Health Care Compliance Update

September 2018

Today's Agenda

- Adjustments for 2018
- Employer Mandate, Penalty and Reporting
- Association Health Plans
- ACA Changes
- State Legislation

Grandfathered Plans

- Employers should revisit grandfathered status requirements, weighing the restrictions of remaining grandfathered against the additional requirements that apply to non-grandfathered plans
  - Remember, an employer must look back to the coverage in effect on March 23, 2010 to know whether a change results in a loss of this status
- If grandfathered status is retained, provide appropriate notice to participants and beneficiaries in all materials describing the group health plan and maintain records documenting the retention of this status for as long as it is claimed
- Once it's lost, it cannot be restored
  - If it hasn't been communicated as required, then it's not GF
- Grandmothered plans in some states

Cost-Sharing Limits

- For plan years beginning on or after January 1, 2018, non-grandfathered plans cannot impose out-of-pocket limits on EHBs that exceed the following limits:
  - $7,350 for self-only coverage, and
  - $14,700 for coverage other than self-only
- Additionally, with respect to family coverage, an individual out-of-pocket maximum of $7,350 applies to each person with family coverage (embedded deductible)
- 2019 Limits
  - $7,900 for self-only coverage, and
  - $15,800 for coverage other than self-only

DOL Penalties Increase for 2018

- Federal Civil Penalties Inflation Adjustment Act of 2015 (the "Inflation Adjustment Act") to direct federal agencies to adjust the civil monetary penalties for inflation every year

Description	2017 Penalty	2018 Penalty
Failure to file Form 5500	Up to $2,097 per day	Up to $2,140 per day
Failure of a MEWA to file reports	Up to $1,527 per day	Up to $1,558 per day
Failure to provide CHIP Notice	Up to $112 per day per employee	Up to $114 per day per employee
Failure to disclose CHIP/Medicare Coordination to the State	$112 per day per violation (per participant/beneficiary)	$114 per day per violation (per participant/beneficiary)
Failure to provide SBCs	Up to $1,105 per failure	Up to $1,128 per failure
Failure to furnish plan documents (including SPDs/SMMs)	$149 per day $1,496 cap per request	$152 per day $1,527 cap per request

HDHP, HSA & FSA Limits

Qualified HDHP Limits – 2018 & 2019

- Minimum deductibles of $1,350 self-only/$2,700 family
- Maximum out-of-pocket expenses of $6,650 self-only/$13,300 family, $6,750 & $13,500 for 2019
  - Non-grandfathered HDHPs must follow both sets of out-of-pocket maximum rules

HSA Limits – 2018 & 2019

- Maximum contributions of $3,450 self-only/$6,900 (~~$6,850~~) family, $3,500 & $7,000 for 2019
  - Catch-up contribution (for those 55 or older) of $1,000
  - Relief for plans that adjusted max to $6,850

Health FSA Limits – 2018

- Maximum annual salary reduction contribution of $2,650
- Dependent Care - $5,000

2018 ACA Fees

Reinsurance Fee – $0 (done)

- The fee applied to 2014-2016 calendar years only

Health Insurer Fee – approximately 3% of plan costs

- 2018 applicable amount – $14.3 Billion ($14,300,000,000.00)
- The fee applies to insured medical, dental, and vision plans
- Paid by the carrier
- Relief for CY 2017 and 2019

2018 ACA Fees (continued)

PCOR Fee – About $2.39 per covered life per plan year

- No significant changes for 2018
- Paid by the employer for a self-funded medical plan or HRA/carrier for an insured medical plan
  - The employer will pay the fee to the IRS each year by July 31 using Form 720 (quarter ending 6/30)
- Next due date is July 31, 2018:
  - $2.39 per covered life for November 2016, December 2016, January 2017 plan years
  - $2.26 per covered life per year for all other 2016-2017 plan years
  - Set to sunset 09/30/2019

