MARSH & McLENNAN AGENCY

Employee Benefits Legislative Compliance
Monthly Newsletter, MMA West Edition

November 2017 | Issue 11

IN THIS ISSUE

IRS RELEASES ANNUAL INFLATION ADJUSTMENTS FOR 2018

On October 19, 2017, the Internal Revenue Service (IRS) released IRS Revenue Procedure 2017-58, which contains the annual inflation adjustments for over 50 tax provisions for 2018. These adjustments include increases to voluntary employee salary reductions for health flexible spending arrangements (FSAs), increases to qualified transportation and parking benefits, and increased penalties for failures to file or furnish a return. These changes are effective beginning January 1, 2018, and are generally applicable to tax returns filed in 2019.

FSAs and Transportation Fringe Benefits

The chart below highlights the adjusted items relevant to employers who sponsor Healthcare Flexible Spending Accounts (FSAs), and employers who offer transportation benefits to employees.

Plan Type	2018	2017	Change
Health FSA	$2,650	$2,600	$50 Increase
Qualified Transportation Fringe Benefits	$260/month for qualified transit expenses; $260/month for qualified parking expenses	$255/month for qualified transit expenses; $255/month for qualified parking expenses	$5 Increase

Failure to File or Furnish Returns

The chart below highlights penalty amounts for any failure relating to a return required to be filed in 2019 (for the 2018 tax year).

For persons with average annual gross receipts for the most recent three taxable years of more than $5,000,000, failures are:

Scenario	Penalty Per Return	Calendar Year Maximum
General Rule for failure to furnish/file correct informational returns (§ 6721(a)(1))	$270	$3,282,500[1];
Failure to furnish/file correct informational returns with intentional disregard of filing or furnishing requirement	Greater of (i) $540, or (ii) 10% of aggregate amount of items required to be reported correctly[2]	No limit

Action Required

Employers that administer the above types of plans/forms should take note of the inflationary adjustments above, and amend and administer their plans accordingly.

Please note, employers are not required to increase the contribution/ fringe benefit amounts for the upcoming plan year. Employers have discretion over the amounts employees may contribute to their health FSAs, and have discretion as to the amount an employee may benefit from as it relates to both commuter/transit benefits and parking benefits.

For the complete details, see IRS Revenue Procedure 2017-58, here:
https://www.irs.gov/pub/irs-drop/rp-17-58.pdf

[1] For employers with less than $5,000,000 of average annual gross receipts over the most recent three taxable years the calendar year maximum is $1,094,000

[2] See IRS Revenue Procedure 2017-58 for complete details regarding penalties for intentional disregard of filing requirements

HHS RELEASES FREQUENTLY ASKED QUESTIONS ADDRESSING THE NOTICE REQUIREMENTS UNDER SECTION 1557 OF THE ACA

Background

On May 13, 2016, the Department of Health and Human Services (HHS) released its final rules implementing Section 1557 of the Affordable Care Act (ACA), titled *Nondiscrimination in Health Programs and Activities*. The final rules went into effect in 2017. Recently, however, HHS released a Frequently Asked Questions (FAQs) in relation to the Section 1557 final rules, clarifying that certain publications and communications are considered "significant," requiring those disclosures to include nondiscrimination language under Section 1557.

Background on Covered Entities

Section 1557 of the ACA prohibits "covered entities" from discriminating against individuals by excluding them from participation in, or denying them the benefits of health programs and activities based on race, color, national origin, sex, age, or disability. Covered entities are defined as:

- Any health program or activity that receives federal financial assistance through HHS (including Medicaid, most Medicare, and student health funds);
- Any health program or activity administered by an entity established under Title I of the ACA, including state-based marketplaces; and
- The HHS and the programs it administers, including the federally facilitated marketplace.

Generally, this would include entities such as hospitals, health clinics, health insurance issuers, state Medicaid agencies, community health centers, physician's practices, and home health care agencies.

Notice Requirements under Section 1557 of the ACA

The final regulations require covered entities to provide initial and continuing notification to beneficiaries, enrollees, applicants, and the public, of an individual's rights provided under Section 1557. The notice should include the following information:

- Statement that the covered entity does not discriminate on the basis of race, color, national origin, sex, age, or disability
- Statement that the covered entity provides appropriate aids and services without charge and in a timely manner, including qualified interpreters, for people with disabilities
- Statement that the covered entity provides language assistance including translated documents and oral interpretation free of charge and in a timely manner
- Instructions on how to obtain aids and services from the covered entity
- Information on how to contact the individual responsible for compliance within the organization
- Information about the availability of a grievance procedure; and
- Instructions on how to contact OCR to file a discrimination complaint.

