2018 Year-end Review & Reminders

Similar to last year, 2018 was a relatively quiet year. On the legislative front, only one piece of legislation has a significant impact on employers sponsoring health plans; most of the developments in 2018 have been regulatory. One federal court ruling in 2018 may affect some employer sponsored wellness programs. In this Technical Bulletin we summarize significant developments for the first ten months of 2018, provide some reminders for 2018, and then take a look at what's anticipated for 2019. As always, we include action steps and provide links to additional resources.

What Happened in 2018?

In January 2018, Congress passed a short-term spending bill that included three provisions that may affect employers sponsoring health plans: (1) the "Cadillac Plan" tax is delayed for another two years and is not scheduled to take effect until 2022; (2) the health insurer fee is suspended for 2019; and (3) the medical device tax is delayed until 2020. The delay of the "Cadillac Plan" tax and the medical device tax may directly impact some employers. The suspension of the health insurer fee may impact employers with insured health plans.

On the regulatory front, the Departments of Labor ("DOL") and Health and Human Services ("HHS") and the Internal Revenue Service ("IRS") provided additional guidance with respect to requirements under the Patient Protection and Affordable Care Act ("PPACA"), the Mental Health Parity and Addiction Equity Act ("MHPAEA"), and National Medical Support Notices ("NMSNs"). The IRS provided guidance on Health Savings Accounts ("HSAs") and coverage of male contraceptives as preventive care.

In December 2017, the District of Columbia District Court issued a ruling that vacates the maximum 30% incentive provision from the Equal Employment Opportunity Commission's ("EEOC's") May 2016 final wellness regulations under the Americans with Disabilities Act ("ADA") and the Genetic Information Nondiscrimination Act ("GINA").

PPACA DEVELOPMENTS

Although there was no legislation affecting PPACA in the first 10 months of 2018, regulators continued to provide additional guidance that may affect some employers. The good news is the regulatory guidance primarily provided clarification rather than adding new rules or making major changes to existing rules. Following is a short summary of the regulatory guidance that may affect many employer-sponsored health and welfare plans.

Section 6055 and 6056 Reporting Requirement

In order to administer the Employer Shared Responsibility ("ESR") Mandate and the Individual Shared Responsibility Mandate, the IRS needs information about the medical coverage that individuals are actually enrolled in and about offers of medical coverage made by employers to full-time employees. Under Section 6055, insurers (and employers with self-insured medical plans that are not Applicable Large Employers ("ALEs") are required to report on individuals enrolled in medical coverage. An ALE is generally an

employer with 50 or more full-time and full-time equivalent employees. The information must be reported for individuals covered by a medical plan on a monthly basis for the entire calendar year. Employers that are not ALEs that provide self-insured coverage must report on that coverage using Forms 1095-B.

Although the individual mandate was not technically repealed, the Tax Cuts and Jobs Act reduced the penalty to $0 beginning in 2019. As a result, the IRS will not need coverage information for the purpose of assessing penalties against individuals for failure to maintain minimum essential coverage after 2018, which has caused employers to wonder whether Section 6055 reporting will be required for 2019 and later years. Although the information on coverage will not be needed to assess individual penalties, the regulators may be able to use the information provided for other purposes. For example, information about coverage may be useful in administering premium tax credits for individuals who purchase Marketplace medical insurance. Individuals who are enrolled in Minimum Essential Coverage ("MEC") - even if the coverage is not affordable or does not provide minimum value - are not eligible for a premium tax credit. Section 6055 reporting provides the IRS with information about individuals who are enrolled in MEC. In addition, although the penalty was reduced to $0 beginning in 2019, there is always the possibility that Congress will pass a law that reinstates a penalty. The data capture and reporting mechanisms for MEC tracking are already in place; the regulators may believe that it would be easier to leave them in place rather than stop the Section 6055 reporting process only to find that it must be re-started at a future date. We will need to wait and see what the IRS does (or does not do).

Under Internal Revenue Code Section 6056, ALEs are required to report to the IRS on coverage offered to their full-time employees. ALEs with self-insured medical plans are also required to report on individuals enrolled in coverage under their medical plans. This information must be reported on a monthly basis for the entire calendar year using Forms 1095-C. Employers reporting on offers of coverage to full-time employees must use Forms 1095-C, which shows offers of coverage to full-time employees, and Form 1094-C, which is a transmittal form that must accompany Forms 1095-C when submitted to the IRS. ALEs with self-insured medical plans are required to report both offers of coverage under Section 6056 for each full-time employee and actual coverage under 6055 for individuals enrolled in MEC using Forms 1095-C. In addition to full-time employees and their spouses and dependent children, ALEs with self-insured medical plans may be reporting on actual coverage for individuals who are not full-time employees (to the extent they are covered) such as part-time employees, retirees, and COBRA qualified beneficiaries.

