MARSH & McLENNAN AGENCY

Employee Benefits Legislative Compliance
Monthly Newsletter, MMA West Edition

June 2018 | Issue 6

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IRS RELEASES AFFORDABILITY PERCENTAGE FOR 2019

Under the Employer Mandate portion of the Affordable Care Act (ACA), an employer may be subject to penalties if it fails to offer affordable medical coverage to its employees (in addition to other penalties that an employer may be exposed to under the Employer Mandate). Originally, under the ACA, a plan was considered unaffordable to an employee if he/she paid more than 9.5% of his/her household income for an employer-sponsored plan. The ACA mandates that every year the original affordability percentage of 9.5% be subject to inflation, which has typically resulted in an increase of the affordability percentage every year.

On May 21, 2018, the Internal Revenue Service (IRS) released Revenue Procedure 2018-34, which **increases** the amount an employee can pay for health coverage (as a percentage of his/her household income), and still be considered affordable to that employee. The affordability percentage was **increased** to 9.86% of an employee's household income in 2019, from 9.56% of an employee's household income in 2018.

Affordability Percentage for 2019

	2018	2019	Change
Employer Affordability Percentage	9.56%	9.86%	+0.3%

Affordability Safe Harbors

As a reminder, employers are afforded three affordability safe harbors to utilize when calculating whether they are/are not offering affordable coverage under the IRS Code. Those three safe harbors are: Rate of Pay, Federal Poverty Line, and Box 1 of an employee's W-2. We have included an example below, to illustrate how to calculate affordability using the rate of pay safe harbor and the **2019** affordability percentage.

If a Full-Time **hourly** employee earns $15 per hour in a calendar month, $15 is multiplied by **130** (the requisite hours multiplier under the rate of pay safe harbor), which equals $1,950 ($15 X 130 hours = $1,950) per calendar month. For the plan to be considered affordable to an employee who earns $15 per hour, the **maximum** amount an employee can be required to contribute towards self-only coverage in 2019 would be **$192.27** ($1,950 X 9.86% in 2019) per calendar month.

No Action Required

Employers should be aware of the changes to the 2019 affordability safe harbor percentage, 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. 2018-34.

IRS CREATES WEBPAGE TO HELP APPLICABLE LARGE EMPLOYERS UNDERSTAND LETTER 227

Background

Under the Employer Mandate, Applicable Large Employers (defined as employers with 50 or more Full-Time and/or Full-Time equivalent employees in the previous calendar year) are subject to potential IRS penalties for failing to offer Minimum Essential Coverage (MEC) to "substantially all" (defined as at least 95%) of their Full-Time employees, and one employee goes to the Marketplace/Exchange and receives a premium tax subsidy. In addition, even if an Applicable Large Employer (ALE) offers "substantially all" of its Full-Time employees MEC, an employer may still be exposed to penalties for failing to offer its Full-Time employees both affordable and Minimum Value coverage, and that specific employee who was not offered affordable/Minimum Value coverage goes to the Marketplace/Exchange and receives a premium tax subsidy.

The IRS assesses penalties based on information received from the Marketplace/Exchange and from an ALE's Form 1094-C (Employer Reporting Form). If the IRS finds potential penalties, they will notify the ALE in the form of a Letter 226J. ALEs have 30 days to respond to the Letter 226J using Form 14764 to indicate their agreement or disagreement with the proposed penalties.