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2016 – January 31, 2017	$2.26/covered life/year	July 31, 2018
March 1, 2016 – February 29, 2017	$2.26/covered life/year	July 31, 2018
April 1, 2016 – March 31, 2017	$2.26/covered life/year	July 31, 2018
May 1, 2016 – April 30, 2017	$2.26/covered life/year	July 31, 2018
June 1, 2016 – May 31, 2017	$2.26/covered life/year	July 31, 2018
July 1, 2016 – June 30, 2017	$2.26/covered life/year	July 31, 2018
August 1, 2016 – July 31, 2017	$2.26/covered life/year	July 31, 2018
September 1, 2016 – August 31, 2017	$2.26/covered life/year	July 31, 2018
October 1, 2016 – September 30, 2017	$2.26/covered life/year	July 31, 2018
November 1, 2016 – October 31, 2017	$2.39/covered life/year	July 31, 2018
December 1, 2016 – November 30, 2017	$2.39/covered life/year	July 31, 2018
January 1, 2017 – December 31, 2017	$2.39/covered life/year	July 31, 2018

Employer Mandate

There are two possible penalties

- The applicable penalty will depend on the particular circumstances of the large employer
- To trigger a penalty, the FTE must actually receive subsidized coverage in the Marketplace

"A" Penalty

Applies if the large employer does not offer at least 95% of FTEs and their children group health plan coverage and at least one FTE receives a subsidy

- "A" Penalty Amount × # FTEs – 30
- CY 2018 "A" penalty amount, $2,320
- annual ($193.33/month)

"B" Penalty

Applies if a large employer offers coverage to at least 95% of FTEs and their children but the coverage is not minimum value, affordable, or the FTE is one of the excluded 5% and receives a subsidy

- Lesser of: "B" Penalty Amount × each subsidized FTE or "A" penalty
- CY 2018 "B" penalty amount, $3,480 annual
- ($290/month)

Employer Mandate Affordability

An employer may use a safe harbor to determine that the lowest cost minimum value plan is affordable

An employer will not be subject to a penalty with respect to an FTE if that employee's required contribution for 2018 for the employer's lowest cost self-only coverage that provides MV does not exceed:

- 9.56% of W-2 wages (Box 1 on Form W-2); or
- 9.56% of the employees rate of pay (either $/hour multiplied by 130 hours or monthly salary); or
- 9.56% of the FPL ($96.72/month for 2018) (FPL for 48 contiguous states)
- Affordability number for 2019 is 9.86%

Forms 1094-C and 1095-C

- All Applicable Large Employers (ALEs) must use Forms 1095-C and 1094-C to report offers of coverage (or no offer of coverage) to ACA FTEs
- Gathering SSNs for self-funded plans
  - Initial solicitation: first enrollment
  - First annual solicitation: 75 days later
  - Second annual solicitation: by December 31 of the year following initial solicitation
- Employers that are not considered an ALE but offer a self-insured group health plan are responsible for MEC reporting on behalf of covered members
  - Small employers with self-insured plans should use Forms 1094-B and 1095-B

IRS Letter 226J

The IRS has begun issuing Letter 226J to certain ALEs describing the proposed Employer Shared Responsibility Payment (ESRP) owed for calendar year 2015

- provides specific information on the ESRP and instructions for responding to the proposed assessment
- If an employer disagrees with the assessment, timely responding via Form 14764 and including a statement explaining the objections and any back up documentation is crucial
- ALEs that receive these letters should carefully review them. It will be important to have 2015 Forms 1094-C and 1095-C available as you work through the information

The IRS will issue a Notice and Demand for payment of the proposed assessment if the ALE fails to timely respond to Letter 226J

- 2016 Penalty letters late 2018

IRS Letter 226J (continued)

- The first page of the letter provides a general overview of the Employer Shared Responsibility rules and contains some important information
  - Tax Year, Date of the Letter, Contact Name and Number for IRS personnel responsible for the specific letter
  - Response Date – This date is important
  - The proposed penalty assessment
- Letter 226J is a package of information and includes
  - An ESRP Summary Table itemizing the proposed ESRP by month
  - Form 14764 – the ESRP Response Form
  - Form 14765 – the Employee PTC Listing
  - An envelope for submitting response to the IRS

  The IRS will issue a Notice and Demand for payment of the proposed assessment if the ALE fails to timely respond to Letter 226J

IRS Letter 226J (continued)