The final 2018 forms and instructions for 6055/6056 reporting are available. The good news is that there has been no significant change in the forms or instructions from last year. Employers should be prepared to file 2018 calendar year reports with the IRS by February 28, 2019 – or April 1, 2019 if filing electronically. (Electronic filing is normally due on March 31, but will be due on April 1 in 2019 because March 31 is a Sunday.) Statements about offers of coverage and actual coverage must be provided to individuals by January 31, 2019. Statements may be provided electronically to participants and covered individuals as long as the IRS consent rules are followed. The IRS is not providing an automatic extension this year as in prior years.

The IRS previously issued guidance on the steps employers must take to obtain Tax Identification Numbers ("TINs") for individuals that it must include on Form 1095-B or 1095-C. For individuals, the TIN is the individual's Social Security Number. Employers will virtually always have the employee's Social Security

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Number, but may need to obtain Social Security Numbers for covered spouses and dependents. An employer must make at least three attempts to obtain this information. Our August 2016 Healthcare Reform Update newsletter article *"IRS Proposes Changes to Section 6055 Reporting for Soliciting TINs, Catastrophic Coverage, and Other Issues"* provides more information (click here for a copy.)

Employers that file 250 or more Forms 1095 are required to file those forms electronically. The IRS had proposed changing the method of determining the 250-form threshold by aggregating different types of forms, but as of November 15 has not finalized that proposal. Because the final Forms and Instructions for 2018 have already been released, it appears unlikely that they will make this change for 2018, but they may do so in the future.

More detailed information is available in our Section 6055 and 6056 Toolkit – click here

ESR Mandate Penalty Process

In late October 2017, the IRS issued guidance on the ESR Mandate penalty process in the form of four questions and answers (Q&As 55 through 58) that are available on the IRS website (click here to access). The guidance explains the process for penalty determination, payment and appeal. The IRS has also begun sending penalty assessment letters to ALEs for 2015 and 2016. The IRS first sends Letter 226J, which contains a preliminary calculation of an ESR penalty and describes the penalty assessment process. The mailing also includes Form 14764 "ESRP Response" and Form 14765, which lists the ALE's full-time employees who qualified for a premium tax credit for at least one month. Letter 226J also includes contact information for a specific IRS employee and a description of the steps the IRS will take if the ALE does not respond by the date shown in the letter. Once the ALE responds to Letter 226J, the IRS will acknowledge the response by sending one of five versions of Letter 227, which advises the ALE of the IRS's agreement or disagreement with the ALE's response to the original penalty letter and dictates the ALE's options for next steps. If a penalty is being assessed the IRS will ultimately issue Notice CP220J, which is a demand for payment.

The IRS has also begun sending Letters 5699 and 5698 to employers that it believes are ALEs but from whom the IRS has not received Forms 1095 for 2016. Letter 5699 describes which employers must file Forms 1095 and notes which employers must file electronically. It includes a section with check boxes that the employer must use to respond. The check boxes represent five choices which are: (1) the employer is an ALE and has already filed; (2) the employer is an ALE and Forms 1095 are attached (an employer may not check this box if electronic filing is required), (3) the employer is an ALE and will file by a date specified in the employer's response, (4) the employer is not an ALE, or (5) "Other" with an explanation. The letter gives the employer 30 days from the date of the letter to respond. Contact information and the date of the letter are contained in the upper right corner on the first page of the letter. Some employers have also received Letter 5698, which is a follow-up to Letter 5699 and informs the employer that the IRS had previously sent a Letter 5699, but did not receive a response. Letter 5698 instructs the employer to check the appropriate box in Letter 5699 which is attached to Letter 5698 and return it to the IRS within 30 days of the date of the letter.

Other PPACA Developments

Additional regulatory guidance on current market rules issued in 2018 includes a new model Marketplace notice; revisions to the requirements for insurer rate reviews and medical loss ratio requirements; a scaling back of some of the functionality in federally-facilitated SHOP marketplaces; changes intended to give states more flexibility in selecting an essential health benefits benchmark plan beginning in 2020, and final rules on coverage of contraceptives for non-grandfathered plans. New guidance was issued in response to a presidential Executive Order intended to expand types of coverage available. This new guidance focuses on three potential areas for expansion: (1) association health plans (2) short-term limited duration insurance and (3) health reimbursement arrangements.

Updated Marketplace Notice

All employers subject to the Fair Labor Standards Act are required to provide a PPACA Marketplace notice to every new employee within 14 days of the employee's hire date. The notice provides general information about the existence of the public Marketplace, the possibility that the individual may qualify for a subsidy for medical insurance purchased in the Marketplace, and, if the employer offers a medical plan, some basic information about that medical plan. The notice must be provided to all employees – not just full-time or full-time and regular part-time employees. In addition, it must be provided by employers that do not offer any medical plan at all. The Department of Labor provided a revised Marketplace notice in September 2018.

Health Insurance Rate Review and Medical Loss Ratio Requirements

PPACA requires health insurers to submit a justification for what the regulators deem to be an "unreasonable" premium increase to HHS and any applicable state entity. The rule applies to non-grandfathered individual and small group health insurance contracts subject to PPACA – generally major medical. The threshold that was used in the past was an increase of 10% or more. In April HHS increased the federal threshold from 10% to 15% for rate filings beginning in 2019.