Letter 227

Following the review of Form 14764, the IRS will send the ALE a Letter 227 which will explain the outcome of the IRS's review and the next steps to fully resolve the penalty assessment. The IRS has created a webpage to help ALEs understand the five different variations of Letter 227 that they may receive in response to their Form 14764. Below is a brief explanation of what each letter means:

- **Letter 227-J** states that the proposed penalty amount will be assessed against the ALE because the ALE agreed with the proposed penalty. No response is required to this version of the letter, and the case is deemed closed.
- **Letter 227-K** shows that the penalty amount has been reduced to zero. No response is required to this version of the letter, and the case is deemed closed.
- **Letter 227-L** shows that the proposed penalty amount has been revised. This version of the letter includes an updated Form 14765 (PTC Listing) and revised calculation table. The ALE can agree with the revised penalty amount, request a meeting with the IRS, or appeal the determination.
- **Letter 227-M** shows that the penalty amount did not change. This version of the letter also includes an updated Form 14765 (PTC Listing) and revised calculation table to the extent any data used in the computation of the proposed penalty amount changed based on information provided by the ALE. The ALE can agree with the revised penalty amount, request a meeting with the IRS, or appeal the determination.
- **Letter 227-N** acknowledges the decision reached by the IRS appeals office and shows the resulting penalty amount. No response is required to this version of the letter, and the case is deemed closed.

As illustrated above, only Letters 227-L and 227-M call for a response, which must be provided by the date stated in the letter.

No Action Required

Employers should read and review their Letter 227 carefully. The letter will explain the next steps that are available to them.

For the complete details, read Understanding Your Letter 227.

NEW JERSEY ADOPTS INDIVIDUAL MANDATE

On May 30, 2018, New Jersey Governor Phil Murphy signed The New Jersey Health Insurance Market Preservation Act ("New Jersey Mandate") into law. The New Jersey Mandate requires New Jersey taxpayers (and their dependents) to have Minimum Essential Coverage ("MEC") during each month of the year. The New Jersey Mandate takes effect January 1, 2019. The revenue collected under the New Jersey Mandate will be used to fund a state-based reinsurance program.

Background

Under the federal Individual Mandate provisions of the Affordable Care Act ("ACA"), every nonexempt individual who is a US Citizen or legal resident, faces a federal tax penalty if they fail to maintain Minimum Essential Coverage ("MEC"). On December 20, 2017, Congress passed, and President Trump signed into law, the Tax Cut and Jobs Act of 2017 ("the Act"). The impact of the Act on the ACA is that the Individual Mandate penalty would be reduced to $0 for individuals who failed to purchase MEC for any tax years after December 31, 2018. The New Jersey Mandate was drafted in response to the repeal of the federal Individual Mandate, and is now a state-based individual mandate that penalizes New Jersey residents who fail to enroll in medical coverage for any given month.

New Jersey Individual Mandate Penalties

Similar to the ACA Individual Mandate, New Jersey residents who fail to have MEC may be subject to a penalty that is equal to the amount they would have paid if the federal ACA penalty had not been adjusted to $0: $695 for adults ($347.50 per child) or 2.5 percent of a taxpayer's income, whichever is greater. This amount is adjusted for inflation each year.

The potential penalty would be capped at the average premium for a bronze plan in New Jersey. Individuals in New Jersey who fail to maintain MEC will be penalized for each month of noncompliance, unless they qualify for an exemption (e.g., bona fide resident of another state, taxable income is below the minimum taxable income threshold, or otherwise qualifies for a hardship exemption). Under the New Jersey Mandate, similar to the ACA, a taxpayer is also exempt from the individual mandate penalty if their coverage is considered unaffordable. The Commissioner of Banking and Insurance, in consultation with the State Treasurer, will determine the income threshold for coverage to be considered "unaffordable." However, in making such a determination, the threshold shall be consistent with the ACA. In addition, the Commissioner of Banking and Insurance will have the authority to make determinations as to hardship exemptions.

If, for some reason, a taxpayer must pay both the federal penalty and the New Jersey penalty, the taxpayer would receive a credit (in the amount of the federal penalty) against what they would owe under the state law. This federal penalty credit could not exceed the amount the taxpayer would owe under the state penalty. As indicated above, because the federal Act reducing the ACA Individual Mandate penalty to $0 takes effect on the same day as the New Jersey Mandate (January 1, 2019), the credit presumably will only be relevant if the federal ACA Individual Mandate penalty is restored in the future.

