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IRS RELEASES MAXIMUM ANNUAL HSA AND HDHP LIMITS FOR 2018

The Internal Revenue Service (IRS) released its 2018 Health Savings Account (HSA) and High-Deductible Health Plan (HDHP) annual limits, adjusted for inflation. These limits include: (1) HSA contribution limits; (2) HDHP minimum deductibles; and (3) HDHP maximum out-of-pocket (OOP) limits.

Compared to the slight increase in the HSA contribution limits for self-only coverage from 2016 to 2017, there are more significant increases to all HSA and HDHP limits from 2017 to 2018. Highlights from the IRS Revenue Procedure 2017-37 detailing these limits are as follows:

HSA and HDHP Limits for Self-Only and Family Coverage, 2017-2018

	2017	2018	Change
HSA Statutory Contribution Amount			
• Self-only	$3,400	$3,450	$50
• Family	$6,750	$6,900	$150
Catch-up Contribution (age 55 or older)	$1,000	$1,000	No change
HDHP Minimum Deductible Amount			
• Self-only	$1,300	$1,350	$50
• Family	$2,600	$2,700	$100
HDHP Maximum Out-of-Pocket Amount			
• Self-only	$6,550	$6,650	$100
• Family	$13,100	$13,300	$200

As a reminder, in December of 2016, the Department of Health and Human Services (HHS) released its finalized out-of-pocket (OOP) maximums for non-HDHP coverage for 2018. These ACA OOP maximums for 2018 for non-HDHP coverage are $7,350 for self-only coverage, and $14,700 for family coverage.

Action Required

Employers should be aware of the increase in these 2018 annual limits, and ensure the health plans they offer are in compliance with these limits.

For the complete details, read IRS Rev. Proc. 2017-37:
https://www.irs.gov/pub/irs-drop/rp-17-37.pdf

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IRS RELEASES AFFORDABILITY PERCENTAGES

The Internal Revenue Service (IRS) released its 2018 affordability percentages, adjusted for inflation. These percentages include a reduction to an employer's affordability safe harbor percentage and a reduction to the percentage for an exemption from the individual mandate penalty.

As highlighted in the chart below, the employer affordability percentage has **decreased** for 2018 to 9.56%, compared to 9.69% in 2017. This means that coverage offered by an employer will be considered unaffordable if the employee's premium contribution for self-only coverage for the lowest cost plan is greater than **9.56%** of that employee's household income in 2018. This decrease in the affordability percentage will likely require employers to contribute more towards the cost of its employees' coverage in 2018, in order to ensure that coverage is affordable to employees, and to avoid paying a penalty.

In addition, the percentage of the cost of employer-sponsored coverage that an employee can be required to pay in order to be exempt from the individual mandate has decreased to 8.05% for 2018, compared to 8.16% in 2017. For 2018, if the required employee contribution for self-only coverage for the lowest cost plan exceeds 8.05% of the employee's household income, that individual would most likely be exempt from the individual mandate penalty if that employee failed to have Minimum Essential Coverage (MEC).

2018 Affordability Percentages

	2017	2018	Change
Employer Affordability Safe Harbor Percentage	9.69%	9.56%	-0.13%
Exemption from Individual Mandate due to Cost of Coverage to Employee	8.16%	8.05%	-0.11%

No Action Required

Employers should be aware of the changes to the 2018 premium subsidy credit qualification percentages, and ensure the health plans they offer are affordable in order to avoid being subject to a penalty.

