Benefits BULLETIN

1st Quarter 2020

Benefits Tips Brought to You by Insure NW

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2020 Benefit Plan Limits Announced

Many employee benefits are subject to annual dollar limits that are periodically increased for inflation. The IRS recently announced cost-of-living adjustments to the annual dollar limits for various welfare and retirement plan limits for 2020.

Although some of the limits will remain the same, many of the limits will increase for 2020.

Employers should update their benefit plan designs for the new limits, and communicate the new benefit plan limits to employees.

HDHPs and HSAs
The health savings account (HSA) contribution limits will increase to $3,550 for individuals and $7,100 for families, effective Jan. 1, 2020. However, the catch-up contribution for HSA-eligible individuals who are age 55 and older will remain at $1,000.

For plan years beginning on or after Jan. 1, 2020, the high deductible health plan (HDHP) minimum deductible will increase to $1,400 for individuals and $2,800 for families. The HDHP maximum out-of-pocket limit will increase to $6,900 for individuals and $13,800 for families.

Health FSAs
The health flexible spending account (FSA) dollar limit on employee salary reduction contributions is $2,750 for taxable years beginning in 2020. There is no change for dependent care FSA contributions.

401(k) Plan Contributions
The employee elective deferrals for 401(k) contributions and catch-up contributions will both increase $500 for 2020. The pre-tax contribution limit will increase to $19,500. The limit on catch-up contributions will increase to $6,500.

Transportation Fringe Benefits
The monthly limits on transit pass and vanpooling (combined), and parking will increase $5 each for 2020, bringing the monthly limits for each to $270.

Adoption Assistance Benefits
The annual tax exclusion for adoption assistance benefits will also increase from $14,080 to $14,300 for 2020.

For More Information
Contact us today to learn more about the updated limits, or for copies of employee communications that detail these changes.

Upcoming Group Health Plan Compliance Dates

Employers must comply with numerous reporting and disclosure requirements throughout the year in connection with their group health plans.

Listed below are upcoming important compliance deadlines for employer-sponsored group health plans, organized chronologically. For these requirements, the information provided herein shows the deadlines that apply to calendar year plans. For non-calendar year plans, these deadlines will need to be adjusted to reflect each plan's specific plan year.

January 2020
Employers that filed 250 or more IRS Forms W-2 for the prior calendar year must file Forms W-2 with the Social Security Administration and furnish Forms W-2 to employees by Jan. 31 of each year, unless an extension applies.

February 2020
ALEs that sponsor fully or self-insured health plans are required to report information about the coverage to the IRS each year, using IRS Forms 1094-C and 1095-C. Employers that

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are not ALEs use IRS Forms 1094-B and 1095-B to meet these reporting obligations. The deadline for filing paper versions of the forms is Feb. 28, 2020. The deadline for electronic filing is March 31, 2020.

March 2020
Group health plan sponsors that provide prescription drug coverage to Medicare Part D-eligible individuals must disclose to the Centers for Medicare & Medicaid Services (CMS) whether prescription drug coverage is creditable or non-creditable within 60 days after the beginning of the plan year. For calendar year plans, the deadline is March 1, 2020.

ALEs that sponsor fully or self-insured health plans to report information about the coverage to covered employees each year, using IRS Form 1095-C. Employers that are not ALEs use IRS Form 1095-B to provide this information. The IRS recently extended the deadline for furnishing 2019 employee statements, from Jan. 31, 2020, to March 2, 2020.

The electronic filing deadline for Code Sections 6055 and 6056 reporting is March 31, 2020. ALEs that sponsor fully or self-insured health plans are required to report information about the coverage to the IRS each year, using IRS Forms 1094-C and 1095-C. Employers that are not ALEs use IRS Forms 1094-B and 1095-B to meet these reporting obligations.

For More Information
Keeping track of these compliance deadlines can be tricky, but we're here to help. Contact us today for assistance in meeting your first quarter compliance obligations.

HHS Rescinds Health Plan Identifier Under HIPAA

The Department of Health and Human Services (HHS) recently released a final rule to rescind the health plan identifier (HPID) and requirements for its use. Under HIPAA, HHS is required to adopt standards for certain electronic transactions. One of the standards is a unique identifier for health plans—the HPID.