Flexibility on Defining MEC

The definition of MEC under the New Jersey Mandate is the same as that under the ACA. The New Jersey Mandate further authorizes the Commissioner of Banking and Insurance and the State Treasurer to recognize additional types of health benefits as MEC.

Notification in November

Between November 1 and November 30, the State Treasurer will send a notification to taxpayers who failed to be enrolled in MEC in the previous tax year. The notification will include information on how to obtain coverage, including information on how to obtain coverage through the Marketplace.

NEW JERSEY ADOPTS INDIVIDUAL MANDATE (CONTINUED)

Reporting Requirement

The New Jersey Mandate will require certain entities (e.g., employers that offer job-based coverage, the Department of Health and Human Services, and carriers licensed to offer health coverage), to submit a return to the State Treasurer. The return will include data on individuals covered under MEC such as names, Social Security numbers, and dates of coverage. This requirement may be satisfied by filing a return that is currently required under the ACA, or the submission of information that is similar to that required by employers under the ACA.

Action Required

Employers with employees in New Jersey should communicate to employees that if he/she waives the employer-provided coverage, he/she could still be subject to a penalty for failure to have Minimum Essential Coverage for himself/herself, as well as any dependents. In addition, Applicable Large Employers (ALEs) should continue to file Form 1095-C, which may be used to confirm medical plan enrollment of employees in New Jersey. If an employer is not an ALE, it should retain information on whether an employee is enrolled in its coverage, if information is requested of it by the State Treasurer.

For the complete details, read the New Jersey Health Insurance Market Preservation Act.

DULUTH, MINNESOTA ENACTS PAID SICK AND SAFE LEAVE ORDINANCE

On May 29, 2018, Duluth, Minnesota adopted Ordinance No. 10571 (Ordinance), which will require covered employers to provide covered employees up to 40 hours of paid sick leave per year. The Ordinance will go into effect on January 1, 2020. Highlights of the law are detailed below.

Covered Employers

This Ordinance applies to employers that employ five (5) or more employees nationwide, and that have employees working in the city of Duluth.

Covered Employees

Covered employees are those who perform work within the geographic boundaries of the city for more than 50 percent of their working time in a 12 month period; or are workers who are based in the city of Duluth and spend a substantial part of their time working in the city and do not spend more than 50 percent of their working time in a 12 month period in any other particular location.

Accrual of Sick and Safe Leave

Covered employees begin to accrue paid sick and safe leave on the first day of employment or January 1, 2020, whichever date is later. Employers can choose to provide employees paid sick and safe leave either through an accrual method, or a frontloading method. Under the accrual method, employees will be entitled to accrue one (1) hour of paid sick leave for every 50 hours worked, up to a total of 64 hours per year. Under the frontloading method, employers can provide employees with 40 hours of sick and safe leave upon the employee's eligibility date, and on the anniversary date of that eligibility date each subsequent year.

DULUTH, MINNESOTA ENACTS PAID SICK AND SAFE LEAVE ORDINANCE (CONTINUED)

Carryover

Covered employees can roll over up to 40 hours of unused sick leave for immediate use in the following year.

Employers can continue using their existing paid time off policies (including personal, sick, and/or vacation) provided that they are equal to, or greater than, the sick and safe leave provided for under the Ordinance.

Permitted Uses of Sick and Safe Leave

Employees become eligible to use sick and safe leave upon their 90th day of employment. Paid sick and safe leave may be taken in increments "consistent with the current business/ payroll practice as defined by industry standards or existing employer policies," as long as the increment does not exceed four hours.

Eligible absences include:

- time needed for the diagnosis, care, treatment, or recovery from an employee's mental or physical illness, injury, or other health condition, or for the preventive medical care of the employee
- time needed for the employee to care for a family member needing diagnosis, care, treatment, or recovery from the family member's mental or physical illness, injury, or other health condition, or requiring preventive medical care for the family member; or
- an absence due to domestic abuse, sexual assault, or stalking of the employee or employee's family member.