A covered entity must include this notice in all "significant" publications and communications that are disclosed to beneficiaries, enrollees, applicants, and members of the public. Taglines must be included in each notice and other significant publication in the top 15 non-English languages in the entity's state. The taglines inform individuals of the availability of language assistance services. For small-sized significant publications (e.g., postcards), covered entities must post taglines in at least the top two non-English languages in the state.

In response to comments regarding the length of the notice, the final regulations permit covered entities to combine the above-listed content with the content of other notices required under other Federal civil rights laws. If the notices are combined, the final notice must clearly convey the information listed above and inform individuals of their civil rights under Section 1557. The final rules permit small-sized significant communications to include a shorter non-discrimination statement.

The final rules also allow some flexibility for covered entities to determine the size and location of the notices and taglines in their facilities. The final rules state that the notice content must be sufficiently conspicuous and visible, such that individuals participating in, or seeking services from, the health program or activity could reasonably be expected to see and be able to understand the information within the communication.

The Office for Civil Rights provides a sample notice and taglines on its website in sixty-four (64) languages that covered entities may use as a guide for their notice.

HHS Releases FAQs Addressing the Notice Requirements under Section 1557 of the ACA (continued)

Examples of Significant Publications or Communications set forth in HHS Frequently Asked Questions

The recently released Frequently Asked Questions issued by HHS specifically address what is considered to be a "significant" publication or communication. HHS specifically lists documents such as the Summary of Benefits & Coverages (SBCs) and the Notices of Privacy Practices as "significant" publications and communications. This guidance suggests that Breach Notification letters issued to health plan participants who may have had their protected health information (PHI) breached by a health plan could be considered a significant communication.

Action Required

Employers need be aware of these nondiscrimination provisions. Many employers will not be considered covered entities under these rules. However, any employer qualifying as a covered entity should review their significant communications to make sure the notice of nondiscrimination and the required taglines are included.

For the complete details, see:

Section 1557 Final Rule: https://www.gpo.gov/fdsys/pkg/FR-2016-05-18/pdf/2016-11458.pdf

Section 1557 FAQs: https://www.hhs.gov/civil-rights/for-individuals/section-1557/1557faqs/index.html

Sample Nondiscrimination Statement: https://www.hhs.gov/sites/default/files/sample-ce-notice-english.pdf

CALIFORNIA EXTENDS PARENTAL LEAVE TO SMALL EMPLOYERS

On October 12, 2017, Governor Jerry Brown signed Senate Bill No. 63, the New Parent Leave Act (Act), into law, requiring small employers with 20 to 49 employees in California to provide covered employees with up to twelve (12) weeks of unpaid, job-protected parental leave. Currently, only California employers with 50 or more employees are required to offer eligible employees twelve (12) weeks of parental leave. The Act will be effective beginning January 1, 2018.

Covered Employer

The Act applies to private, state, and municipal employers that employ at least twenty (20) employees within a 75 miles radius of the workplace.

The Act does not apply to employees already covered by the Family and Medical Leave Act (FMLA) and the California Family Rights Act, which already require employers with 50 or more employees to provide employees twelve (12) weeks of unpaid, protected leave. Therefore, the Act only applies to employers with 20 to 49 employees.

Covered Employee

The Act applies to an employee that meets the following requirements:

- has worked for the employer for at least twelve (12) months;
- has worked at least 1,250 hours during the 12 month period prior to requesting leave; and
- works at the workplace that employs at least 20 to 49 employees within a 75 mile radius.

Amount and Permitted Uses of Leave

A covered employer is required to provide covered employees twelve (12) weeks of unpaid, job-protected parental leave in order to bond with a new child through birth, adoption, or foster care placement. The employee must use the leave within one (1) year of the birth, adoption, or placement. If both parents are entitled to leave under the Act and are employed by the same employer, the parents are entitled to a combined total of twelve (12) weeks of parental leave. The employer may choose to grant the leave simultaneously to both parents, but is not required to do so.