HHS's April 2018 guidance also made changes to the Medical Loss Ratio rules that have the effect of relaxing the Medical Loss Ratio standards and permitting health insurers to spend more on administrative costs. Under the Medical Loss Ratio insurers that spend more than 20% on administrative costs (15% in the large group market) are required to pay rebates to insureds.

Essential Health Benefits

Non-grandfathered health insurance in the individual and small group markets is required to cover 10 categories of benefits specified under PPACA – called Essential Health Benefits ("EHBs"). States define the scope of coverage in each of the 10 categories by selecting a benchmark plan. States are also permitted to require categories of EHBs in addition to the 10 required by PPACA.

HHS's April 2018 guidance made changes intended to give states greater flexibility in selecting a benchmark plan. Under this guidance, a state may select a benchmark plan on an annual basis and beginning in 2020 may decide to:

- Keep their 2017 benchmark plan;

- Select the 2017 benchmark plan of another state;
- Replace one or more 2017 EHB categories of benefits with the same 2017 benefits from another state's EHB benchmark plan; or
- Select a new benchmark plan.

SHOP Marketplace

In 2018, HHS made a number of changes to the SHOP Marketplace rules for Federally Facilitated Exchanges and states that use the federal platform. Major changes include the elimination of online enrollment for SHOP coverage and SHOP performance of certain functions such as employee eligibility, enrollment and premium aggregation services. Employers that want to purchase SHOP coverage must work directly with the insurer or a SHOP-registered agent or broker. The SHOP will continue to certify plans for sale through the SHOP and will continue to provide information about Qualified Health Plans on the federal website (Healthcare.gov). The federal website will also include a premium calculator that provides estimated premiums, but will not have any information about employer contributions. Small employers will still need to obtain an eligibility determination to purchase SHOP coverage. Small employers that are eligible and want to claim the small employer health insurance tax credit must purchase coverage through a SHOP.

States that do not use the federal platform are permitted to offer services such as online enrollment and aggregated billing for employers.

Final Rules on Coverage of Contraceptives

On November 7, the Departments of Health and Human Services, Labor, and Treasury (the "Tri-Agencies") released guidance in the form of final rules addressing the contraceptive mandate under PPACA. One set of rules provides for expanded exemptions and accommodations to the contraceptive mandate based upon sincerely held religious beliefs, and the other set provides for a new exemption and accommodation process based upon moral conviction. The Tri-Agencies previously issued rules in the form of interim final regulations, intended to be effective on October 6, 2017. However, a nationwide injunction was issued, primarily focused on a lack of note and comment period, blocking implementation of the interim rules. Since that time, the Tri-Agencies received over 100,000 comments on the interim rules. The final rules are substantially unchanged from the interim rules and are effective 60 days after November 13, 2018 (the date published in the Federal Register), but litigation may continue to impact implementation.

Association Health Plans

In response to an Executive Order, the DOL issued a final regulation in June 2018 addressing association health plans ("AHPs"). AHPs are designed to allow small employers to pool together to purchase health coverage. The final regulation changes the definition of "employer" under ERISA to permit a "bona fide group or association of employers" to establish a group health plan if certain requirements are met. The final regulation requires an association to have at least one substantial purpose other than the offering of health coverage to member employers; requires that the association be controlled by the employer members; permits only employees, former employees, and working owners (and their family members) to be eligible for AHP coverage; and requires employer members to have a "commonality of interest."

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Commonality of interest may be employer members that are either in the same trade, industry, line of business or profession or that share a principal place of business in a common geographic area that does not exceed the boundaries of the same state or metropolitan area – such as the Greater New York City area, which covers portions of New York, New Jersey, and Connecticut.

Specific rules that prohibit discrimination based on a health factor and other federal laws such as ERISA and PPACA also apply to AHPs. Finally, because all AHPs are multiple employer welfare arrangements – or MEWAs - states have the authority to regulate health coverage that they offer. The amount and type of state regulation varies depending on the state and whether the coverage is insured or self-insured.

The effective date of the new regulation is September 1, 2018 for fully insured plans, January 1, 2019 for self-insured plans that were in existence when the regulation was issued and that already complied with the previous requirements for multiple employer welfare arrangements, and April 1, 2019 for new self-insured health plans.

Short-Term Limited Duration Insurance

Also in response to an Executive Order, the Departments of HHS, Labor, and Treasury issued final regulations that significantly change the requirements for short-term limited duration health insurance. Originally, these contracts were intended to bridge gaps in coverage for individuals such as those with no coverage between jobs, or for employees who had not yet satisfied a coverage waiting period. The original requirement was that the coverage period be less than 12 months. This 12-month time frame was reduced to three months in October 2016. The final regulations issued in August 2018 revert to the original requirement of a coverage period of less than 12 months, but also permit renewals or extensions for a maximum duration of no longer than 36 months in total. The final requirements also include specific language that must be included in a required notice.

It is important to note that short-term limited duration insurance is not defined as individual or group health insurance under PPACA, and as a result is not required to comply with a number of PPACA"s insurance market requirements. For example, these plans may use pre-existing condition limitations, include annual or lifetime dollar limits on essential health benefits, may use medical underwriting, and are not required to cover all 10 essential health benefits.

