MARSH & McLENNAN AGENCY

Employee Benefits Legislative Compliance
Monthly Newsletter, MMA West Edition

April 2018 | Issue 4

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HHS RELEASES FINAL BENEFIT AND PAYMENT PARAMETERS FOR 2019: UPDATE TO MAXIMUM OUT-OF-POCKET LIMITS

On April 9, 2018, the Department of Health and Human Services (HHS) released the Final Notice of Benefit and Payment Parameters for 2019. The Notice discusses many topics, including the Marketplace/Exchange, the risk adjustment program, and the Maximum Out-of-Pocket limits for medical plans. The focus of this short article is the Maximum Out-of-Pocket limits for 2019.

The Maximum Out-of-Pocket limits have increased for medical plans for 2019, as follows:

	2018	2019	Change
Self-Only Coverage OOP Limits	$7,350	$7,900	$550
Family Coverage OOP Limits	$14,700	$15,800	$1,100

Health plans should be aware of these changes in preparation for 2019.

No Action Required

Employers/Insurers should be aware of the increase in Maximum Out-of-Pocket limits for 2019.

For the Final Rule on HHS Notice of Benefit and Payment Parameters for 2019, see:

https://www.federalregister.gov/documents/2018/04/17/2018-07355/patient-protection-and-affordable-care-act-benefit-and-payment-parameters-for-2019

CMS EXTENDS TRANSITION RELIEF TO NON-COMPLIANT SMALL GROUP/INDIVIDUAL PLANS FOR ANOTHER YEAR

Current Guidance

On April 9, 2018, the Centers for Medicare & Medicaid Services (CMS) issued guidance that extends the compliance deadline for non-compliant Affordable Care Act (ACA) individual policies and/or small group plans. The transition policy has been extended to policy years beginning on or before October 1, 2019, provided that all non-compliant ACA policies end by December 31, 2019. This means individuals and small businesses may be able to keep their non-ACA compliant coverage through the end of 2019, depending on the policy year. This is subject to the discretion of each state's authority, and allows a state to choose to apply the transitional policy to the individual market, the small group market, or both markets.

Background

On November 14, 2013, CMS issued a bulletin to State Insurance Commissioners, outlining a proposal for providing transition relief to non-compliant, non-grandfathered coverage in the small group and individual health insurance markets. The letter stated that, pursuant to State authorities, health insurance issuers may choose to continue certain coverage that would otherwise be cancelled due to failing to meet all of the requirements for health coverage under the ACA. Under the transitional policy, non-grandfathered health insurance plans in the individual and small group market that renewed for policy/plan years between January 1, 2014 and October 1, 2014 would not be considered out of compliance with the ACA. CMS has extended this transitional relief several times.

Transitional Relief Policy

Under the transition relief extension, at the option of the states, issuers that have issued policies under the transitional relief in 2014 may renew these policies at any time through October 1, 2019 and affected individuals and small businesses may choose to re-enroll in the coverage through October 1, 2019. Policies that are renewed under the extended transition relief may still allow for the following:

- Consumers might be charged more based on factors such as gender or a pre-existing medical condition, which may not comply with rules limiting medical premiums only to age (PHS Act section 2701);
- Guaranteed availability and renewability are not required to be offered for these plans/policies (PHS Act sections 2702 & 2703);
- If the coverage is an individual market policy, the transitional policy allows a plan to exclude coverage for treatment of an adult's pre-existing medical condition such as diabetes or cancer (PHS Act section 2704);
- If the coverage is an individual market policy, consumers may have their premiums increased based on claims experience or the receipt of health care (PHS Act section 2705);
- Certain coverage benefits may have unlimited cost-sharing, including certain prescription drugs or maternity care (PHS Act section 2707); and
- Certain consumers might not have coverage for services related to a clinical trial for a life-threatening or other serious disease (PHS Act section 2709).

To qualify for the transition relief, issuers must send a notice to all individuals and small businesses that received a cancellation or termination notice with respect to the coverage (or to all individuals and small businesses that would otherwise receive a cancellation or termination notice with respect to the coverage).

The transition relief only applies with respect to individuals and small businesses with coverage that was in effect since 2014. It does not apply with respect to individuals and small businesses that obtain new coverage after 2014.

No Action Required
Employers in the small group market may have the opportunity to continue offering health insurance coverage that may not be compliant with the ACA for one or more plan years, so long as state law allows for such extension.

For complete details, see the CMS Bulletin, here:
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html

COMPLIANCE REMINDER: SAN FRANCISCO HEALTH CARE SECURITY ORDINANCE ANNUAL REPORT DUE APRIL 30, 2018

Covered Employers (defined as for-profit employers with 20 or more total employees and nonprofit employers with 50 or more total employees) **must** file an Annual Report with the City on their required minimum health care expenditures made for the benefit of its employees working in San Francisco. The 2017 Annual Reporting Form (ARF) must be filed no later than **April 30, 2018**. The 2017 ARF is currently available here.