Since the statutorily required leave is unpaid, the Act allows employees to use accrued paid time off (e.g., paid vacation or sick time) while on leave. Leave provided under this Act is job-protected, meaning that when an employee returns from leave, the employee is entitled to the same or comparable position with the employer.

California Extends Parental Leave to Small Employers (continued)

Benefits While on Leave

When an employee takes leave pursuant to this Act, the employer must maintain and pay for that employee's coverage under the employer's group health plan at the same level as if the employee was not on leave. However, if the employee fails to return to work, other than due to a continuation, recurrence, or onset of a serious health condition or circumstances beyond the employee's control, the employer is entitled to recover the cost of premiums paid while the employee was on leave.

No Retaliation or Discrimination

An employer may not refuse to hire, or fire, suspend, retaliate against, or discriminate against an employee for exercising their rights under the Act.

Mediation Pilot Program

The Act requires the Department of Fair Employment and Housing to create a "mediation pilot program." Under this program, if an employer receives a right-to-sue notice, which an employee may have filed to claim that they had their rights violated pursuant to this law, the employer has 60 days from receipt of that notice to request to participate in the mediation program. If the employer makes a timely request, the employee would be prevented from pursuing a civil action until the mediation is complete.

Action Required

Employers in California with 20 to 49 employees should be aware of the Act's requirement that they must offer twelve (12) weeks of unpaid, protected leave to their covered employees, and should create or update their leave policies accordingly, by January 1, 2018.

For the text of the Act, see: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB63

EXPANSION TO THE TYPES OF EMPLOYERS WHO MAY CLAIM AN EXEMPTION TO THE CONTRACEPTIVE COVERAGE MANDATE

On October 6, 2017, the Departments of Treasury, Labor, and Health and Human Services (HHS) issued interim final rules expanding the types of employers that may claim an exemption from the Affordable Care Act's (ACA) contraceptive coverage mandate. The final rules are effective as of October 6, 2017.

The ACA requires that most health plans cover certain preventative services at no cost to an insured. FDA approved contraceptive services and products are included as a category of preventative services, meaning they must also be provided at no cost to an insured. However, certain religious employers (e.g., houses of worship), can claim a religious exemption from this requirement.

The interim final rules released on October 6, 2017, expand the kinds of employers who may also claim an exemption from the contraceptive coverage mandate, beyond the current exemption for religious employers. These new categories of employers include any non-profit employer, closely-held-for-profit employer, and private college or university with a **religious or moral objection** to covering contraceptive services. Publicly traded companies may also claim an exemption based on a religious objection, but not based on a moral objection. If an employer does claim an exemption, then contraceptives and contraceptive services need not be covered under the employer's health plan.

Employers may also seek an accommodation from the mandate, which would allow an employer who was approved for the accommodation to offer a health plan that may still cover certain contraceptives and contraceptive services, but the coverage is paid for by the insurer or TPA, and not by the employer. The accommodation based on a religious or moral objection may be requested from HHS, a third party administrator, or the insurer.

No Action Required

Employers who have religious or moral objections to offering contraceptive services should be aware of these new regulations, as employers who may not have previously been able to receive such an exemption/accommodation as a religious organization, now may qualify for relief under these new regulations. If an employer is claiming an exemption or accommodation, they should amend their plan documents to reflect whether contraceptives and contraceptive services are covered under the plan.

For the text of the Interim Final Rules, see: https://www.gpo.gov/fdsys/pkg/FR-2017-10-13/pdf/2017-21851.pdf

HHS AND CMS RELEASE STATEMENT ANNOUNCING DISCONTINUANCE OF COST-SHARING SUBSIDIES IN THE MARKETPLACE

Background

Under the Affordable Care Act (ACA), insurance Exchanges (i.e., Marketplaces) allow individuals in the United States to purchase coverage through Marketplaces set up by states or the Federal government. Built within the Marketplace, individuals applying for coverage are eligible for premium tax subsidies if they meet certain requirements, and if they earn between 100% and 400% of the federal poverty line. These subsidies help to reduce the **premium** cost to individuals when they purchase insurance coverage within the Marketplace.