Health Reimbursement Arrangements

In late October 2018, the DOL, HHS, and IRS released proposed regulations for Health Reimbursement Arrangements ("HRAs"). These regulations, if finalized, would make major changes in the rules applicable to HRAs. One of the changes would be to permit integration with individual health insurance, subject to certain requirements. A second change would be to modify the rules to permit a new "supplemental" benefit HRA that would be an excepted benefit HRA with an annual limit of $1,800 – also with specific rules to be followed. There is a comment period for these proposed regulations that ends on December 28, 2018. These are only **proposed** regulations; the guidance specifically states that these rules may not be relied upon. Given the scope of the proposed changes, the likelihood of the agencies receiving many comments, and recent election results, there is no way to predict what will happen. The final rules may be very different

from what has been proposed; alternatively, the regulators may not issue final regulations, which would leave the current rules in place.

PPACA Dollar Values for 2018

PPACA includes a number of dollar values that are indexed each year. In addition to the change in the maximum out-of-pocket levels for non-grandfathered medical plans, there are two important areas where dollar values change each year – the ESR Mandate and PCORI fee applicable to group health plans.

Out-of-Pocket Maximums

Under PPACA, non-grandfathered medical plans may not have a maximum out-of-pocket amount that exceeds a specified level. For 2018 plan and policy years, the maximum out-of-pocket levels are $7,350 for self-only coverage and $14,700 for other than self-only coverage. PPACA also prohibits non-grandfathered medical plans from using an out-of-pocket maximum for any one person that exceeds the individual out-of-pocket maximum under other than self-only coverage. For example, if a family plan covering four individuals has a $12,000 family out-of-pocket maximum and one of the family members has $10,000 in claims, the plan must limit the out-of-pocket maximum for that family member to $7,350 in 2018 even though the family out-of-pocket limit has not been reached.

Employer Shared Responsibility Mandate

Under the ESR Mandate, an ALE must offer minimum essential coverage to its full-time employees or face a potential penalty. There are two potential penalties under the ESR Mandate – the headcount penalty and the individualized penalty. The headcount penalty applies if the employer does not offer MEC to at least 95% of its full-time employees, and to dependent children of the employee (there are no penalties associated with failing to offer coverage to spouses).

The individualized penalty applies if the employer offers MEC to a sufficient number of full-time employees, but the coverage offered to the employee either doesn't provide "minimum value," or is not affordable as defined by PPACA. For the purpose of the individualized penalty, the coverage offered to dependent children is not required to provide minimum value or be affordable. In order to be minimum value, the plan must be designed to reimburse at least 60% of covered expenses and must include significant coverage for inpatient hospital and physician services. "Affordable" is generally defined as requiring an employee contribution for self-only coverage that does not exceed 9.56% of the employee's household income for 2018. The 9.56% value for affordability for 2018 is significantly lower than the 9.69% for 2017. As a result, employers needed to review employee contribution levels carefully before the beginning of the 2018 plan year to prevent inadvertently triggering an ESR penalty for failure to offer "affordable coverage" based on the lower threshold for "affordable" for 2018.The affordability percentage is indexed each year.

The dollar amount of both the headcount and individualized penalties are indexed each year based on a formula included in PPACA. The original 2014 penalty amounts were $2,000 for the headcount penalty and $3,000 for the individualized penalty. The corresponding amounts for 2018 are $2,320 and $3,480.

More information about the ESR mandate is available in our ESR Toolkit – click here.

PCORI Fee

Insurers and self-insured health plans are required to pay the Patient-Centered Outcomes Research Institute ("PCORI") fee. The PCORI Fee is due by July 31 each year. The fee applies to all health plans that are not HIPAA excepted benefits. The insurer must pay the fee for insured plans; the plan sponsor must make payment for self-insured plans. The fee is based on the number of covered lives. For plan years that end on or after October 1, 2017 and before October 1, 2018 the fee is $2.39 per covered life.

More detailed information is available in our Healthcare Reform Fees Toolkit – click here

WELLNESS PROGRAM COURT DECISION UPDATE

In May 2016, the EEOC released final ADA and GINA regulations, which became effective on January 1, 2017. However, the EEOC's final regulations were challenged in court in the fall of 2016 and a federal district court issued a ruling in August 2017. In that ruling, the District of Columbia District Court stated that the maximum incentive provision contained in the EEOC's final regulations was "arbitrary and capricious," and that the EEOC did not adequately explain why it chose to issue a rule that a plan could have an incentive up to 30% and still be considered voluntary. Prior to its 2016 final regulations, the EEOC had ostensibly taken the position that any incentive made the plan involuntary. In December 2017, the court issued an order vacating the EEOC's 30% rule beginning January 1, 2019. The EEOC has indicated that it does not expect to provide additional guidance until June 2019 at the earliest. Unfortunately, with no clear guidance from the EEOC, it may be difficult for employers to design a wellness program that the employer can be assured will survive a court challenge. Some employers are considering eliminating incentives that relate to ADA or GINA requirements (i.e. incentives involving a medical exam, disability related inquiry or request made related to genetic information) until more guidance becomes available. Other employers are considering reduced incentives. Until guidance is provided employers will need to be prepared to justify the level of their incentives if challenged in court. Although the maximum incentive provision is vacated effective January 2019, all other provisions of the EEOC's final regulation remain in effect, as do all the rules for health-contingent wellness programs under HIPAA (as amended by PPACA).