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

- spouse
- child or grandchild
- parent or grandparent; or
- "any other individual related by blood or whose close association with the employee is the equivalent of a family relationship."

Request and Notice for Use of Sick and Safe Leave

Employers may continue using their current policy for allowing employees to request leaves of absences, provided that the requirements "do not interfere with the purposes for which the leave is needed." Employers are allowed to require documentation from an employee to substantiate the need for sick and safe leave if the absence is greater than three consecutive days.

Enforcement and Violations

Employers are required to provide notice to employees of their entitlement to paid sick and safe leave. An employee must also be notified of his/her right to file a written compliant to the city clerk if the employee's request for sick and safe leave is denied or if the employee is retaliated against for taking earned sick and safe leave. If the city clerk determines that there has been a violation of the ordinance, the city clerk may require that the employer pay an administrative penalty, in addition to being required to pay an employee any accrued sick and safe leave that was unlawfully withheld by the employer.

Action Required

Covered employers should make sure that their paid leave policies are updated by January 1, 2020 to comply with the new law.

For the complete details, read Ordinance Number 10571.

COMPLIANCE REMINDER: PCORI FEE DUE TO IRS BY JULY 31, 2018

The Affordable Care Act (ACA) imposes a fee (PCORI fee) on health insurance carriers and sponsors of self-funded health plans that helps to fund the Patient-Centered Outcomes Research Institute (PCORI) and support clinical effectiveness research. The PCORI fee is due annually and must be reported on IRS Form 720 by **July 31, 2018**.

For **self-funded plans**, the **employer/plan sponsor** will be responsible for submitting the fee and accompanying paperwork to the IRS. For **fully-insured plans**, the IRS collects this fee from the insurance carrier. Third-party reporting and payment of the fee is not permitted for self-funded plans. The process for remitting payment by sponsors of self-funded plans is described in more detail below.

PCORI Fee Reporting and Payment

The IRS will collect the fee from the insurer or, in the case of self-funded plans, the plan sponsor, in the same way many other excise taxes are collected. The fees are reported and paid annually on IRS Form 720 by July 31st of the year following the last day of the plan year. This year, Form 720 and the fee are due to the IRS on July 31, 2018.

The **PCORI fee due on July 31, 2018 is $2.39 per covered life for policy and plan years ending on or after October 1, 2017 and on or before December 31, 2017**. Also, for plans **ending on or after January 1, 2017 and before October 1, 2017**, the per covered life fee is **$2.26**. IRS regulations provide three options for determining the average number of covered lives (actual count, snapshot, and Form 5500 method).

The **PCORI fee must be paid by the plan sponsor**; it is not permissible to pay this fee in whole or in part through the plan assets from participant contributions. The PCORI expense should not be included in the plan's cost when computing the plan's COBRA premium. The IRS has indicated the fee is, however, a tax-deductible business expense for employers with self-funded plans.

How to File IRS Form 720

The filing and remittance process to the IRS is straightforward and is largely unchanged from last year. On page two of Form 720, under Part II, the employer needs to designate the average number of covered lives under its "applicable self-insured plan".

Part II

IRS No.	Patient - Centered Outcomes Research Fee (see instructions)	(a) Avg. number of lives covered (see inst.)	(b) Rate for avg. covered life	(c) Fee (see instructions)	Tax	IRS No.
	Specified health insurance policies					
	(a) With a policy year ending before October 1, 2017		$ 2.26			
133	(b) With a policy year ending on or after October 1, 2017, and before October 1, 2018		$ 2.39			133
	Applicable self - insured health plans					
	(c) With a plan year ending before October 1, 2017		$ 2.26			
	(d) With a plan year ending on or after October 1, 2017, and before October 1, 2018		$ 2.39			

COMPLIANCE REMINDER: PCORI FEE DUE TO IRS BY JULY 31, 2018 (CONTINUED)

The **Payment Voucher** (720-V) should indicate the tax period for the fee is "2nd Quarter."