In addition, the Federal government also provides cost-sharing reduction (CSR) payments to reimburse insurers offering plans in the Marketplace. These CSRs defray the expense to insurers who help individuals reduce their co-pays and deductibles after purchasing coverage in the Marketplace. These CSR payments are contingent upon the kind of policy an individual chooses inside of the Marketplace, and are limited to individuals who annually earn between 100% and 250% of the federal poverty line. Essentially, under the CSR payments program, insurers that offer plans in the Marketplace are required to reduce the amount lower income individuals pay towards co-pays and deductibles. Insurers are then reimbursed by the Federal government for those subsidies they provided to Marketplace participants.

CSR Payments Discontinued

On October 12, 2017, Health and Human Services (HHS) released a statement indicating that based on a legal opinion letter from the Attorney General, the CSR payments would be discontinued, immediately. The reasoning the Attorney General used in crafting its legal opinion was that due to the way the ACA was drafted, both the premium tax subsidies and the CSR payments needed to be approved by Congress. The Attorney General agreed that the premium tax subsidies were approved by Congress, which means that they would remain untouched, however, because Congress never separately approved the CSR payments, at this time, CSR payments could not be legally paid out to insurance carriers in the Marketplace. Therefore, because Congress has yet to separately approve the CSR payments, and because the CSR payments are not tied to the approval of the premium tax subsidies, the CSR payments would need to be halted, immediately, until further action and approval by Congress.

Future of the CSR Payments

Due to the complications associated with insurance carriers relying on the CSR payments to reduce costs for lower income enrollees, in the interim, many states and Congress are currently planning to find other ways to continue maintaining these CSR payments. The potential effects, if the CSR payments are not replaced, are that carriers within the Marketplace may choose not to offer coverage in the Marketplace due to the losses they may suffer if they do not receive CSR payments from the Federal government.

No Action Required

Employers should be aware that employees may have the ability to have special enrollment into an employer's health plan, if the plans they have currently elected are no longer offered in the Marketplace.

For the complete details, see HHS Statement and Attorney General Legal Opinion Memo:
https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf

DEPARTMENTS ISSUE ADDITIONAL GUIDANCE ON QUALIFIED SMALL EMPLOYER HEALTH REIMBURSEMENT ARRANGEMENTS

Introduction

On October 17, 2017, the Department of Labor, Department of Treasury, and the Department of Health and Human Services (hereinafter, collectively referred to as "the Departments") released Notice 2017-67, which clarified areas of the original Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) regulations. Background on the QSEHRA program and some highlights regarding Notice 2017-67 are contained below.

Background

The 21st Century Cures Act (Cures Act) was enacted on December 13, 2016. It amended the Employee Retirement Income Security Act (ERISA), and the Public Health Service Act (PHSA), to permit an eligible employer to provide a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) to its eligible employees. As a reminder, employers who are considered "eligible" to offer a QSEHRA must meet all of the below requirements:

1. The QSEHRA must be offered to **all** eligible employees, however, small employers **may** consider the following employees not to be eligible for the QSEHRA:
    a. Employees who have not completed 90 days of service
    b. Employees under age 25
    c. Part-Time and seasonal employees
    d. Union employees (if health benefits are covered under their collective bargaining agreement); and
    e. Non-resident aliens without U.S. source income
2. The QSEHRA must be provided under the same terms to all eligible employees. However, employers may vary benefits based on the cost of health insurance in the individual market.
3. The QSEHRA must be funded solely with employer contributions. Employee salary contributions to the QSEHRA are not permitted.
4. QSEHRA pays or reimburses eligible employees for medical expenses (defined under the Internal Revenue Code (IRC) Section 213(d)) incurred by the employees or their family members following proof of coverage.
    a. Eligible medical expenses also include individual health insurance premiums, or Medicare supplemental insurance.
5. Reimbursements under a QSEHRA cannot exceed $4,950 for employee-only coverage or $10,000 if the QSEHRA provides family coverage.
    a. These amounts are pro-rated for employees who are covered for only part of the year, and indexed for inflation.
6. Employers must provide eligible employees with a written notice that informs them of their ability to participate in the QSEHRA, at least 90 days before the beginning of the plan year.
7. Employers cannot offer a group health plan.
8. Employees must also be **enrolled** in Minimum Essential Coverage (MEC).