If the ALE **AGREES** with the proposed ESRP

- Complete, sign and date Form 14764 and return it to the IRS by the response date
  - Include the Payment amount via check or money order. Payments may be made electronically if enrolled in the Electronic Federal Tax Payment System
  - A Notice and Demand will be issued for the remaining balance if not paid in full

If the ALE **DISAGREES** with the proposed ESRP

- Complete, sign and date Form 14764 and return it to the IRS by the response date
  - Include a signed statement as to why they disagree with the ESRP
  - Make sure the statement describes needed corrections made to the information reported on Forms 1094-C and 1095-C
  - Make changes, if any, on the Employee PTC Listing using the indicator codes in the Instructions
  - Include the revised Employee PTC Listing, if necessary, and any additional documentation

My Benefit Advisor can provide clients with assistance to understand and respond to the letter including sample wording for responding to common issues that triggered the letter

Tax Cuts and Jobs Act - EB impact

Employer-provided health and welfare-related provisions

- **Individual Mandate:** The law sets the Individual Mandate penalty to $0 starting in 2019
- **Medical Expense Deduction:** The law expands the medical expense deduction for 2017 and 2018 for qualified expenses exceeding 7.5% of adjusted gross income (from 10% under current law)
  - In 2019, the deduction will increase to expenses in excess of 10% of adjusted gross
- **Transportation Benefits:** The law eliminates the employer's deduction for qualified transportation fringe benefits
  - Qualified transportation fringe benefits remain excludable from employee's income
  - Suspends the exclusion from an employee's gross income and wages for qualified bicycle commuting benefits
- **Employer Tax Credit for FMLA Leave** – discussed further at slide 25

Association Health Plans

- Currently, with respect to most association plans (and to the extent compatible with state law), ERISA permits the formation of association health plans (AHPs) as Multiple Employer Welfare Arrangements (MEWAs)
- In most of these arrangements, each entity participating in the program is treated as a single employer subject to ERISA and the underwriting rules applicable based on each employer's group size
- From an underwriting perspective, these rules limit the ability of groups of small employers (generally fewer than 50 employees) to buy insurance in the large group market based on their collective covered lives

Association Health Plans (continued)

The New Rule

- Relaxes the definition of “employer” under ERISA 3(5) allowing more employers to meet the commonality-of-interest test
  - Same trade, industry, line of business/profession; or
  - Principal place of business in same state or metropolitan area
- Permits working-owners of businesses, including partners in a partnership, to act as employers for purposes of participating in an employer group or association sponsoring a health plan and to be treated as employees to be covered by that plan
- Maintains strict nondiscrimination rules that would prohibit the group or association from discriminating as to eligibility, premiums, and contributions based on a health factor
  - Association can’t deny access to an employer based on claims
  - No experience rating at each employer level
  - Collectively form a single plan
- Current rules still apply

Association Health Plans (continued)

- AHP is a MEWA
- Must file
  - M-1
  - Form 5500 (small AHP's not exempt)
- Subject to all ERISA requirements
  - SPD/Wrap
  - SBC
  - Marketplace Notice
- COBRA – unclear – no IRS guidance yet
- AHP subject to Federal & State rules/regulations

Association Health Plans (continued)

Implementation

- 09/01/18 Fully insured
- 01/01/19 Existing Self-Insured
- 04/01/19 New Self-Insured
- Single plan Vs. employer size / rating
- No Changes to existing state laws
- Excluded from sponsoring:
  - Health Insurance Issuer
  - Subsidiary
  - Affiliate
  - Health care Organization
  - Provider Network

Association Health Plans (continued)

Eligible Participation

- Must be Association member
- Employee
- Working owner (20 HR/WK, 80 HR/MO)
- Sole Proprietor & beneficiaries
- Partner & beneficiaries
- Independent Contractor

Lawsuit

- Filed by New York & Massachusetts Attorney's General
- 9 states & DC joined
- Future effective dates impact

Qualified Small Employer HRA

Under The 21st Century Cures Act, a QSEHRA is an arrangement that meets the following criteria:

- The arrangement is funded solely by an eligible employer **(less than 50 full-time employees (including full-time equivalent employees)** in the preceding calendar year not offering a group health plan to any of its employees);
- The arrangement provides, after the eligible employee provides proof of coverage, for the
- Payment or reimbursement of the medical expenses incurred by the employee or the
- Employee's family members;
- The amount of payments and reimbursements described above cannot exceed certain thresholds ($5,050 self-only/$10,250 for family coverage for 2018); and
- The arrangement is generally provided on the same terms to all eligible employees of the eligible employer

