VOLUME 14
ISSUE I
JANUARY
2017

SITZMANN • MORRIS • LAVIS

Employee Benefits | Life Insurance | Risk Management

INSURANCE BRIEF

INSIDE THIS ISSUE:

Corporate Headquarters
3697 Mt. Diablo Blvd. Suite 100
Lafayette, CA 94549
Toll Free: 800.733.3131
Tel: 510.452.0458
Fax: 510.452.1378

Santa Rosa Office
Fountaingrove Center
3554 Round Barn Blvd., Suite 309
Santa Rosa, CA 95403
Toll Free: 800.733.3131
Tel: 707.577.8300
Fax: 707.577.0609

Visit us on the web
www.smlinc.com

CA Insurance License #0D04053

ACA in 2017

Employer Reporting Extension. On Friday November 18th the IRS released Notice 2016 - 70. This notice extends the due date for furnishing to individuals the 2016 Form 1095-B, Health Coverage, and the 2016 Form 1095-C, Employer-Provided Health Insurance Offer and Coverage, from January 31, 2017, to March 2, 2017.

This notice also provides for transitional good-faith relief from the penalties imposed by sections 6721 and 6722 of the Internal Revenue Code relating to the 2016 information reporting requirements under sections 6055 and 6056.

- The Internal Revenue Code imposes penalties for failing to file and furnish an accurate and complete information return, including Forms 1094 and 1095.
- However, the IRS is extending penalty relief to reporting entities that can show they made a good faith effort to comply with the 2016 calendar year information reporting requirements.
- The relief applies to missing and inaccurate taxpayer identification numbers and dates of birth, as well as other information required on the return or statement. To determine good faith, the IRS considers whether an employer made reasonable efforts to prepare for reporting the required information to the IRS and furnishing it to employees and covered individuals, such as gathering and transmitting the necessary data to an agent to prepare the data for submission to the IRS, or testing its ability to transmit information to the IRS.

In addition, the IRS will consider the extent to which the employer is taking steps to ensure that it will be able to comply with the reporting requirements for the 2017 calendar year.

Opt-out payment and Affordability. On December 14th the IRS finalized proposed regulations issued earlier this year. Based on the IRS's comments in the proposed regulations, we expected these final regulations to contain final guidance on when opt-out payments must be included for purposes of affordability.

However, in the spirit of the college football bowl season, the IRS punted this final guidance to a later date. "Several comments on the proposed [regulations] were received. The Treasury Department and the IRS continue to examine the issues raised by the opt-out arrangements and expect to finalize regulations on the effect of opt-out arrangements … at a later time."

In these final regulations, the IRS confirmed that employers may continue to rely on the transition relief contained in both Notice 2015-87 and the proposed regulations.

In Notice 2015-87, the IRS explained that opt-out payments (i.e., payments for waiving coverage under an employer's group health plan) must be included in the affordability calculation for purposes of Health Care Reform's pay or play penalty. (Under the pay or play pen-

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Small Employers' HRA

On December 13th the President signed the 21st Century CURES Act. This very lengthy piece of legislation (824 pages) contains a provision that changes the treatment of health reimbursement arrangements (HRAs) for employers with fewer than 50 full-time equivalent employees. Under the Affordable Care Act (ACA) an HRA has to comply with group health plan requirements. This includes providing preventive services at no cost and the prohibition on annual limits. As a result, an employer cannot use an HRA to simply pay premiums for coverage of employees and their dependents in the individual market without being subject to an excise tax.

Title XVIII of the CURES Act provides an exemption for certain small employers. If you are under 50 full-time equivalent employees and therefore not subject to the ACA large employer mandates, *and* you do not offer a group medical plan, you can offer a "qualified small employer HRA" (QSEHRA) and not be subject to an excise tax if you meet the following conditions:

1) It is provided on the same terms to all eligible employees. Notwithstanding this general rule, the benefit may vary based on the cost of health insurance tied to the employee's age and/or number of family members covered. Thus, an employer could provide a greater benefit to an employee who is older or covers multiple family members.
2) It is funded solely by the employer. No employee salary reduction contributions are allowed.
3) The QSEHRA pays or reimburses an employee for medical expenses under Code Section 213(d) following proof of coverage. Eligible expenses include premiums for an individual health insurance policy.
4) Reimbursements under the QSEHRA do not exceed $4,950 for the employee only or $10,000 for family coverage. These amounts are pro-rated for an employee who is covered for a partial year and will be indexed in future years.
5) All employees must be offered coverage under the QSEHRA other than:
    a) Employees with less than 90 days of service;
    b) Employees younger than age 25;
    c) Part-time and seasonal employees;
    d) Union employees; and
    e) Non-resident aliens.