OTHER DEVELOPMENTS IN 2018

There were several other important benefits-related developments in 2018. In January 2018, the DOL issued indexed dollar values for certain penalties for 2018; in October 2018, HHS issued indexed dollar values for certain penalties. In April 2018, the DOL, HHS, and IRS provided additional guidance under MHPAEA; HHS provided guidance on NMSNs; and the IRS provided transition relief for HSAs related to HSA-qualified High Deductible Health Plans that cover male contraceptives pursuant to state insurance law.

Increased Penalties for 2018

In January 2018, the DOL published inflation-adjusted ERISA penalties, such as penalties for failing to provide certain documents to the DOL upon request, GINA violations, failure to provide the Summary of Benefits and Coverage, and failure to provide the annual CHIP notice to participants. In October 2018, CMS provided inflation adjusted penalties for violations of HIPAA's privacy, security, and breach notification

requirements, Medicare Secondary Payer violations and failure to provide a Summary of Benefits and Coverage as required (for insurers and self-insured nonfederal governmental plans).

MHPAEA Guidance

The 21st Century Cures Act directed federal regulators to create program materials that would enhance medical plan compliance with Mental Health Parity and Addiction Equity Act, or MHPAEA. The law specified that materials should include illustrative examples and provide recommendations for internal controls. In June 2017, federal regulators issued FAQ#38, which included a model draft disclosure form that participants (or their family members) could use to request information from their health plan or insurer regarding non-quantitative treatment limits that may affect their mental health or substance use disorder benefits under the plan. The model was revised in April 2018; however, as of November 15 it is still in draft form.

In April 2018, the DOL, HHS, and IRS issued additional guidance in the form of MHPAEA FAQs. The DOL also provided a self-compliance toolkit and a fact sheet on enforcement for 2017. HHS provided an Action Plan for Enhanced Enforcement. Mental Health Parity compliance continues to be a major focus for the federal regulators.

National Medical Support Notice Guidance

In December 2017, HHS posted 19 questions and answers about Medical Child Support Notices ("NMSN"). The NMSN is a standard notice used by state child support agencies to obtain coverage for children in response to a child support order. A properly completed NMSN is a Qualified Medical Child Support Order that employers and plan administrators are required to follow.

HSA Transition Relief for Plans Covering Male Contraceptives as Preventive Care

In early March 2018, the IRS issued a Notice providing guidance for plans that include benefits for male sterilization or male contraceptives. In that Notice the IRS reiterated that the definition of "preventive care" under an HSA-qualified high deductible health plan ("HDHP") is defined by federal regulations, not by state law. Under IRS guidance, male sterilization and contraceptives are not preventive care that may be reimbursed at 100% under a qualified HDHP. Reimbursing expenses under an HDHP before the deductible is met - other than expenses for preventive services as defined by the IRS - results in the HDHP not being qualified, so that those covered under that plan may not contribute to an HSA. However, because several states have enacted laws requiring health insurance contracts to cover male contraceptives or sterilization at 100%, the IRS is providing transition relief for individuals covered under plans in those states that require 100% coverage for male contraceptives or sterilizations until 2020.

Year-end Reminders

We do not have any new reminders this year, just a list of important reminders that apply every year. We have marked one requirement – the requirement to obtain a unique health plan identifier – "**Delayed,**" because as of November 15, 2018 it is still delayed.

Cafeteria plans – Perform year-end nondiscrimination tests for the 2018 plan year. Notify highly compensated individuals and/or key employees if they will have any additional taxable income. Once enrollment data for 2019 becomes available, employers may also want to perform preliminary nondiscrimination testing for 2019 and notify highly compensated participants and/or key employees if it appears that the plan might need to modify any 2019 elections in order to pass the actual tests at the end of the year.

Certificates of Creditable Coverage (Drug) – Provide a Certificate of Creditable Coverage to Medicare-eligible individuals. Notices are generally required when an employee becomes Medicare Part D eligible, if there is a plan design modification that changes the status of the drug plan (e.g., from creditable to non-creditable), and annually.

Creditable Coverage Notice to CMS – Plan sponsors that provide prescription drug coverage must disclose annually to the Centers for Medicare and Medicaid Services ("CMS") whether the plan's prescription drug coverage is "creditable prescription drug coverage." The disclosure must be transmitted to CMS online within 60 days after the first day of the plan year. If there is a change in the creditable coverage status of the plan (e.g., from creditable to non-creditable), or a termination of the drug plan during the year, a new notice is required within 30 days after the change or termination. Instructions on how to complete the online disclosure to CMS are posted on the CMS website.

CHIP Notice – Distribute an updated general Children's Health Insurance Program ("CHIP") notice to employees about the potential for premium assistance under a State CHIP or Medicaid program.