For the complete details, read IRS Rev. Proc. 2017-36:

https://www.irs.gov/pub/irs-drop/rp-17-36.pdf

DOL CLARIFIES ERISA DISABILITY CLAIMS AND APPEALS PROCEDURE

On December 19, 2016, the Department of Labor (DOL) released its final rule ("Final Rule") revising the existing claims and appeals procedures under the Employee Retirement Income Security Act of 1974 (ERISA) for employer sponsored disability benefit plans. ERISA establishes minimum requirements for benefit claims procedures, by requiring that employee benefit plans provide written notice to any participant or beneficiary whose claim for benefits has been denied, set forth specific reasons for the denial, and provide claimants with a reasonable opportunity to demand a full and fair review of the claim (i.e., an appeal). The DOL sought to improve the process for disability claims and appeals by reexamining and clarifying the current rules. The Final Rule took effect on January 18, 2017, and will apply to all disability benefits claims filed on or after January 1, 2018. Highlights of the Final Rule are discussed below.

Claims and Appeals Must Be Decided by Independent, Impartial Decision Makers

The claims and appeals determination process must be designed to ensure the decision makers involved in the benefit determination are independent and impartial. The Final Rule clarifies that decisions relating to hiring, compensation, termination, promotion, and other matters cannot be based on an individual's likelihood to support a denial of disability benefits. As an example, a plan cannot offer bonuses to claims adjudicators based on their likelihood of issuing claims denials.

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DOL Clarifies ERISA Disability Claims and Appeals Procedure (continued)

Improved Disclosure Requirements

Although existing disability claims procedures under ERISA already require denial notices to include an explanation for the reason the claim was denied, the DOL wanted to clarify the following procedural requirements in the Final Rules to reinforce the need for these procedures.

Plans Must Provide Basis for Denial Decisions

Where a plan denies a disability claim, it must provide a detailed analysis of its denial decision, including its basis for disagreeing with the views of the Social Security Administration or any of its or the claimant's health care professionals or vocational professionals. If the plan consults several experts, and denies a claim based on the advice of one expert (known as "expert shopping"), the plan must explain its basis for relying on the advice of one expert over another expert. The Final Rule clarifies that a mere statement that the plan or reviewing physician disagrees with the opinion or finding of another physician is inadequate.

Denial Notice Must Provide Internal Guidelines Relied Upon in Denial of Claim

The denial notice must contain the internal rules, guidelines, or criteria that the plan relied upon in denying the claim (or a statement that such criteria does not exist). This requirement protects claimants from claim denials based upon an internal rule, whereby the disability benefit plan refuses to disclose the rule they are relying upon to deny the claim, by asserting confidentiality or proprietary concerns.

Denial Notice Must Explain that Claimant May Request, and Is Entitled to Receive, Relevant Claim Documents

The Final Rule clarifies that an initial claim denial must contain a statement that the claimant is entitled to receive, upon request, documents relevant to the denial of claim for benefits. Previously, this statement was only required in the denial of appeal notice.

Right to Review and Respond to New Information Before Final Determination

The Final Rule clarifies that plans must provide claimants with new or additional evidence or rationale developed by the plan upon request, so claimants have an opportunity to respond to new information before their appeals are denied.

Plans Cannot Prevent Claimant Suits Based on the Plan's Violation of Claims Procedures

ERISA requires that plans and claimants follow an administrative, or internal, claims and appeals process, before claimants can seek remedies in court. The Final Rule clarifies that if a plan fails to follow the claims procedure regulations, then a claimant will be considered to have exhausted all administrative remedies and can bring suit seeking a court review of a claim denial. In other words, plans cannot argue that claimants failed to exhaust their administrative remedies to file or appeal a claim, if the plan itself failed to comply with the claims procedure requirements.

The Final Rule permits limited exceptions if the plan's violations were due to minor errors.

Coverage Rescissions May Be Considered Denial of Benefits

The Final Rule clarifies that certain coverage rescissions may be treated as a denial of coverage, which triggers the plan's appeal procedures. Rescissions of coverage include any denial, reduction, or termination of, or failure to provide or pay for a benefit, in whole or in part.

This provision does not apply if the rescission was due to a claimant's failure to pay required premiums.