Form **720-V** (2018)

▼ Detach here and mail with your payment and Form 720. ▼

720-V
Department of the Treasury
Internal Revenue Service

Payment Voucher

► Don't staple or attach this voucher to your payment.

OMB No. 1545-0023
2018

1 Enter your employer identification number (EIN) (see instructions).

2 Enter the amount of your payment. ►
Make your check or money order payable to "United States Treasury."
Dollars | Cents

3 Tax Period
- 1st Quarter
- 2nd Quarter
- 3rd Quarter
- 4th Quarter

4 Enter your business name (individual name if sole proprietor).

Enter your address.

City or town, state or province, country, and ZIP or foreign postal code.

Please Note: Self-funded plan sponsors who are required to pay the PCORI fee but are **not** required to report or pay any other excise tax liabilities must report the payment of the PCORI fee on their **2nd Quarter** Form 720. Failure to properly designate "2nd Quarter" on the voucher will result in the IRS's software generating a tardy filing notice, with all the incumbent aggravation on the employer to correct the matter with the IRS.

Action Required

Plan sponsors are required to submit the fee using Form 720, the Quarterly Federal Excise Tax Return.

For detailed instructions for Form 720, read Instructions for Form 720.

QUESTION OF THE MONTH

Can We Satisfy the COBRA Initial Notice Requirement by Including the Notice in Our SPD?

QUESTION: Can we satisfy the COBRA initial notice requirement by including the notice's contents in our group health plan's summary plan description (SPD) rather than providing a separate notice?

ANSWER: Yes, but it may be better to use a stand-alone initial notice. The DOL's COBRA regulations expressly permit a plan administrator to satisfy the initial notice requirement by including the notice's contents in an SPD. In fact, the DOL has suggested that plans may prefer to take advantage of the reduced cost and added efficiency of providing a single document satisfying both the initial notice requirement and the SPD requirement. Even so, a stand-alone initial notice may be preferable. Although it is a close call, we offer the following reasons why a stand-alone initial notice, in addition to the SPD, may be a better way to go:

- The information that must be included in the initial notice is important to covered employees and covered spouses because it can affect their ability to maintain health coverage. A stand-alone initial notice may be more likely to be noticed and read by the covered employee and covered spouse than the same information contained in the SPD.
- If you use a single document, your SPD distribution procedures must comply with the COBRA rules regarding distribution of the initial notice. Generally, the deadline for delivery of the initial notice will be the same as the deadline for delivery of the SPD—within 90 days after plan coverage begins. However, COBRA requires the initial notice to be provided to both the participant and any covered spouse, while SPDs are only required to be delivered to the participant. Therefore, if the SPD is used to satisfy the initial COBRA notice requirement, delivery procedures must be modified to include covered spouses.
- It may be administratively simpler to send out stand-alone initial notices, particularly if procedures are already in place to ensure that covered employees and covered spouses are provided with initial notices when their coverage starts. Plan administrators including the initial notice in the SPD may find it difficult to implement SPD delivery procedures so that SPDs are delivered according to the COBRA initial notice delivery requirements. For example, a spouse who is added to coverage after the participant's initial enrollment must be sent an initial notice. In addition, plan administrators using stand-alone initial notices may find it easier to maintain records sufficient to prove delivery of the notice to a particular covered employee or covered spouse.
- If changes are required to the initial notice, or if the employer prefers to distribute a new initial notice to every employee at open enrollment, an initial notice is smaller and less costly to distribute than a full SPD. And as a practical matter, many COBRA initial notices are provided on behalf of employers by third-party administrators (TPAs) that are engaged to provide COBRA administrative services. These TPAs may provide stand-alone initial notices as part of their contractual COBRA administrative responsibilities and will likely continue to do so even if the information is also included in the SPD. *Source: EBIA*

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