Domestic Partner Coverage – Employers that currently cover domestic and/or civil union partners will want to make sure that their records are updated so that imputed income for health coverage, which may apply to domestic and/or civil union partners, is calculated and reported correctly.

FSA – Unless the plan includes a carryover or grace period provision for the health FSA for the 2018 plan year, remind employees about the use-it-or-lose-it rule.

Grandfathered Status – In addition to making plan changes – such as covering required preventive care services with no cost-sharing, following ERISA claim rules, and making sure that plan design elements such as out-of-pocket maximum comply with the requirements for non-grandfathered plans – plans losing grandfathered status should remember to remove the special grandfathered plan language from plan documents and other plan materials.

Group Term Life Insurance Imputed Income – Determine the amount of imputed income for employer-provided group term employee life insurance in excess of $50,000 and the value of all dependent life insurance amounts if the employer-provided amount is more than $2,000. For discriminatory plans, the total value of all employer-provided coverage must be included in key employees' income.

Health Coverage Imputed Income – Calculate the amount of imputed income for coverage of any non-federal tax dependent covered under the employer's health care plan. This may include a domestic partner or an older child (e.g., age 28). *Note: imputed income does not apply to coverage of the employee's child*

up to the end of the calendar year in which the child attains age 26. A child is not required to be the employee's tax dependent for this exclusion to apply.

In addition, calculate the amount of imputed income for highly compensated individuals under a self-insured health plan that did not satisfy Internal Revenue Code Section 105(h) nondiscrimination rules.

HIPAA Business Associate Agreements – Make sure that all Business Associate Agreements have been updated to reflect privacy, security, and breach notification regulations.

Delayed! – HIPAA Unique Health Plan Identifier (HPID) – A health plan that is a Controlling Health Plan ("CHP") is required to obtain an HPID; a Subhealth Plan ("SHP") may obtain their own HPID or use the CHP's HPID. HPIDs must be obtained online on the CMS portal. Large plans (more than $5 million) were required to obtain an HPID by November 5, 2014. Small plans were given until November 5, 2015. The CMS news release on October 31, 2014 delayed enforcement of this requirement until further guidance is issued.

HIPAA Opt-Out Notices – Self-insured nonfederal governmental plans that chose to opt out of any of four HIPAA group health plan requirements – the Mental Health Parity and Addiction Equity Act, Women's Health and Cancer Rights Act, Newborns and Mothers Health Protection Act, or Michelle's Law – must provide an annual notice to CMS and plan participants. The notice to CMS must be provided electronically on the CMS website. Click here for the CMS website with more information.

HIPAA Privacy Notice – Provide a notice of the availability of the Notice of Privacy Practices every third year. Employers may want to provide this notice every year to eliminate the need for tracking.

Medical Plan Notices and Communications – Send the annual "Women's Health and Cancer Rights Act" notice. Provide a new Summary of Benefits and Coverage using the appropriate template. Update the SPD (or benefits booklet) and plan document as needed.

Preventive Care Services – Non-grandfathered plans should check to determine what new preventive health care services must be covered with no cost sharing in the upcoming plan year. Non-grandfathered health plans must include coverage for newly recommended procedures on the first day of the plan year that begins one year after the service is added to the required preventive services list.

Vacation/PTO – For calendar year plans, determine the number of days that will be cashed out before the end of the year.

What's Coming Next?

Following is a high level look at indexed dollar values that will become effective in 2019 and other requirements that may become effective in 2019. At the end of this section under "still to come," we briefly touch on several requirements where guidance has not been issued as of November 15, 2018, and the enforcement date is either unclear or not yet known.

- As a result of the district court's order, the EEOC will be reviewing the ADA and GINA regulations applicable to wellness programs. The timeline the EEOC provided to in its regulatory update agenda indicates that it is targeting June 2019.
- We may see additional guidance related to MHPAEA based on the requirements of the 21st Century Cures Act and continuing concern among regulators about compliance problems with respect to non-quantitative treatment limits. For example, we may see final version of the proposed draft model form for MHPAEA disclosures in 2019.
- Regulators issued proposed rules to expand Health Reimbursement Arrangements beginning in 2020. There is a comment period that ends on December 28, 2018. We may see final regulations issued sometime in 2019.
- The IRS may issue guidance covering nondiscrimination rules for non-grandfathered fully insured health plans, guidance for "Simple" cafeteria plans created by PPACA, or final regulations for cafeteria plans.
- OCR may issue additional guidance on the delayed HPID or even possibly eliminate the requirement and may provide guidance on the "minimum necessary" standard for disclosure of protected health information under HIPAA privacy, security, and breach notification rules.
- Regulators may provide guidance on the quality of care reporting requirement added by PPACA.

INDEXED DOLLAR VALUES FOR 2019

A number of dollar values will be indexed for 2019, including the parameters for high deductible health plans and HSAs, PPACA values for non-grandfathered health plans, Medicare, and dollar values for other health and welfare plans such as the maximum salary reduction amount for health FSAs and adoption assistance plans.