Notices and Disclosures Must Be Culturally and Linguistically Appropriate

The Final Rule clarifies that plans must provide notices to claimants in a culturally and linguistically appropriate manner. If a claimant resides in a county where ten (10) percent or more of the population is literate only in the same non-English language, then denial notices must include a statement in that language clearly explaining how to access the plan's language services. In addition, plans must provide customer assistance in the non-English language, and must provide written notices in the non-English language, upon request.

Action Required

Employers who sponsor disability plans should work with their carriers, third party administrators, and/or attorneys to review their claims and appeals procedures before the end of the calendar year, and ensure the claims and appeals procedures described in their plan documents are in compliance with the final regulations released by the Department of Labor.

For the Final Rule, see: https://www.federalregister.gov/documents/2016/12/19/2016-30070/claims-procedure-for-plans-providing-disability-benefits

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FINAL RULE ISSUED ON MARKET STABILIZATION FOR HEALTH INSURANCE EXCHANGES

On April 13, 2017 the Centers for Medicare & Medicaid Services (CMS) released its final rule aimed at stabilizing the individual health insurance marketplace. This rule finalizes the proposed rules that were released in February, and are effective beginning in 2018. The March Legislative Compliance Monthly Newsletter detailed the proposed rules, and this rule finalizes many provisions as proposed with a few slight changes. Highlights of the final rule are discussed below.

Guaranteed Availability of Coverage

Under the guaranteed availability provisions, insurers must generally offer coverage and accept every individual/employer in the state that applies for coverage, unless an exception applies. Therefore, an individual or employer may continue to enroll/offer coverage, even though an individual/employer defaulted on their premium payments in the previous year.

The *proposed rule* allows insurers to deny coverage to an individual/employer who failed to pay their premium, until the insurer received full payment of any past due premiums owed by the insured for the previous twelve (12) months. The *final rule* permits this denial of coverage and clarifies that the rule applies to both small and large group issuers. The final rule also extended the proposed rule to allow insurers that are members of the same controlled group, as the insurer owed the premium, to deny coverage. However a different insurer, or insurer outside the same controlled group as the previous insurer, still may not deny coverage for premiums owed.

Open Enrollment Periods

The final rule affirms that the 2018 Exchange open enrollment period would be shortened to 45 days, from November 1, 2017 to December 15, 2017, to match the 2019 open enrollment period which will run from November 1, 2018 through December 15, 2018.

Special Enrollment Periods

Pre-Enrollment Verification

Beginning June 2017, CMS will require a pre-enrollment verification process to include all individuals applying for midyear Exchange enrollment, either on the Federally-facilitated Exchange or a State-based Exchange. The process for verification of a status change would begin with an individual submitting an application for coverage in the Exchange and the approval of that application would be considered “pending” until their eligibility for special enrollment was verified.

If the approval takes longer than two (2) months, and the individual would be required to pay two (2) or more months of premiums to have coverage retroactive to the date they elected a plan option, that individual could choose to start their coverage one (1) month later than his/her effective date would have been approved.

Limits on Eligibility for Special Enrollment Periods

The final rule allows an insurer to deny an individual’s application requesting special enrollment if that individual lost coverage for non-payment of premiums, unless that applicant pays the past-due premiums.

Second, the special enrollment period due to marriage is limited. An individual seeking to enroll midyear on account of marriage would need to confirm that at least one spouse had minimum essential coverage (MEC) on one or more days during the previous sixty (60) days.

Third, if an individual applies for special enrollment due to moving residence, that individual must prove that they had MEC for one or more days in the previous sixty (60) days, unless they moved from outside of the United States (or from a United States territory).

Lastly, the final rule significantly limits the ability to request special enrollment for an “exceptional circumstance” (e.g., serious medical condition or natural disaster) for the remainder of 2017 and future years. This rule requires the circumstance which the employee relies on to specially enroll in Exchange coverage to be “truly exceptional,” and the individual must provide supporting documentation to verify the circumstances, if practicable.

