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Friday News Brief

Preferred Benefits Services Agency, Inc.

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20 States Sue Federal Government to Kill ACA

Twenty Republican states have banded together to sue the federal government in an attempt to finally abolish the Affordable Care Act in the wake of the elimination of the individual mandate by the Trump administration.

Modern Healthcare reports that the Republican-governed states, led by Ken Paxton, Texas attorney general, and Brad Schimel, Wisconsin attorney general, called the law an "unconstitutional and irrational regime" forced on the states that undermined their sovereignty.

In their complaint, the states wrote, "Once the heart of the ACA—the individual mandate—is declared unconstitutional, the remainder of the ACA must also fall."

The individual mandate was eliminated in Trump's tax cut law, when it was zeroed out. And although the ACA was upheld in 2012 as constitutional, when the Supreme Court ruled it was a tax penalty, the elimination of that penalty means that, according to the states, the rest of the ACA "can't stand as law," the report says.

While the states regulate health insurance, the ACA not only required states to create or adopt exchanges where individuals could purchase plans, it also imposed certain requirements on plans, including covering pre-existing conditions and adhering to a list of essential elements of care.

An *Insurance Journal* report points out that the individual mandate in the ACA was intended to ensure a viable health insurance market by compelling younger and healthier Americans to buy coverage.

Reuters reports that Republicans Paxton and Schimel were joined in the lawsuit by 18 states including Arizona, Florida, Georgia, Utah, and West Virginia. It was filed in U.S. District Court in the Northern District of Texas.

IRS Updates Q&As About ACA Form 1095-C

In the meantime, employers still need to follow ACA rules & regs.

The **March 2 deadline is here** and the IRS is answering additional questions from employers on how to complete Form 1095-C.

Applicable large employers (generally those that had 50 or more full-time-equivalent employees) and self-funded employers must report 2017 health coverage information using Form 1095-C or similar forms.

The information reported on Form 1094-C and Form 1095-C is used in determining whether an employer is potentially liable for a payment under the employer shared responsibility provisions of section 4980H, and the amount of payment, if any. Form 1095-C is also used by the IRS and the employee in determining the eligibility of the employee (and the employee's family members) for the premium tax credit under section 36B.

The Q&As provide additional information about completing Form 1094-C and Form 1095-C for calendar year 2017 that are to be filed in 2018.

Click here to link to the Q&As.

Source: ThinkHR

2018 Increases to DOL Fines for Violations of ERISA & Other Federal Laws

The Department of Labor (DOL) issued a final rule that increases the DOL civil monetary penalties for violations of the Employee Retirement Income Security Act (ERISA) and other federal laws such as the Fair Labor Standards Act (FLSA), Family Medical Leave Act (FMLA) and Occupational Safety and Health Act (OSHA). The increased amounts apply for penalties assessed after January 2, 2018 (for any violations that occurred after November 2, 2015).

Examples of Actions Subject to DOL Fines

- Failure to file Form 5500 or M-1 (MEWAs).
- Failure to provide a Summary of Benefits and Coverage (SBC).
- Failure to furnish information required by the DOL.
- Repeated violations of minimum wage or overtime requirements under FLSA.
- Willful violations of the poster requirement under the FMLA or OSHA.

Action Steps for Employers

Employers should become familiar with the new penalty amounts and review their benefit plan administration, pay practices and safety protocols to ensure they are in compliance with federal requirements.

Background

The 2015 Inflation Adjustment Act (ACT) included provisions to strengthen civil monetary penalties under various federal laws in order to maintain their deterrent effect. The Act required an initial "catch-up" adjustment in 2016, and since 2017 has required the DOL and other federal agencies to adjust their civil monetary penalties annually for inflation, no later than January 15th, and to post these changes on their websites.

Matrix of Penalty Amounts

ERISA Violations Subject to Penalty	ERISA Section	2017 Penalty Amount	2018 Penalty Amount
Form 5500—failure to file.	ERISA §502(c)(2)(5500)	Up to $2,097 per day	Up to $2, 140
Form M-1—failure to file by multiple employer welfare arrangement (MEWA)	ERISA §502(c)(5)	Up to $1,527 per day	Up to $1,558 per day
Failure to furnish information requested by DOL under ERISA §104(a)(6)	ERISA 502(c)(6)	Up to $149 per day not to exceed $1,496 per request	Up to $152 per day not to exceed $1,527 per request
SBC—failure to provide Summary of Benefits Coverage.	ERISA § 715 (SBC)	Up to $1,105 per failure	Up to $1,128 per failure
CHIP—employer failure to inform employees of CHIP coverage	ERISA §502(c)(9)(A)(CHIP)	Up to $112 per day	Up to $114 per day
GINA—failure by any group health plan sponsor, or any health insurance issuer, to meet the requirements with respect to genetic information.	ERISA 502(c)(10)(B) (1)(GINA)	$112 per day during non-compliance period	$114 per day during non-compliance period
FMLA—willful failure to post FMLA general notice.	FMLA	Up to $166 per violation	Up to $169 per violation
FLSA—repeated or willful violations of overtime or minimum wage requirements.	FLSA	Up to $1,925 per violation	Up to $1,964 per violations
OSHA—violation of posting requirements	OSHA	Up to $12,675 per violation	Up to $12,934 per violation

