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Compliance Digest

Compliance Bulletins Released January - March

2017 Compliance Bulletins

January

February

March

Relief for Small Employers with HRAs

Published: January 9, 2017

On December 13, 2016, President Obama signed into law the "21st Century Cures Act" which allows small employers without group medical plans to reimburse individual premiums and other medical expenses of employees under health reimbursement arrangements ("HRAs"), effective with the 2017 plan year, and provides relief from penalties to all small employers reimbursing individual premiums of employees for earlier plan years. In addition, the Cures Act provides a medical innovation package that funds medical research, accelerates cutting-edge treatments for rare diseases, and makes significant reforms to the mental health system.

The Issue

An employer cannot offer employees cash to reimburse the purchase of an individual policy, without regard to whether the employer treats the money as pre-tax or post-tax to the employee. Such arrangements are subject to the market reform provisions of the Affordable Care Act ("ACA"), including prohibition on annual limits and the requirement to provide certain preventive services without cost sharing with which it cannot comply. Such an arrangement may be subject to a $100/day excise tax per applicable employee (which is $36,500 per year, per employee). There was relief from this rule afforded to small employers that expired July 1, 2015.

An HRA must also be integrated with a group medical plan.

New Law

The Cures Act provides relief for small employers and HRAs which comply with all of the following:

1. **Employer eligibility**
   An employer must:

   - have less than 50 full-time employees (including full-time equivalent employees) in the preceding calendar year; and
   - not offer a group health plan to any of its employees.

2. Employee eligibility

The HRA must be provided to all "eligible employees." "Eligible employees" are all employees except that the following employees may be excluded:

- employees who have not completed 90 days of service;
- employees who have not attained age 25;
- part-time or seasonal employees;
- employees covered by a collective bargaining agreement; and
- employees who are nonresident aliens and receive no earned income from the employer which constitutes income from sources within the United States.

3. Consistent benefit amount

The HRA must be provided on the same terms to all eligible employees.

The employee's "permitted benefit" can vary in accordance with the variation in the price of an insurance policy in the relevant individual health insurance market based on:

- the age of the eligible employee (and, in the case of an arrangement which covers medical expenses of the eligible employee's family members, the age of such family members); or

- the number of family members of the eligible employee the medical expenses of which are covered under such arrangement.

The variation permitted under the preceding sentence shall be determined by reference to the same insurance policy with respect to all eligible employees.

4. Monthly limits

The monthly limits are as follows:

- $412.50 ($4,950 annually for someone covered by the HRA all year) in the case of an HRA that only provides for payments for the employee; and

- $833.33 ($10,000 annually for someone covered by the HRA all year) in the case of an HRA that also provides for payments or reimbursements for family members of the employee).

These amounts are subject to cost-of-living adjustments.

5. Source of contributions

Per existing HRA rules, contributions are made by employers and not employees (i.e., there are no salary reduction contributions).

6. Eligible Expenses

Expenses for medical care (as defined in Code Sec. 213(d)) incurred by the eligible employee or the eligible employee's family members, including premiums for individual policies, can be reimbursed.

7. Substantiation

The employee must provide proof of coverage in order to be reimbursed.

8. Reporting

The amount is reported by the employer on FormW-2.

9. Federal Taxation

Contributions and benefits are non-taxable for federal taxation purposes provided the individual has minimum essential coverage.

Contributions are deductible to the employer provided the individual has minimum essential coverage.

If applicable, states will need to determine the tax impact under state income tax rules.

10. Notice Requirement

Not later than 90 days before the beginning each year(or, in the case of an employee who is not eligible to participate in the arrangement at that time, the date on which such employee is first eligible), the employer must provide written notice to employees including:

- A statement of the amount of the eligible employee's permitted benefit under the HRA for the year.
- A statement that the eligible employee should provide the information described in the bullet above to any Marketplace to which the employee applies for advance payment of the premium assistance tax credit.
- A statement that if the employee is not covered under minimum essential coverage for any month the employee maybe subject to the Individual Mandate tax for such month and reimbursements under the arrangement maybe includible in gross income.

Penalty for failure to notify, unless it is shown that such failure is due to reasonable cause and not willful neglect, is $50 per employee per incident of failure up to $2,500.