Notice 2017-67 Highlights

Notice 2017-67 contained much needed clarification to employers wanting to offer a QSEHRA program to their employees. Generally, the clarifications addressed the conditions by which an employer could and/or could not offer the program. Below are the highlights of the Notice:

- Even though employers who offer QSEHRAs are prohibited from offering a group health plan, if the employer chooses to offer a retiree health plan and no other group health plan, the employer would not be prohibited from offering a QSEHRA to its employees.
- If an employer offers an "annual run out period" for any HRA/FSAs already offered to employees as part of a group health plan, it would not interfere with the ability for that employer to offer a QSEHRA, so long as the HRA/FSA plans do not reimburse any expenses of employees in the same plan year the QSEHRA was offered.
- If multiple employers within the same controlled group/affiliated services group offer a group health plan, the entire controlled group/affiliated services members would be unable to offer a QSEHRA. In the same logic, if a controlled group of entities is permitted to offer a QSEHRA, the reimbursement account must be offered to all eligible employees of that controlled group/affiliated services group and cannot just be offered to one member.
- The excludable class of Part-Time employees could be employees who have less than 35 hours of work a week, so long as other employees in similar work with the same employer have substantially more hours. For the class of excludable seasonal employees, employees who have less than nine (9) months could be the excluded group, so long as other employees in

Departments Issue Additional Guidance on QSEHRAs (continued)

similar work with the same employer have substantially more months of work. Notwithstanding, any employee whose customary employment is less than 25 hours, or whose customary annual employment is less than 7 months, would qualify as a part-time/seasonal employee.

- Employers cannot provide a choice to employees of whether they would like to participate in a premium reimbursement program or a medical reimbursement account. Employers, it seems, may only offer one program, or the other program, but not both.
- The maximum allotted statutory dollar limit for a QSEHRA is prorated, based on the number of months an individual is eligible to participate in a QSEHRA.

Conclusion

The above are only highlights from the FAQs, and the FAQs contain significantly more information than provided in this article. Employers planning to offer a QSEHRA should review these FAQs carefully.

No Action Required

Small employers who are not ALEs, that are considering offering a QSEHRA, should work with legal counsel in reviewing these FAQs, to build their QSEHRA program.

For the complete details, see FAQs: https://www.irs.gov/pub/irs-drop/n-17-67.pdf

NEW YORK CITY EXPANDS COVERAGE UNDER SICK LEAVE LAW TO INCLUDE SAFE TIME

On November 6, 2017, New York City Mayor Bill de Blasio signed into law Int. No. 1313-A, which amends the NYC Earned Sick Time Act ("ESTA"). The amendments include an expansion of the covered reasons for leave under the ESTA as well as broadening the definition of a covered "family member" under the law. The expanded covered reasons for leave permitted under the ESTA would now allow eligible employees to use earned time off for situations where an employee or employee's family member is a victim of a family offense matter, sexual offenses, stalking or human trafficking (collectively "safe time"). The law renames, the ESTA, to the "NYC Earned Safe and Sick Time Act." The NYC Earned Safe and Sick Time Act takes effect on May 5, 2018, which is 180 days after the bill becomes law.

Expansion of Covered Reasons for Paid Sick Leave

Currently under the law, employees who work in NYC for more than eighty (80) hours in a year are allowed to accrue up to forty (40) hours of paid sick leave per year that may be used for the following covered purposes:

- The employee's own mental or physical illness, injury, or health condition, need for medical diagnosis, care, treatment or preventative care, or elective surgery, including organ donations;
- Care of a family member who needs medical diagnosis, care, or treatment of an illness, injury, or health condition or preventative care, or who has elective surgery, including organ donations; and
- Closure of an employee's workplace due to a public health emergency or to care for a child whose school or child care provider is closed due to a public health emergency.

Under the new NYC Earned Safe and Sick Time Act, employees would be entitled to use earned time off for reasons due to any of the following reasons when the employee or a covered family member has been the victim of a family offense matter, sexual offenses, stalking, or human trafficking as defined in the bill:

- To obtain services from a domestic violence shelter, rape crisis center, or other shelter or service program for relief from a family offense matter, sexual offenses, stalking or human trafficking
- To participate in safety planning, temporarily or permanently relocating, or take other actions to increase the safety of the employee or the employee's family members from future family offense matters, sexual offenses, stalking, or human trafficking

New York City Expands Coverage under Sick Leave Law to Include Safe Time (continued)

- To meet with an attorney or other social service provider to obtain information and advice on, and prepare for or participate in any criminal or civil proceeding, including but not limited to, matters related to a family offense matter, sexual offense, stalking, human trafficking, custody, visitation, matrimonial issues, orders of protection, immigration, housing, discrimination in employment, housing or consumer credit
- To file a complaint or domestic incident report with law enforcement or meet with a district attorney's office
- To enroll children in a new school; or
- To take other actions necessary to maintain, improve, or restore the physical, psychological, or economic health or safety of the employee or the employee's family member or to protect those who associate or work with the employee.