Are Voluntary Benefits To Be Reported in the Form 5500 Report?

The answer no doubt will frustrate you...*Maybe*. Some voluntary benefits are to be reported and others are not. For example:

- ABC Company offers an Aflac Critical Illness benefit and is to be reported in the Form 5 500 (even though the participant pays 100% of the premium).

In contrast:

- Smith Company permitted Aflac to publicize to its employees a Critical Illness benefit. This benefit is also 100% paid by the employee. However, the critical illness benefit for Smith Co. is not to be part of the benefit plan nor is it reported in the 5500.

How can the same benefit through Aflac be treated differently?

The key to knowing if the voluntary benefit should be reported within a Form 5500 all depends on if the Plan Sponsor ***endorses*** the benefit policy. To endorse does not mean to simply pay a portion or full amount of a benefit's premium. This would make the decision to include or not include too easy. Endorsing by the Plan Sponsor can be done in a number of different ways, some so subtle that often the Plan Sponsor endorses inadvertently.

Here is the general list of nine forms of endorsing which could position the voluntary benefit to be an ERISA Voluntary benefit.

1. Selecting an Insurer
2. Negotiating the terms and linking coverage to Employee Status
3. Using Employer's name/Associating policy with other Employer's policies (i.e. OE material)
4. Recommending policy
5. Including the benefit within its Wrap Plan Document and SPD
6. Saying ERISA applies
7. Conducting more than permitted payroll deductions
8. Allowing Employees to pay premium through ER's Cafeteria Plan on a pre-tax basis
9. Assisting employees with claims and disputes

Another way to look at endorsing...by "not endorsing" also known as reaching Safe Harbor. According to the DOL, the employer's neutrality is the key to the Safe Harbor.

Per the DOL: *An endorsement within the meaning of section 2510.3-1(j)(3) occurs if the employee organization urges or encourages member participation in the program or engages in activities that would lead a member reasonably to conclude that the program is part of a benefit arrangement established or maintained by the employee organization."*

To add more spice to the scenario, there are two other factors to consider:

First, some benefits regardless of being endorsed or not, are not to be reported on a 5500 since they are never to be under ERISA. Some of these are:

- Section 132—Commuting Benefits
- State of NY, NJ, CA, RI and HI plus Puerto Rico mandated temporary disability insurance—partial wage replacement for workers who are unable to work due to non-work related injuries or illnesses, including pregnancy.
- Benefits provided outside the US for non-resident aliens
- Workers Compensation (with an exception for the State of Texas Worker Injury Benefit)
- Health Saving Account—HSA (generally no)

Second, if the benefit is simply listed in the Wrap Plan Document and SPD, the benefit would very likely need to be listed in the Form 5500. After all, the Wrap Plan Document and SPD are establishing the benefits of the ERISA Plan.

Overall, to determine endorsing is not easy; to make the decision is a difficult one due to many aspects in grey. Some may feel the need to take the conservative road and include the benefit in the Form 5500. This should only be done with careful consideration. To include within the Form 5500 subjects the benefit to all of ERISA such as COBRA. When there is uncertainty, the best approach is to ask an ERISA attorney to review and offer advice.

Source: Wrangle

The key to knowing if the voluntary benefit should be reported within a Form 5500 all depends on..."

Employers' Opt-out Healthcare Arrangements May Run Afoul of the IRS

"This percentage is set at 9.5 percent, but it is adjusted annually for the per capita growth in insurance premiums..."

Under the Affordable Care Act's (ACA) Employer Shared Responsibility provisions—also known as the "employer mandate" or "pay or play provision" - applicable large employers (ALEs) with 50 or more full time employees (working an average of 30 hours or more) risk significant penalties if they don't make affordable health coverage available to their employees. Under these provisions, employers must either offer minimum essential coverage that is "affordable" and provides "minimum value" to full time employees, or potentially pays an employer shared responsibility payment to the IRS. These provisions penalize employers who either do not offer coverage or do not offer coverage which meets minimum value and affordability standards.