High Deductible Health Plans and HSAs

The IRS annually provides indexed values that apply to qualified high deductible health plans that make an individual eligible to contribute to an HSA. The minimum deductible is based on the type of coverage and will remain at $1,350 for self-only coverage and $2,700 for any other type of coverage (for example employee plus spouse or family coverage) in 2019. The out-of-pocket maximums will increase to $6,750 for self-only coverage and $13,500 for other than self-only coverage in 2019. Maximum contributions to an HSA will be $3,500 for those with self-only coverage and $7,000 for those with other than self-only coverage. Individuals who are 55 or older at the end of the calendar year have an additional $1,000 available as a catch-up contribution. The $1,000 catch-up contribution is not indexed.

PPACA Values

Under PPACA, non-grandfathered medical plans may not have a maximum out-of-pocket amount for in-network services that exceeds a specified level. For 2019 plan and policy years, the maximum out-of-pocket levels will be $7,900 for self-only coverage and $15,800 for other than self-only coverage. These

dollar values started out at the same level as the maximums for qualified high deductible health plans back in 2014, but are indexed differently so that the 2019 out-of-pocket maximums for non-grandfathered medical plans and qualified high deductible health plans are different. High deductible health plans that are non-grandfathered must comply with both requirements.

The percentage for affordability under PPACA's ESR mandate will increase from 9.56% in 2018 to 9.86% in 2019. The penalties under the employer shared responsibility mandate will increase from $2,320 to $2,500 for the headcount penalty, and from $3,480 to $3,750 for the individualized penalty.

The PCORI fee increases from $2.39 to $2.45 for plan years that end on or after October 1, 2018 and before October 1, 2019.

Medicare

HHS provided 2019 values for standard drug plans under Medicare Part D in April 2018. The Part D values for a "standard" plan are important to employers that sponsor health plans because the standard Part D values determine if the drug coverage that the employer offers is "creditable" or "noncreditable." Employers that provide drug coverage are required to provide Medicare-eligible participants with certificates that indicate whether the employer's coverage is creditable or noncreditable, and must provide that information to CMS on the CMS website. It is important to note that this requirement is not limited to plans covering active employees, it also applies to retiree plans.

Individuals with income above certain thresholds are required to pay an additional income-adjusted premium amount for Part D coverage. For example, a single individual with income greater than $85,000 but less than or equal to $107,000 will have an income-related adjustment to their monthly Part D premium of $12.40. For individuals who file a joint return the additional $12.40 will apply if their income is greater than $170,000 but less than or equal to $214,000. The amount of the adjustment will vary from $12.40 to $77.40 per month depending on income and tax filing status.

2019 indexed values for Medicare Part A and Part B were announced in October. The Medicare Part A deductible will increase to $1,364. Part A coinsurance increases to $341 per day for days 61 through 90 and $682 per day for lifetime reserve days. The coinsurance for skilled nursing facility care increases to $170.50 per day for days 21 through 100. The Part B deductible will increase to $185 and the standard Part B premium will increase to $135.50. Similar to Part D, there is a premium adjustment for Part B premiums for individuals with incomes above certain thresholds. The additional premium ranges from $189.60 to $460.50 per month depending on income and tax filing status.

The Social Security base wage for 2019, which was announced in October 2018, will increase from $128,400 to $132,900. One word of caution on using this value: in October 2018 HHS provided a value of $128,700 for 2018. However, in late November 2017, they adjusted that number downward to $128,400 for 2018.

Other Indexed Dollar Values

In early November, the IRS announced a number of indexed dollar values for 2019. Many of the values relate to individual tax values such as the standard deduction; others relate primarily to pension plans.

There are two values applicable to health and welfare plans - the compensation level used in determining highly compensated employees under cafeteria plans and the compensation level used to determine key employees for cafeteria plans and group term life insurance. In 2019, the compensation level for highly compensated employees will increase from $120,000 to $125,000 and the compensation level for key employees will increase from $175,000 to $180,000.

On November 15, in Revenue Procedure 2018-57 the IRS announced the following indexed values for 2019:

- Health FSA maximum salary reduction amount - $2,700
- Transportation Assistance programs - $265 (parking and mass transit)
- Adoption Assistance plans - $14,080
- Average annual wages for the small employer health coverage tax credit - $27,100
- QSEHRA maximum - $5,150 ($10,450 family)

Additional values such as deductible long term care premiums and values for Archer Medical Savings Accounts are also included in the IRS announcement. Click here for a chart comparing key 2018 and 2019 values. Click here to access IRS Revenue Procedure 2018-57.

STILL TO COME

There are several other requirements applicable to employer-sponsored health and welfare plans for which additional guidance is anticipated (or may be needed). Those requirements with their current status follow:

- **Nondiscrimination requirement for non-grandfathered insured health plans**: Prohibits discrimination in favor of highly compensated individuals using rules similar to those for self-insured health plans – delayed until the IRS issues guidance.

- **Quality of care reporting**: Group health plans and insurers are required to report certain information concerning coverage benefits and provider reimbursement arrangements that might affect the quality of care. The requirement applies to non-grandfathered health plans. The effective date is unclear, as no guidance has been provided to date.