Actuarial Value

The final rule alters the de minimis ranges used to determine the actuarial value for metal level plans. The changes to the de minimis ranges for AV metal levels will apply on and off the Exchange, and are adjusted as follows:

- Platinum/Gold metal level: +/-2 to -4/+2 percentage points
- Bronze metal level: +5/-2 to +5/-4 percentage points.

Network Adequacy

Currently, CMS reviews qualified health plans (QHPs) for network adequacy to ensure insurers in the Exchange offer networks with a sufficient number of qualified providers. The final rule transfers the responsibility of network adequacy reviews to certain states where a

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Final Rule Issued on Market Stabilization for Health Insurance Exchanges (continued)

Federally-facilitated Exchange is operating. Additionally, an insurer is required to contract with at least twenty (20) percent of available essential community providers (ECPs), which is lowered from the previous thirty (30) percent standard.

No Action Required

Interested employers and individuals may want to review the final rule, which enacts the proposed rules and reflects the administration's current approach to stabilizing the individual and small group marketplace.

Interested parties can review the final regulation, here:
https://www.federalregister.gov/documents/2017/04/18/2017-07712/patient-protection-and-affordable-care-act-market-stabilization

GEORGIA ENACTS LAW PERMITTING EMPLOYEES TO USE PAID SICK LEAVE TO CARE FOR FAMILY MEMBERS

On May 8, 2017, Georgia Governor Nathan Deal signed a new law which will require covered employers to provide covered employees up to five (5) paid sick leave days per calendar year, to care for immediate family members. The law will go into effect on July 1, 2017. Highlights of the law are detailed below.

Covered Employers

This law applies to Georgia employers that employ twenty-five (25) or more employees, and who already have a paid sick leave policy in place (or put a paid sick leave in policy in place going forward).

Covered Employees

Covered employees are those who work thirty (30) or more hours a week, and whose employer offers paid sick leave benefits. Covered employees will be eligible to use up to five (5) earned paid sick leave days per calendar year, to care of an immediate family member under this law.

An "immediate family member" is defined as an employee's:

- Spouse
- Child or grandchild
- Parent or grandparent
- Dependent shown in the employee's most recent tax return

Impact of New Law

This law does not require Georgia employers to provide paid sick leave benefits, but rather amends those sick leave policies of employers who already provide such benefits.

This law is set to expire on July 1, 2020, unless the legislature extends the law.

No Action Required

Covered employers with twenty-five (25) or more employees who offer paid leave benefits should review their paid leave policies to ensure they comply with this law before July 1, 2017.

For bill text, see: http://www.legis.ga.gov/Legislation/20172018/170794.pdf

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WASHINGTON D.C. ENACTS PAID PARENTAL AND FAMILY LEAVE ACT, AWAITING FUNDS FOR IMPLEMENTATION

Background

The Universal Paid Leave Act of 2016 (the Act), which requires that employers provide employees in Washington D.C. (the District) with paid parental leave, family leave, and personal medical leave, became effective on April 7, 2017. However, many provisions would not take place until March 1, 2019, as implementation is still in development. Notably, the Act requires employers to collect payroll taxes to fund paid leave benefits starting March 1, 2019, and allows employees to begin using paid leave starting in 2020.

We previously provided an overview of the Act's provisions in our January 2017 Legislative Compliance Monthly Newsletter, after it was passed by the Washington, D.C. Council on December 20, 2016. This article focuses on the next steps needed before the Act's implementation, and current attempts to revise the Act.

Types of Leave and Permitted Uses

Generally, the Act requires covered employers to provide covered employees with three (3) types of paid leave:

1. Up to eight (8) weeks of paid parental leave following the birth, adoption, or foster placement of a child
2. Up to six (6) weeks of paid family leave to care for a family member who has been diagnosed with a serious health condition; and
3. Up to two (2) weeks of paid personal leave following the occurrence or diagnosis of a serious health condition of the employee.

