testing
- Emergency paid sick leave
- Emergency family and medical leave

Coronavirus Aid, Relief, and Economic Security acts

Summary: On March 27, 2020, the president signed the Coronavirus Aid, Relief, and Economic Security Act, the third act in response to the coronavirus pandemic. This alert describes Title III (Supporting America's Health Care System in the Fight Against the Coronavirus), Part II (Access to Healthcare for COVID-19 Patients), Subpart A (Coverage of Testing and Preventive Services) of the CARES Act, which expands upon Division F, Health Provisions, of the Families First Coronavirus Response Act.

Transparency in Coverage Proposed Rule sets new requirements for group health plans

Summary: The Departments of Treasury, Labor, and Health and Human Services published a *proposed rule* that would require most employer-based group health plans and health insurance issuers offering group and individual coverage to disclose price and cost-sharing information to participants, beneficiaries, and enrollees up front. This will make previously unavailable price information accessible in a standardized way, allowing for health plan participants to make easy comparisons. The standardized information that the proposed rule calls for includes estimates for out-of-pocket costs that participants must pay to meet a plan's deductible, copayment, or coinsurance requirements.

Congress to repeal three healthcare taxes

The U.S. Senate passed an omnibus bill on December 19, 2019, in the form of Senate Amendment to H.R. 1865, Further Consolidated Appropriations Act, 2020, to fund the federal government through fiscal year 2020.

This bill includes the repeal of three health-related taxes established by the Affordable Care Act (ACA). They include:

- The health insurance providers fee (also known as the health insurance tax)
- The medical device excise tax
- The excise tax on high-cost employer health plans (also known as the Cadillac tax)

Although the Cadillac tax has been twice delayed, it was scheduled to go into effect in 2022. The medical device excise tax was scheduled to expire on December 31, 2019. The health insurance providers fee had a moratorium placed on it during 2019, will go back into effect in 2020, and will be eliminated permanently beginning in 2021.

Five health insurance changes employers should watch in 2020

Link to original article: Five Health Insurance Changes Employers Should Watch in 2020

In a joint release, the IRS, DOL, and HHS have issued regulations expanding the scope of health reimbursement arrangements (HRAs), finalizing proposed regulations from 2019. The following are applicable to plan years beginning on or after January 1, 2020:

In the dynamic and rapidly evolving healthcare landscape, employers to need to keep an eye on regulatory changes that may impact their health benefits plans in 2020. There are a few key areas to look out for:

1. In 2019, **new treatments for chronic conditions were added to the list of preventive care benefits** than can be paid before the deductible with an HDHP plan. This isn't a requirement, and may help make HDHPs with HSAs an attractive option for those with chronic conditions.
2. **Two more states, Rhode Island and California, enacted individual mandates**, which went into effect January 1, 2020. This means more healthcare reporting requirements.
3. The affordability test under the ACA changed. In 2020, the **lowest-cost, single-coverage option must not exceed 9.78% of an employee's household income**. This is a reduction from the previous year.
4. There is increased regulatory interest in prescription drug reform. HHS and the United States Food and Drug Administration (FDA) released a roadmap outlining two options **to lay the foundation for the safe importation of certain drugs**.
5. Court decisions related to wellness incentive rules in 2016 and 2017 left uncertainty for employers deciding on an incentive limit, ultimately leading to an incentive reduction for many employer-sponsored wellness plans. It is expected that those court decisions **will be clarified soon to help employers understand whether they should still be complying with the 30% incentive limit**.

HEALTH & WELFARE KEY DATES FOR APRIL 2020 TO DECEMBER 2020

JULY 28
- Provide a Summary of Material Modifications to participants if the plan adopted amendments for the plan year ending December 31, 2019, unless the information was included in an updated and timely distributed Summary Plan Description

JULY 31
- Payment of the final PCORI fee, covering the plan years ending from January 1, 2019 to September 30, 2019, to IRS on Form 720
- File 2019 Form 5500 Annual Return/Report, unless an extension applies

AUGUST 3
- Maximum penalties begin to apply for failures to file, or for filings of Forms 1094-B, 1095-B, 1094-C, or 1085-C after August 1, 2019

SEPTEMBER 30
- Summary Annual Report (SAR) to plan participants, if the Form 5500 was filed on July 31 and no extension applies
- MLR insurance rebates to policyholders, including ERISA-covered plans

OCTOBER 15
- Medicare Part D creditable/noncreditable coverage notice to Medicare-eligible participants
- File 2019 Form 5500 Annual Return/Report if July 31 filing date was extended

NOVEMBER 1
- Open enrollment begins in the federal health insurance exchanges/ marketplaces for coverage to begin January 1, 2021

DECEMBER 1
- Distribution of Summary of Benefits and Coverage for plans without an open enrollment period (for plans with an open enrollment period, provide the SBC to participants and beneficiaries with the enrollment materials and upon renewal or reissuance of coverage)

DECEMBER 15
- Open enrollment ends in the federal health insurance exchanges/ marketplaces for coverage to begin January 1, 2021
- Summary Annual Report to plan participants, if the Form 5500 was filed with an extension

DECEMBER 31
- Deadline to make discretionary plan amendments implemented in 2020 or that will take effect in 2021 but need to be adopted before implementation
- Nondiscrimination testing for section 125 cafeteria plans
- Pay any MLR rebates received on September 30 to participants or use the amounts for benefit improvements or establish a trust to hold the rebates as plan assets
- If not previously provided to plan participants along with other communications (e.g., open enrollment materials), furnish the Children's Health Insurance Program Reauthorization Act notice, the Women's Health and Cancer Rights Act (WHCRA) notice, and any other notices that must be provided annually
- Deadline for self-insured non-federal governmental group health plans to notify plan participants and the CMS of the plan opting out of the Mental Health Parity and Addiction Equity Act, the WHCRA, the Newborns' and Mothers' Health Protection Act, and Michelle's Law requirements

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