- **Cafeteria plans**: Proposed regulations were issued in August 2007 and are in effect until final regulations are provided. No definite date for issuance of final regulations has been provided.

- **"SIMPLE" cafeteria plans**: Created by PPACA effective in 2010. To date no regulatory guidance has been provided.

- **Health Plan Identifier ("HPID")**: Health plans were required to obtain a unique HPID from CMS by applying on the CMS Portal. The HPID was intended to be used in HIPAA standard electronic transactions. Large plans were originally required to obtain the HPID by November 5, 2014; small health plans were given an additional year. On October 31, 2014, CMS delayed enforcement of this requirement until further notice.

There is no information currently available on when any of this guidance may be forthcoming.

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Action Steps

The “Year-end Reminders” section that begins on page 9 includes many of the action steps that employers will want to take before the end of the year. Here are some additional steps that employers may want to take:

- **Review employee contributions for 2019 to confirm that coverage will be affordable in order to avoid a PPACA penalty for failure to offer affordable coverage**. Although the percentage used to determine affordability will increase from 9.56% to 9.86% in 2019, employers will still want to review their 2019 required employee contributions to confirm that the coverage is affordable in order to avoid an ESR penalty in 2019.
- **Review your health and welfare plans.** Make sure that you have implemented any required plan changes. For non-grandfathered plans, make sure that you have updated the list of preventive services that will be covered with no cost sharing for your next plan year. Plans losing grandfathered status may need to make specific plan design changes. If your plan is losing grandfathered status, be sure to make changes to comply with requirements for non-grandfathered plans, such as covering specified preventive services with no cost sharing.
- **Report as required under Section 6056 (and 6055 if applicable) on offers of coverage and actual coverage for 2018.** Review the final Forms and Instructions for 2018. Make sure to follow the IRS rules for requesting Social Security Numbers from covered individuals. Be certain to follow IRS rules if statements will be provided electronically. The deadline for reporting to the IRS is February 28, 2019 (April 1, 2019 if filing electronically. The date is April 1 for 2019 because March 31 is a Sunday). Statements to participants are due by January 31, 2019.
- **Respond to IRS letters on a timely basis.** Report to a Letter 226J by the date shown in the letter (or ask the IRS for additional time to respond). Respond within 30 days of the date of Letter 5699 or Letter 5698. If any IRS letters received resulted from an oversight in current procedures, take corrective action as needed.
- **Review any wellness programs to ensure compliance.** Review your wellness program to ensure that it will continue to comply with HIPAA, GINA, and ADA regulations. Although the EEOC anticipates issuing additional guidance, it is not expected until at least June 2019. Employers with wellness programs subject to ADA or GINA will want to review their programs to determine what, if any, incentives will be included in their program.
- **Review your plan for MHPAEA compliance.** Review your plan to confirm that it will continue to be in compliance with MHPAEA regulations. If a final model notice for disclosures to participants becomes available, review the model to determine if you will use the model or an alternative. Coordinate roles and responsibilities for disclosure with your health insurer or third party administrator.

- **Update plan documents and materials, as needed.** Adopt formal plan amendments for any changes made to the plan. Be sure to update other documents such as the Summary Plan Description or Benefits Booklet.
- **Review and update employee communications, as needed.** Review current employee communication materials including benefits booklets, SPDs, SBCs, new hire packages, and annual enrollment materials to ensure that they are accurate and up-to-date. Some benefits may require additional communication materials or forms.
- **Review existing HIPAA privacy, security, and breach notification policies and procedures.** Become familiar with the OCR's revised audit program and protocol and determine if existing policies and procedures will meet the new standards, or if modifications will be needed.
- **Self-insured nonfederal government plans need to send/submit their HIPAA opt-out notices.** Plans that have opted out of one or more of HIPAA's portability provisions as permitted by law, will want to make sure that annual notices are sent to plan participants and that the annual notice to CMS is provided on the CMS website.

Although the "Cadillac Plan" tax has been delayed until 2022, employers with multi-year collective bargaining agreements may need to prepare for the potential impact of the "Cadillac Plan" tax before upcoming negotiations.

Additional Resources

Gallagher has a wealth of information and materials to help you as you continue to comply with federal laws and regulations affecting employer-sponsored health plans. We have a number of toolkits with helpful materials covering a single topic – such as our ESR Mandate and Section 6055 and 6056 Reporting toolkits. All of the toolkits contain either an explanatory article or whitepaper. The remaining contents of each toolkit vary based on the topic, but contents may include checklists, FAQs, sample communications, charts and timelines, worksheets, and recorded webinars. We also have many articles in our Healthcare Reform Update Newsletters, recorded Webinars, and Directions newsletters. Click here to access a seven-page summary of additional GBS resources with clickable links.

Gallagher Benefit Services, through its compliance experts and consultants, will continue to monitor legislative and regulatory changes that may impact your health and welfare benefits and will provide you with relevant updated information as it becomes available. In the interim, please contact your Gallagher Benefit Services Representative with any questions that you may have.

The intent of this analysis is to provide general information regarding the provisions of current federal laws and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.