Employers must provide a written notice at least 90 days before the beginning of the Plan year. The notice must state:

1) The amount of the permitted benefit under the QSEHRA for the year;
2) A statement that if the employee is applying for advance payment of the premium tax credit for health insurance on the Marketplace, the employee must inform the Marketplace of the amount of the permitted benefit under the QSEHRA.
3) A statement that if the employee is not covered under minimum essential coverage for any month, the employee may be subject to a tax under Code Section 5000A (the individual mandate penalty) and reimbursements under the QSEHRA may be taxable income.

For 2017 there is a transition rule that allows employers to provide the notice within 90 days after the date of enactment of the new law. That makes the deadline March 13, 2017. For newly eligible employees the notice must be provided by the date of initial eligibility. There is a penalty of $50 per employee up to a max of $2,500 per year for failure to provide the notice.

Per item 3 in the Notice, an employee may be taxed on reimbursements from the QSEHRA if he or she does not have minimum essential coverage. In other words, an employee cannot enjoy a tax benefit from the QSEHRA if the employee does not maintain minimum essential coverage. It is unclear how or if an employer is to verify whether an employee has minimum essential coverage.

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ACA in 2017

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alty, an applicable large employer must generally offer full-time employees coverage that is both affordable and of minimum value, or pay an excise tax.) Here is an example:

> *An employer charges $50 per month for employee-only coverage under the employer's lowest-cost group health plan providing minimum value. The employer also offers employees who waive coverage $75 per month. For affordability purposes of both the pay or play penalty and reporting on Form 1095-C, the cost of this employer's coverage is $125 per month ($50 + $75 = $125), not $50 per month.*

Notice 2015-87 provided "transition relief" that allowed an employer to exclude opt-out payments from the affordability calculation if the employer adopted the opt-out arrangement before December 16, 2015. The transition relief applies to plan years beginning before January 1, 2017 or—if later—the effective date of final regulations.

The proposed regulations provided that the transition relief will continue to apply to plan years beginning before the later of: (i) January 1, 2017; or (ii) the effective date of final regulations. In these proposed regulations, the IRS also extended transition relief to opt-out payments that are required under collective bargaining agreements ("CBAs") that were in effect before December 16, 2015. This transition relief applies until the later of: (1) the first plan year beginning after the expiration of the CBA (disregarding any extensions on or after December 16, 2015); and (2) the effective date of the final regulations.

Lastly, in the proposed regulations the IRS indicated that an opt-out payment that is made under an "eligible opt-out arrangement" is not required to be included in the affordability calculation. An eligible opt-out arrangement is an arrangement under which an employee's right to receive the opt-out payment is conditioned on the employee providing reasonable evidence that the employee, spouse and dependents (for whom the employee reasonably expects to claim a personal exemption deduction for the tax year that begins or ends within the plan year) have alternative minimum essential coverage (other than through the individual market) during the period of coverage for which the opt-out payment applies.

Here is an example of an eligible opt-out arrangement:

> *Employer offers its employees coverage under a group health plan and requires employees to contribute $3,000 annually for employee-only coverage. If employees decline coverage under Employer's group health plan, Employer provides the employee with an opt-out payment of $500. However, in order to be eligible for the opt-out payment, the employee must attest that the employee, spouse and dependents, if any, are covered under another group health plan (e.g., a group health plan that is sponsored by the spouse's employer).*

For employers with opt-out arrangements that don't satisfy the requirements of transition relief, it appears that these employers may avoid including the cost of the opt-out payment for affordability purposes by using an "eligible opt-out arrangement."