A covered employer is any private or nonprofit employer with at least one employee in the District, and excludes the United States, D.C., or any other employer who the District is not authorized to tax under federal law or treaty. A covered employee is any individual who spends fifty (50) percent or more of his or her time working in the Washington D.C. (the District) for a covered employer. This includes full-time and part-time employees, and individuals who work in the District, but reside out of state.

Program Implementation in Development

On February 14, 2017, D.C. Mayor Muriel Bowser allowed the law (Bill B21-0415) to pass without her signature, and the bill proceeded to Congress for Congressional review. Among other issues, Mayor Bowser expressed concerns that the Act required a costly and extended implementation process. Currently, the District does not have a system in place to administer the paid leave program, so a new agency would have to be established to administer the paid leave program. In addition, the District will need establish certain administrative procedures matters relating to claims submission methods, payment timeframes, and drafting a notice of rights for employers.

Universal Paid Leave Fund

The Act requires covered employers to contribute 0.62% of the annual salary of each covered employee into a Universal Paid Leave Fund used to pay for benefits, but the government must establish and administer this fund. Moreover, within 180 days of the Act's effective date, the mayor is required to prescribe the manner in which employers will make contributions into this fund.

Claims Submission System

In addition, the mayor must provide the District Council with a timeline for the payment of claims under the Act by December 30, 2017. Moreover, employees must be able to submit claim forms and supporting documentation through an online portal.

Government-Provided Notice of Rights

Finally, the mayor must provide a notice of paid leave rights for covered employers to use. Employers are required to post the notice in a conspicuous location at the workplace, and provide a copy to each covered employee at the time of hire, and annually.

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Washington D.C. Enacts Paid Parental and Family Leave Act (continued)

Efforts to Revise the Act Already In Progress

While implementation of the Act is pending, councilmembers are already vying to amend its provisions.

District Councilmembers Mary Cheh and Jack Evans introduced the Paid Leave Compensation Act of 2017 (B22-130), which proposes lowering the 0.62% payroll tax to 0.20% for large employers (defined as employers with fifty (50) or more employees, or whose annual payroll equals or exceeds $3.5 million), and 0.40% for small employers (defined as employers with between five (5) to forty-nine (49) employees, or whose annual payroll is less than $3.5 million). Notably, this alternative bill would require that large employers administer benefits for their own employees, while the District government would administer the program for small employers. However, the types of leave and duration of leave required under the Act would remain unchanged.

Second, the Universal Paid Leave Compensation for Workers Amendment Act of 2017 (B22-133), proposed by Councilmembers Evans and Vincent Gray, would require all employers to purchase private insurance to provide paid leave to employees during their covered time off, limit the payroll tax to 0.10%, and exempt small businesses with fewer than fifty (50) employees.

Action Required

Although the details are still pending, Washington, D.C. employers should take this time to review their paid leave policies to ensure their existing policies are in compliance with the Act, or revise their policies as needed. In addition, employers should stay tuned for additional information to confirm whether the Act is implemented as passed, or revised.

Text of Bill: http://lims.dccouncil.us/Download/34613/B21-0415-Introduction.pdf

COMPLIANCE REMINDER: HEALTH INSURANCE PROVIDER FEE TO RETURN IN 2018

The Consolidated Appropriations Act of 2016 placed a one year moratorium on the Health Insurance Providers Fee for the 2017 calendar year. This means that health insurance issuers are not required to pay these providers fees for 2017. However, since the moratorium only applies for one year, insurance providers will again be subject to this fee for the 2018 calendar year on fully insured medical, dental, vision, and retiree plans. This fee does not apply to plans that are self-insured or partially self-insured.

The Health Insurance Providers Fee was implemented via the Affordable Care Act (ACA) and ACA requires an aggregate annual fee be collected and paid by all covered entities. The total applicable amounts for fee years are:

- **2014** –$8 billion
- **2015 & 2016** – $11.3 billion (each respective year)
- **2017** – $13.9 billion (not collected due to moratorium)
- **2018** – $14.3 billion

The fee amount for each covered entity is based on that entity's net premiums for health insurance written; the covered entity is charged a portion of this fee based on its net premiums in relation to the aggregate net premiums written by all covered entities. Therefore, each covered entity must report its net premiums during the previous year to the IRS by April 15th of the year in which the fee is due on Form 8963. Covered entities also must pay their final fees to the IRS by September 30th of the fee year.