What is an HPID?
The HPID is a standard, unique health plan identifier that is primarily for use in HIPAA standard transactions. The HPID is intended to address any industry confusion of having multiple ways to identify a health plan in a transaction.

HHS has withdrawn the HPID requirement based on overwhelming and persistent industry input that the HPID does not, and cannot, serve its intended purpose.

In 2012, HHS released a final rule that included deadlines for health plans to obtain their own identifiers and start using them in HIPAA transactions. However, based on industry feedback, HHS indefinitely delayed the HPID requirement before the final rule's deadlines. HHS has now withdrawn the HPID requirement because it has concluded that the HPID does not serve a valid purpose.

The Final Rule
HHS' final rule rescinds the HPID requirement. According to HHS, its decision to withdraw the HPID stems from a careful assessment of industry input. This input demonstrates that:

The health care industry has developed best practices for using Payer IDs to conduct HIPAA transactions. The HPID does not have a place in these transactions, and from the industry's perspective, does not facilitate administrative simplification.

It would be a costly, complicated and burdensome disruption for the industry to have to implement the HPID.

What's next?
Health plans are not required to obtain HPIDs and the HPID is not required to be used in HIPAA transactions. The health care industry may continue to use its own standard payer identifier. HHS will deactivate any HPIDs in its system and notify all active users about the deactivation. It is possible that HHS will adopt a more effective HPID standard in the future, considering input from the health care industry.

Proposed Transparency Rule Could Affect Health Plans

On Nov. 15, 2019, the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury (Departments) issued a proposed rule regarding transparency in coverage that would impose new transparency requirements on group health plans and health insurers in the individual and group markets. Specifically, the proposed rule would require plans and issuers to disclose:

- Cost-sharing estimates to participants, beneficiaries and enrollees upon request
- In-network provider-negotiated rates and historical out-of-network allowed amounts on their website.

The proposals would only apply to non-grandfathered coverage, and would also apply to self-insured group health plan sponsors.

This proposed rule was issued in response to an executive order issued on June 24, 2019, aimed at improving price and quality transparency in health care. The order was intended to increase availability of health care price and quality information and protect patients from surprise medical bills.

Among other things, the executive order directed the Departments to issue a proposed rule to require health care providers, health insurance issuers and self-insured group health plans to provide information about expected out-of-pocket costs for items or services to patients before they receive care.

The Proposed Rule Details

The proposed rule includes the following two approaches intended to make health care price information accessible to consumers and other stakeholders, allowing for easy comparison-shopping.

The proposed rule would impose new transparency requirements on group health plans and health insurers in the individual and group markets–including self-insured plans.

In the first approach, each non-grandfathered group health plan or health insurance issuer offering non-grandfathered health insurance coverage in the individual and group markets would be required to disclose personalized out-of-pocket cost information for all covered health care items and services through an internet-based self-service tool and in paper form available to participants, beneficiaries and enrollees (or their authorized representative) upon request. This includes estimates of the individual's cost-sharing liability for health care for different providers.

In the second approach, each non-grandfathered group health plan or health insurance issuer offering non-grandfathered health insurance coverage in the individual and group markets would be required to disclose to the public (including stakeholders such as consumers, researchers, employers and third-party developers) the in-network negotiated rates with their network providers and historical payments of allowed amounts to out-of-network providers through standardized, regularly updated machine-readable files.

The proposed rule would also allow issuers that share savings with consumers that result from consumers shopping for lower-cost, higher-value services, to take credit for those "shared savings" payments in their medical loss ratio (MLR) calculations. This is intended to ensure that issuers would not be required to pay MLR rebates based on a plan design that would provide a benefit to consumers that is not currently captured in any existing MLR revenue or expense category.

What's next?

The proposed rule solicits comments on whether group health plans and health insurance issuers should also be required to disclose cost-sharing information through other means, and how health care quality information can be incorporated. Comments must be submitted by 60 days from the release of the proposed rule.