Expanded Definition of Covered Family Members

Under the previous law, employees could have used their earned sick time to care for a "family member," which was defined as the employee's child, grandchild, spouse, domestic partner, parent, grandparent, sibling, or the child or parent of an employee's spouse or domestic partner. The NYC Earned Safe and Sick Time Act broadens the previous definition of family member for both sick and safe time to also include "any other individual related by blood to the employee; and any other individual whose close association with the employee is the equivalent of a family relationship."

Documenting Use

Employers are permitted to obtain "reasonable documentation" of the need for safe time following an absence of more than three consecutive work days. Such reasonable documentation may be provided by a victim services organization, attorney, clergy member, medical or other professional service provider or by production of police, court records, or even a notarized letter from the employee explaining the need for safe time. All such information obtained would need to be treated as confidential. In addition, an employer cannot require documentation that details an employee's or their family member's status or perceived status as a victim of family offense matters, sexual offense, stalking, or human trafficking.

Notice

Employers would be required to provide notice to current employees, as well as new employees going forward, of their right to safe time within thirty (30) days of the effective date of the amendment.

Action Required

Employers with employees in New York, New York should update their leave policies in light of the new amendments to the New York City paid sick leave law, and the expanded reasons for which an employee may exercise their right to take sick leave time.

For the text of The Earned Safe and Sick Time Act, see:
http://legistar.council.nyc.gov/LegislationDetail.aspx?ID=2867849&GUID=DCC83D1C-0D6A-4E38-9FEB-6974CA947D6F&Options=ID|Text|&Search=Int.+1313-A

CALIFORNIA PASSES LAW REQUIRING INCREASED TRANSPARENCY ON PRESCRIPTION DRUG PRICING

On October 9, 2017, California Governor Jerry Brown approved Senate Bill 17 ("Bill"), which imposes additional notification and reporting requirements on pharmaceutical companies, health care service plans, and health insurers, including the obligation to report certain increases in prescription drug pricing. The Bill implements many new reporting requirements on those industries, but this article focuses on the notice and reporting obligations related to prescription drug pricing. The law is effective beginning January 1, 2018.

Manufacturer Reporting Requirements

Manufacturers whose prescription drugs are purchased by a state purchaser, licensed health care service plan, health insurer, or pharmacy benefit manager (PBM) are subject to the reporting requirements under the Bill. Under the Bill, manufacturers who produce a prescription drug with a wholesale acquisition cost (WAC) of greater than $40.00 for a course of therapy must notify each of its purchasers if the cost of that drug will increase more than 16%. Manufacturers must give notice at least 60 days prior to the date the increase will be effective. This requirement applies if the cost of the drug increases by greater than 16% in the current year, as well as if there has been a cumulative increase of 16% over the previous two calendar years.

The Bill also adds reporting requirements for manufacturers if they put a new prescription drug on the market where the cost of that prescription is over certain thresholds. The specifics of the thresholds and required notifications are in the text of the Bill, and a link to the Bill is provided below.

Lastly, beginning in January 2019, manufacturers must provide quarterly reports to California's Office of Statewide Health Planning and Development (OSHPD) for each drug with an increase in the WAC over 16%, that includes information regarding the sales history of that drug in the previous year, the WAC increases of the drug over the previous five (5) years, and the factors used to decide upon the increase in the cost of the drug.

Health Insurer and Health Plan Reporting

Beginning October 1, 2018, health care service plans and health insurers who are currently required to report rate information under California law, will have an additional obligation to report prescription drug cost information to the Department of Managed Health Care (DMHC) or Department of Insurance (DOI) by October 1 of each year. These reports are required for all covered prescription drugs (e.g., generic, brand name, and specialty drugs) and must include the following information:

- Twenty-five (25) of the most frequently prescribed drugs
- Twenty-five (25) of the most costly drugs by total annual plan spending; and
- Twenty-five (25) of the drugs with the highest year-over-year increase in total annual plan spending.