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No Action Required

Although no immediate action is required, employers should start preparing for the reimplementation of this tax in 2018. Employers with fully insured plans should budget for an increase of three (3) to four (4) percent on upcoming renewals for 2018 and beyond.

Employers should also prepare for insurance carriers to charge a pro-rated amount of this fee for any months a 2017 non-calendar plan year overlaps into the 2018 calendar year.

For more information on this fee, visit: https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010

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QUESTION OF THE MONTH

May Our Company's HRA Reimburse Qualifying Medical Expenses Incurred by Non-Spouse Domestic Partners?

QUESTION: Our company maintains a health reimbursement arrangement (HRA) for eligible employees. Several HRA participants have non-spouse domestic partners. Some of these relationships are recognized as civil unions; others have no formal recognition. May we reimburse qualifying medical expenses incurred by any of these domestic partners?

ANSWER: If your HRA covers tax dependents, you may provide HRA coverage to a domestic partner who is a participant's tax dependent. For domestic partners who are not tax dependents, the answer is less clear. In either case, however, the domestic partner relationship need not be formally recognized by a state (e.g., as a civil union).

Under the Code, the general rule is that HRAs may provide tax-free reimbursement of qualifying medical care expenses incurred by employees' spouses, tax dependents, and children who have not attained age 27 by the end of the taxable year. (The expenses must be incurred while the HRA coverage is in effect.) Consequently, if your company's HRA plan document authorizes, or is amended to authorize, the reimbursement of expenses incurred by tax dependents, it can make tax-free reimbursements for the qualified expenses of domestic partners who are tax dependents.

Although HRAs ordinarily may not provide tax-free reimbursements for expenses incurred by non-tax dependent domestic partners, there is reason to think the IRS would allow HRAs to reimburse the expenses of non-tax dependent domestic partners when the fair market value of the domestic partner's HRA coverage has been included in the participant's federal gross income, thereby making the coverage taxable. Treasury officials have informally approved this approach, as have two subsequent private letter rulings. However, there is no approved methodology for determining fair market value in this situation, so it will be difficult to establish that domestic partner coverage has been fully taxed. COBRA rates are sometimes used as a starting point, but those rates are inherently problematic for HRAs, and the difficulties are compounded by uncertainty over the rate to apply for coverage of a domestic partner.

Before extending HRA coverage to participants' non-tax dependent domestic partners, your company should examine its HRA plan document and amend it if needed to define eligible "domestic partners." There is no uniform definition, but the term is generally understood to mean an unmarried adult who has a close, personal, and financially interdependent relationship with the employee. Your company will need to decide whether to impose additional eligibility conditions such as shared residency, and whether to require documentation of the relationship. The HRA will also need procedures and administrative forms for collecting information about the tax status of domestic partners whose expenses are reimbursed. Note that state income tax treatment of HRA coverage for non-tax dependent domestic partners may vary from state to state. Due to the compliance and administrative complexities associated with extending HRAs to domestic partners, your company will want to review the issues with counsel before implementing such a program.

Contributing Editors: EBIA

CONTACTS

Christopher K. Bao, Esq.
Manager, Employee Benefits Compliance
& Regulatory Affairs, MMA West
chris.bao@barneyandbarney.com
415.230.7224

Iris F. Chou, Esq.
Manager, Employee Benefits Compliance
& Regulatory Affairs, MMA West
iris.chou@barneyandbarney.com
949.540.6924

Brittany D. Botterill, Esq.
Manager, Employee Benefits Compliance
& Regulatory Affairs, MMA West
brittany.botterill@barneyandbarney.com
858.587.7511

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