Below is a link to the 2017 Annual Reporting instructions:

- Instructions: Annual Reporting Instructions

Tips for completing the Annual Reporting Form

1. Do not submit (2) separate 2017 Annual Reporting Forms using the same Business Account Number unless you are submitting a correction. If multiple businesses or locations share the same Business Account Number, combine the relevant data into a single Annual Reporting Form. If multiple forms are submitted, only the most recent submission will be recorded.
2. Fill out the form completely. Do not enter commas in numeric fields. Enter zeros where appropriate. Enter all dollar amounts in whole dollars; do not include cents.
3. Employees who worked for you throughout the year should be counted in each quarter.
4. If you cannot access the online forms, call the HCSO Office at (415) 554-7892 to request a paper copy of the Annual Reporting Form.

Employers who fail to submit the form are subject to a $500.00 penalty for each quarter that the violation occurs.

Irrevocable Expenditures

Beginning January 1, 2017, only **Irrevocable Expenditures** will be included in an employer's health care spending requirement under HCSO.

An Irrevocable Health Care Expenditure is an expenditure that the employer cannot recover. Employers who set up benefit plans, such as a limited scope HRA (e.g. dental-only plan), will no longer be able to recover the unused amounts, even if the employee leaves the job or if the business ceases to exist. An irrevocable expenditure includes premium payments to insurers for medical, dental, vision coverage, contributions to employees' HSA, MSA, etc. Any payment to the City Option is considered irrevocable.

The 2017 and 2018 HCSO-required health care expenditure rates are as follows:

Employer Size	Number of Employees	2017 Expenditure Rate	2018 Expenditure Rate
Large	All employers w/100+ employees	$2.64 per hour payable	$2.83 per hour payable
Medium	Businesses w/20-99 employees Nonprofits w/50-99 employees	$1.76 per hour payable	$1.89 per hour payable
Small	Businesses w/0-19 employees Nonprofits w/0-49 employees	Exempt	Exempt

Notice Update: Covered Employers must replace last year's posted Official Notice with the updated HCSO 2018 Official Notice at every workplace or job site where there is an HCSO-eligible individual.

QUESTION OF THE MONTH

WHAT HEALTH FSA DESIGN AND OPERATIONAL ISSUES SHOULD WE WATCH OUT FOR TO COMPLY WITH THE BENEFITS TEST UNDER THE CODE § 105(h) NONDISCRIMINATION REQUIREMENTS?

QUESTION: Our company offers a cafeteria plan with a health FSA, and we are thinking about redesigning the health FSA for next year. What are some health FSA design and operational issues to watch out for to comply with the Benefits Test under Code § 105(h)?

ANSWER: The Benefits Test requires that health FSA benefits not discriminate in favor of participants who are highly compensated individuals (HCIs). An HCI is an individual who is (1) one of the five highest-paid officers; (2) a shareholder who owns (with the application of certain ownership attribution rules) more than 10% of the value of the employer's stock; or (3) among the highest-paid 25% of all employees (with certain exclusions). The Benefits Test prohibits discriminatory benefits both on the face of the plan and in actual operation.

Here are some things to watch out for to avoid discriminatory benefits on the face of the plan:

- The required employee contributions must be identical for each benefit level. For example, if, under your company's health FSA, non-HCIs who contribute $2,400 per year receive $2,400 of coverage, but HCIs who contribute $2,400 per year receive $3,000 of coverage, the health FSA would fail the Benefits Test.
- The maximum benefit level that can be elected cannot vary based on age or years of service. Thus, providing a higher level of benefits (e.g., more coverage for certain individuals, lower contributions for the same coverage, etc.) for individuals based on their age could violate the Benefits Test if any of them are HCIs. A similar problem is created by linking benefits to years of service. For example, if your company makes a contribution to each participant's health FSA equal to $20 multiplied by each year of employment or $300, whichever is less, some HCIs with long tenure would receive more benefits than non-HCIs would, and your health FSA would fail the Benefits Test.
- The type or amount of benefits subject to reimbursement cannot depend on employee compensation. For example, a health FSA that limits the annual amount of reimbursement available to employees to a percentage of their compensation would violate the Benefits Test if HCIs participate.
- The same types of benefits (e.g., reimbursable medical expenses) available to HCIs must be available to non-HCIs on at least as favorable terms. For example, a health FSA cannot exclude orthodontia expenses for non-HCIs while covering them for HCIs.
- Health FSAs cannot impose disparate waiting periods. Thus, your health FSA could not require non-HCIs to wait 30 days to enter the plan, while allowing HCIs to enter the plan immediately.

A health FSA also must not discriminate in favor of HCIs in actual operation, and this is a "facts and circumstances" determination. Such discrimination might arise, for example, if the administrator approves certain claims submitted by HCIs while denying similar claims for non-HCIs (e.g., by requiring less substantiation from HCIs than from non-HCIs without having justifiable reasons for treating their claims differently).

The plan features described above are only examples, and other features may cause a health FSA to fail the Benefits Test. If the plan does not pass the Benefits Test, then amounts considered to be "excess reimbursements" will not be excludable from HCIs' income. (Non-HCIs will not lose their tax exclusion, however, and the health FSA will remain a valid Code § 105(h) plan.) Your company's health FSA is also subject to an Eligibility Test under Code § 105(h) and is indirectly subject to the Code's nondiscrimination rules for cafeteria plans. Because the Code's nondiscrimination requirements are complex and need careful monitoring, many employers consult a third-party administrator or other advisor for assistance.

Source: EBIA

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