Some employers may choose to offer their employees "opt-out payments" or "cash in lieu of benefits", which are essentially cash incentives to waiver employer-provided medical coverage. These opt-out arrangements are generally permissible under ACA but come with limitations. A key under ACA is to offer employees health care that is affordable, but, when an employee declines the opt-out payment, how do you calculate "affordable"?

'Affordability'

To avoid penalties under ACA, ALEs must offer affordable, minimum value health coverage to substantially all of their full-time employees.

This percentage is set at **9.5 percent**, but is adjusted annually for the per capita growth in insurance premiums in the individual market. For 2017, it was 9.69 percent, but will decline to **9.56 percent in 2018**.

The three affordability "safe-harbors" are in place because employers are not likely to know the household income of their employees, and may be unable to accurately determine what is "affordable". Under these safe harbors, employers are generally allowed to use an employee's W-2 wages, rate of pay, or the federal poverty line, instead of household income in making the affordability determination.

Regardless of the calculation method used, the problem many employers face is they forget they might have to include the value of the cash incentive offered to the employee when making an affordability calculation. Whether an opt-out payment will need to be included when calculating affordability depends on whether the payment is made under a conditional or an unconditional opt-out arrangement.

'Conditional versus 'unconditional'

In Notice 2015-87, 2015-52 I.R.B. 889, the IRS discussed the impact employer opt-out payments have on affordability calculations. The Notice discusses two distinct opt-out payments: conditional and unconditional. Conditional opt-out payments are those which require the employee to provide substantiation of other coverage, such as a spouse's family coverage, in order to receive the payment. Unconditional opt-out payments have no such requirement.

According to the Notice, ALEs are not required to include in their affordability calculations the value of unconditional opt-out arrangements adopted on or before Dec. 16, 2015, or conditional opt-out arrangements, regardless of their date of adoption. The IRS has been pushing for a change in this regard, however.

On July 8, 2016, the IRS issued proposed regulations which would require employers to include nearly all opt-out arrangements in their affordability calculations. Under the proposed regulations, ALEs would have to include cash offered to the employee under all unconditional opt-out arrangements, regardless of when the arrangement was adopted, and under conditional opt-out arrangements which are not deemed "eligible". That's a 180-degree turn from where the IRS stood when it issued Notice 2015-87. For now, these changes are on hold. On Dec. 29, 2016, the IRS published its Final Rule, which finalized many provisions in the July 2016 proposed regulations, but not those revising the rule on opt-out arrangements.

The IRS has said it is still examining issues related to opt-out payments and their impact on affordability. It plans to finalize those pro-

Employers' Opt-out Healthcare Arrangements May Run Afoul of the IRS

posed regulations in the future. No word yet on when the future will come.

'Eligible' opt-out arrangements

If the IRS proceeds with enforcing the proposed regulations concerning opt-out arrangements, all payments offered under opt-out arrangements will count as employee contributions when calculating affordability, unless the arrangement is a conditional opt-out arrangement that meets certain eligibility criteria. To be an "eligible" opt-out arrangement under the proposed regulations:

- The employee's right to receive an opt-out payment must be conditioned on the employee providing reasonable evidence that the employee and the employee's family have or will have minimum essential coverage (other than coverage in the individual market) during the period of coverage to which the opt-out arrangement applies.
- "Reasonable evidence" may include the employee's attestation, and must be provided at least annually, but no earlier than a reasonable period of time before the commencement of the period of coverage to which the opt-out arrangement applies. The reasonable evidence may be obtained during the regular open enrollment period that occurs within a few months before the commencement of the period of coverage without being deemed too early.
- The arrangement must provide the employer will not make opt-out payments if the employer knows or has reason to know the employee or family member does not or will not have minimum essential coverage.

How to calculate affordability

ALEs should review their opt-out arrangements to confirm they meet the eligible exception from the ACA affordability calculation. At least for now, if an arrangement is conditional upon the employee providing some form of substantiation of other coverage, the value of that payment is not included as a contribution when calculating affordability. If the arrangement is unconditional, and was adopted after Dec. 16, 2015, then the value of that payment is included as a contribution by the employee.

For example, an ALE offers its employees coverage that requires employees to contribute $3,000 for self-only coverage, but offers the same employees a $1,000 incentive if they decline to enroll. An employee does not have to provide substantiation of other coverage. For purposes of calculating affordability, an employee's contribution amount would be $4,000. Since this is an unconditional arrangement and an employee who elects coverage is giving up the additional cash compensation, the $1,000 opt-out payment increases the employee's required contribution for affordability purposes regardless of whether the employee enrolls in the plan, or declines to enroll and is paid the opt-out payment. If the same arrangement was made conditional upon proof of other coverage, or if it predated Dec. 16, 2015, it would not be included.