Guidance Issued on QSEHRA

Some highlights from IRS Notice 2017-67:

- An eligible employer's size is determined according to ACA rules
- An eligible employer may not offer a group health plan or allow employees to access funds accumulated in a prior HRA or carried over in an FSA
- A QSEHRA may only be provided to current employees (not non-employee owners)
- An employee that becomes eligible must be provided coverage the next day
- Participation in the QSEHRA may not be waived by the employee
- The QSEHRA may reimburse the same amount regardless of the coverage elected
- Statutory dollar limits for non-calendar or short plan years are prorated
- Reimbursements from the QSEHRA are taxable for any month that MEC is not maintained
- Proof of MEC is required annually

Paid Family Leave Tax Credit

Added by Tax Cuts and Jobs Act:

- Eligible employers can claim a general business tax credit for wages paid to qualifying employees who are on FML if certain requirements are satisfied)
- Employers must have a written policy in place that provides at least two weeks of paid FML annually to all qualifying employees who work full time
- Paid FML must provide at least 50 percent of the wages normally paid to the employee
- Must include all part-time employees
- Any leave paid by a state or local government or required by state or local law will not be considered in determining the amount of employer-provided paid FML
- Additional guidance expected

Tax Years 2018 and 2019 only

State Paid Sick/Family Leave

Paid Sick Leave

- Arizona
- California
- Connecticut
- Washington D.C.
- Maryland
- Massachusetts
- New Jersey (eff Oct 29, 2018)
- Oregon
- Rhode Island (July 2018)
- Vermont
- Washington (Jan 2018)

Paid Family Leave

- California
- Washington D.C. (July 2020)
- New Jersey
- New York (Jan 2018)
- Rhode Island
- Washington (Jan 2020)

Several local jurisdictions such as Seattle, San Francisco, and Los Angeles impose additional pay and benefit requirements on employers. Some are industry specific (such as hotels). Service teams should review Compliance Updates to forward to appropriate clients.

ACA Taxes and CHIP Short-Term Spending Bill

Health Plan-Related Taxes

- **High Cost Employer-Sponsored Health Coverage (Cadillac Tax)** – This is a 40% excise tax on the value of coverage above $10,200 for self-only coverage and $27,500 for coverage other than self-only. Originally scheduled to take effect January 1, 2018, was delayed until January 1, 2020. Effective date now delayed until **January 1, 2022.**
- **Medical Device Tax** – This is a tax equal to 2.3% of the price of the product, imposed on the sale of any taxable medical device by the manufacturer, producer, or importer. It was previously suspended and is further delayed until **January 1, 2020.**
- **Annual Fee on Health Insurance Providers** – This fee is assessed on health insurance carriers and is generally 3% to 4% of insured medical, dental, and vision plans. The tax took effect in 2014, was suspended for 2017 and will again be suspended for **calendar year 2019.**

The Healthy Kids Act

- The Bill expands coverage for children under CHIP and the Public Health Funding Extension Act for a period of six years and expands funding for:
  - Childhood Obesity
  - Pediatric Quality Measures Program
  - Outreach and Enrollment Program

Miscellaneous

Employer Payment Plans

- An employer cannot reimburse an employee for premiums or pay premiums on behalf of the employee for individual health insurance for the employee on a pre-tax basis.
- The prohibition extends to after-tax payments that are conditioned on the purchase of individual health insurance

Cost Sharing Reduction Credit

- Same as 2018 – Insurance Carrier funded. No reimbursement from federal government

Miscellaneous (continued)

Texas Lawsuit

- Hearings began early September
- 20 States
- Lack of individual mandate penalty means the end of ACA
- Decision date & impact

4 Cities Lawsuit

- Baltimore, Chicago, Columbus, Cincinnati
- Uphold ACA
- Suspend Employer Mandate

Bezos, Buffet, Dimon

- Visibility & public outcry
- Middlemen a target

Medicare for all (Single Payer)

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Thank You for Joining Us!