Under the Bill, the DMHC and DOI are required to compile the information provided in the reports into a public report that must be published on their websites by January 1 of each year.

The Bill also requires large group health care service plan contracts to disclose information on covered generic, brand name, and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, including the following:

- Percentage of the premium attributable to prescription drug costs for the prior year for each category of prescription drugs
- Year-over-year increase, as a percentage, in per-member, per-month total health plan spending for each category of prescription drugs
- Year-over-year increase in per-member, per-month costs for drug prices compared to other components of the health care premium
- Specialty tier formulary list
- Percentage of premium attributable to prescription drugs administered in a doctor's office covered under the medical benefit separate from the pharmacy benefit; and
- If there is a pharmacy benefit manager (PBM), then information on the use of the PBM, including components of the prescription drug coverage managed by the PBM and the PBM's name(s).

No Action Required

Employers should be aware of the new requirements on manufacturers, insurers, and health care service plans to disclose prescription drug pricing, so that employers can understand the cost of the prescription drugs covered under their health plan(s).

For the text of SB 17, see: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB17

QUESTION OF THE MONTH

Can HSA Contributions Continue After an Employee Ceases to be HSA-Eligible?

QUESTION: Our cafeteria plan allows employees who participate in our high-deductible health plan (HDHP) to make pre-tax health savings account (HSA) contributions. When an employee drops our HDHP coverage, HSA contributions are immediately discontinued. Is that necessary? Could we amend our plan to let employees continue contributing through the end of the year, whether or not they have obtained HDHP coverage elsewhere, until they reach the maximum contribution for the portion of the year in which we are confident they were HSA-eligible?

ANSWER: HSA contributions for a partial year of HSA eligibility do not have to be made during the months of eligibility. They can be made at any time from the first day of the year until the individual's federal tax return due date, without extensions, for that year. (An employee who did not have an HSA at the start of the year would, of course, have to establish one before receiving any contributions.) Thus, your cafeteria plan could be amended to allow participating employees to continue making HSA contributions through the end of the year in which they lose (or appear to lose) their HSA eligibility, or until they reach their contribution limit for the partial year of eligibility, whichever happens first. In theory, you might go even further and allow contributions from the first few months of the following year to be attributed back to the prior year, but that would raise additional administrative challenges you may wish to avoid.

Allowing pre-tax HSA contributions to continue will let some employees make up for undercontributing at the start of the year—which employees sometimes do purposefully (e.g., because of the timing of annual bonus compensation or because they plan to increase contributions after their compensation reaches the Social Security taxable wage base). The ability to keep contributing could complicate administration, however, because the plan will need to determine and track an individualized limit for each ineligible employee in order to reasonably believe that those post-eligibility contributions are excludable from wages and thus reduce employment taxes. (As a reminder, for an employer to exclude HSA contributions from wages, it must be "reasonable to believe" at the time the contributions are made that the employee will be able to exclude them from income.)

For some plans, post-eligibility contributions are unavoidable. For example, contributions after an employee's loss of HSA eligibility may be necessary to satisfy the HSA comparability rules if an employer makes nonelective HSA contributions at year-end and those contributions are not made under a cafeteria plan. For arrangements that are not subject to the comparability rules, year-end contributions may be the most convenient method for providing broad-based nonelective employer contributions or contributions used as wellness rewards.

If you decide to keep your current rule, employees who lose their company-sponsored HDHP will still be able to make after-tax HSA contributions and take an "above-the-line" deduction—whether or not they itemize deductions—until their total contributions (pre-tax and after-tax) reach the applicable maximum for the portion of the year in which they were HSA-eligible. From a tax standpoint, however, after-tax contributions are not as favorable as pre-tax contributions because only the latter avoid employment taxes.

Source: EBIA

CONTACTS

Christopher K. Bao, Esq.
Manager, Employee Benefits Compliance
& Regulatory Affairs, MMA West
Chris.Bao@MarshMMA.com
+1 415 230 7224

Brittany D. Botterill, Esq.
Manager, Employee Benefits Compliance
& Regulatory Affairs, MMA West
Brittany.Botterill@MarshMMA.com
+1 858 587 7511