The problem is many ALE's do not realize the importance of including their unconditional opt-out arrangements in their affordability calculations, resulting in miscalculations.

Repercussions for employers

ALEs that offer an opt-out payment to their employees should make a careful determination into what type of arrangement is being offered. If the arrangement is unconditional and adopted after Dec. 16, 2015, the ALE must include the opt-out payment as an additional contribution when calculating affordability.

Improperly calculating affordability can subject employers to steep penalties. Employers who offer coverage that provides minimum essential coverage but is not affordable are subject to a monthly penalty which for 2017 was the lesser of $3,390 divided by 12 per full-time employee receiving a premium tax credit, or, $2,260 divided by 12 per every full-time employee minus the first 30 employees (which is the penalty if no coverage at all is provided). These amounts are adjusted annually for inflation. The numbers for 2018 are $3,480 and $2,320, respectively.

Employers should be mindful that this rule exists, and should keep an eye out for any new rules promulgated by the IRS.

Source: Benefits Pro

"The problem is many ALEs do not realize the importance of including their unconditional opt-out arrangements in..."

Ask the Expert!

Question: How do we record a gender-neutral employee for EEO-1 reporting?

Answer: Until the Equal Employment Opportunity Commission (EEOC) addresses another gender or "nonbinary" option, employers are required to report all employees as either male or female, even when an employee chooses not to identify as one of the two genders.

EEO-1 reporting for calendar year 2017 must be filed by March 31, 2018, and must include information on each employee's race, gender, and job category. In general, companies that must report EEO-1 data are those that are:

- Subject to Title VII of the Civil Rights Act of 1964, as amended with 100 or more employees; or
- Subject to Title VII of the Civil Rights Act of 1964, as amended, with fewer than 100 employee if the company is owned by or affiliated with another company and the entire enterprise employs a total of 100 or more employees; or
- Federal government prime contractors or first–tier subcontractors subject to Executive Order 11246, as amended, with 50 or more employees and a prime contract or first-tier subcontract amounting to $50,000 or more.

Self-identification is the preferred method of identifying the gender information necessary for the EEO-1 report, and employees should be reported as the sex with which they identify. If the employee declines to self-identify, employers may reasonably use other available employment records or observations to determine the most appropriate sex determination. However, the situation remains that the only choices on the EEO-1 are male or female.

Disclosure to CMS Form Deadline

Group health plan sponsors that provide prescription drug coverage to individuals eligible for Medicare Part D must disclose to the Centers for Medicare & Medicaid Services (CMS) whether that coverage is "creditable" or "noncreditable." The disclosure obligation applies to all plan sponsors that provide prescription drug coverage, even those that do not offer prescription drug coverage to retirees. A plan sponsor must submit a new disclosure to CMS no later than 60 days after the beginning of each plan year — i.e., by **March 2, 2018** for calendar year plans.

Click here to access the CMS website.

Forms 1094-B, 1095-B, 1094-C and 1095-C Filing Deadline

If you are an applicable large employer (ALE), file paper Forms 1094--C, *Transmittal of Employer -Provided Health Insurance Offer and Coverage Information Returns*, and 1095--C, *Employer-Provided Health Insurance Offer and Coverage* with the IRS. For all other providers of minimum essential coverage, file paper Forms 1094--B, *Transmittal of Health Coverage Information Returns*, and 1095--B, *Health Coverage* with the IRS. **Note:** Paper filing is only available to employers with fewer than 250 information returns. The due date for electronic filers is March 31, 2018. See the Instructions for Forms 1094--B and 1095--B and the Instructions for Forms 1094--C and 1095--C for details about the information reporting requirements.

Click here to access the IRS website

The 2018 W-4 Is Here

The new W-4 Form was just released! If the employee provides a new Form W-4 claiming or changing exemptions from withholding on March 1 or later, you may apply it to future wages but don't refund any taxes withheld while the exempt status wasn't in place. Click here to access the 2018 W-4.

Breakfast Meeting

REFERENCE-BASED PRICING

Join us to learn how Mount Carmel Health System and Custom Design Benefits can introduce you to innovative ways to reduce your health care trend. TrueCost, a nationally recognized copay-only plan design ensures a fair, consistent and transparent reimbursement model that will completely change the way you approach your benefit strategy.

TrueCost partners with Mount Carmel's customizable wellness solutions at the worksite to help employers identify health, wellness and safety trends in their workforce and can help self-funded employers reduce costs while employees achieve optimal health.

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9:00-11:00 A.M.
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1500 POLARIS BLVD.
COLUMBUS, OHIO 43240
REGISTRATION BEGINS AT 8:30

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