ACA Repeal and Replace

Please refer to the SML Update "Post-Election ACA Update" for a helpful Q&A on what might and might not happen under the Trump administration.

What's Next: As things unfold we will keep you updated on how your plans are affected.

Final Benefit Parameters for 2018

On December 16th the Department of Health and Human Services (HHS) released the Final HHS Notice on Benefit and Payment Parameters for 2018. This rule finalizes the Proposed Rule issued in September.

Most of the provisions are aimed at insurance carriers in the Marketplace, but there are of few of interest to employers sponsoring group health plans. Here are the highlights:

Annual Cost-Sharing Limits. The maximum annual limitation on cost-sharing for 2018 would be increased to $7,350 for individual and $14,700 for family coverage. This is compared to $7,150 and $14,300 for 2017.

Insurance Market Rules. In the small group market, the proposed revised age-rating bands for children have been finalized. One age band for ages 1 through 14, and then single-year age bands for 15 through 20. They are finalizing child rating factors that are higher than the current child rating factor and more accurately reflect health care costs for children.

Medical Loss Ratio (MLR). They are finalizing amendments to the MLR provisions that will allow reporting of policies newly issued with a full 12 months of experience in that MLR reporting year be permitted to defer reporting.

QSEHRA *cont'd*

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W-2 Reporting

The employer is required to report the benefit available under the QSEHRA on each employee's Form W-2 beginning in calendar year 2017.

Premium Tax Credit

Individuals who receive QSEHRA contributions are not eligible for premium tax credits if the monthly premium for self-only coverage for the second-lowest cost silver (70 percent actuarial value) plan in their "relevant individual insurance market" is less than one half of 9.5 percent of the employee's household income minus the HRA premium contribution. If coverage is not affordable under this formula, the employee may qualify for a premium tax credit but it will be reduced by the amount of the HRA contribution.

Exempt From COBRA

Unlike other HRAs, a QSEHRA will not be treated as a group health plan for purposes of COBRA continuation coverage. Thus, upon a termination of employment or occurrence of another qualifying event, the employer does not need to provide a COBRA notice or continued coverage under the QSEHRA.

Anthem-Cigna Merger

In what is expected to be one of the final major antitrust cases of the Obama administration, the Justice Department (DOJ) filed a complaint in July seeking to halt Anthem's acquisition of Cigna. The antitrust lawsuit is aimed at preventing concentration among the biggest U.S. health insurers and protecting competition. The first phase of the DOJ's lawsuit is now in the hands of U.S. District Judge Amy Berman Jackson after the government wrapped up its arguments on December 20th. In a few weeks Judge Jackson should issue her decision on whether the combination of the companies risks higher costs for large employers around the country and should be blocked.

The second phase of the trial, which began on December 21st, will focus on sale of insurance to small employers in local markets. A decision in favor of the DOJ blocking the merger would make the second phase moot. "We're going on to phase two, no one should draw any conclusions from that one way or another," the judge said.

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2017 IRS Guidelines

Health Care Flexible Spending Account Maximum	$2,550	$2,600
Dependent Care Spending Account Maximum	$5,000	$5,000
Health Savings Accounts:		
• Maximum Individual Contribution	$3,350	$3,400
• Maximum Family Contribution	$6,750	$6,750
• Catch-Up Contribution	$1,000	$1,000
High Deductible Health Plans:		
• HDHP Minimum Annual Deductible (Individual)	$1,300	$1,300
• HDHP Minimum Annual Deductible (Family)	$2,600	$2,600
• HDHP Maximum Out-of-Pocket Limit (Individual)	$6,550	$6,550
• HDHP Maximum Out-of-Pocket Limit (Family)	$13,100	$13,100
Parking (Monthly)	$255	$255
Mass Transit Passes (Monthly)	$255	$255
Bicycle Commuting (Monthly)	$20	$20
401(k) Limit	$18,000	$18,000
401(k) Catch-up	$6,000	$6,000

3697 Mt. Diablo Blvd., Suite 100 Lafayette, CA 94549 Tel 800.733.3131 Fax 925.297.2081
3554 Round Barn Blvd., Suite 309 Santa Rosa, CA 95403 Tel 707.577.8300 Fax 707.577.0609
WWW.SMLINC.COM