Effect on Affordability

A qualified small employer HRA is treated as constituting affordable coverage for a month, thus rendering the individual ineligible for a subsidy in the Marketplace, if the excess of the amount that would be paid by the employee as the premium for such month for self-only coverage under the second lowest cost silver plan offered in the relevant individual health insurance market over 1⁄12 of the employee's permitted benefit does not exceed 1⁄12 of 9.5% of the employee's household income.

For any month that an employee is provided affordable individual health insurance coverage under a qualified arrangement, he is not eligible for a subsidy.

Effective Date

The new rules outlined above apply to plan years beginning after December 31, 2016.

In addition, transition relief that expired in 2015 has been extended so that small employers can reimburse individual premiums without penalty for plan years beginning before December 31, 2016.

Update on the Status of the ACA

Published: January 17, 2017

With the impending inauguration, recent actions by the Senate and some confusing media reports, we wanted to provide a short Q&A to help you understand current events and what to expect as we head down the health care reform road in 2017.

What's the latest news?

The Senate took action to begin the budget reconciliation process and recent comments from Republican Party leaders appear to favor a "Repeal and Replace" strategy.

Budget Resolution

The Senate (51-48) and House (227-198) both approved a concurrent resolution that directs House and Senate committees to begin working on legislation that will, among other things, repeal pieces of the ACA. This action effectively "kicks off" the budget reconciliation process which allows for the repeal of budget related portions of the ACA with a simple majority (51 votes) in the Senate. Democrats were unsuccessful in trying to amend the resolution protecting certain features of the ACA from repeal or change.

Repeal and Replace

Comments from President-elect Trump and Congressional leaders appear to favor a concurrent "Repeal and Replace" strategy, versus "Repeal and Delay." Recently House Speaker Ryan remarked that Congressional Republicans and the incoming Trump administration are "in complete sync" and that moving forward with health care reform will be done "concurrently, at the same time repeal and replace". It is widely expected that Congressional Democrats will not cooperate with or agree to repeal of the ACA without at least a replacement for the ACA.

Will there be full repeal on day one?

Unlikely. Congress is expected to make changes to the ACA through reconciliation. Reconciliation allows for expedited consideration of certain tax, spending, and debt limit legislation. Such action may affect provisions in the ACA related to the tax code, such as the taxes, subsidies, and individual and employer mandates penalties. It does not allow a complete repeal of the entire ACA.

Repeal of provisions such as mandated benefits (e.g., prohibitions against preexisting condition exclusions) would require 60 votes in the Senate and there are 52 Republicans in the Senate. The Exchanges couldn't be dismantled immediately from a practical perspective.

Remember that non-ACA related laws such as HIPAA, ERISA, and the new wellness rules would all still stand

What's the process and how long will it take?

The appropriate committees will begin drafting legislation, like any other bill in Congress. Once approved by committees, the bill must be passed by the House. Once through the House, the bill will then be sent to the Senate where it could be amended. If the bill is amended, then it goes through a conference committee to resolve differences between the House and Senate versions. Another round of votes will be needed in both chambers to approve of any amended legislation before it can be sent to the President for his signature.

The bottom line, there is no set timeline and historically this is not a "quick" process.

What will likely happen?

Something major. Many provisions of the ACA are expected to be repealed. There could be nonenforcement of others. While a replacement is anticipated, Congress and the Trump administration have not yet articulated a clear plan. Proposals include limitation of employer tax deductions and employee tax exclusions on health coverage, tax credits for purchasing coverage, and expansion of HSAs/HDHPs. It is expected that Congressional Republicans will be meeting shortly after the inauguration with the new administration to hash out the strategy. Hopefully, some details will be provided following that meeting.

Will it be easy to understand/implement?

Doubtful. Dismantling the ACA and implementing a new reform package will likely be even more challenging than the original ACA implementation. Deciphering what stays, what goes, the timing of the changes, along with any new requirements will be difficult for all stakeholders in the health care system. We will keep you posted as we go through this process.

Departments Issue 35th FAQ

Published: January 19, 2017

On December 20, 2016, the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) issued the 35th set of FAQs addressing implementation of the Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act (HIPAA), and the 21st Century Cures Act (Cures Act).

Briefly, the FAQ:

- Clarifies that an otherwise eligible employee may have special enrollment rights when an individual policy purchased by the employee (or dependent) is cancelled by the carrier.
- Requires non-grandfathered health plans to comply with updated Women's Preventive Services Guidelines effective for plan years that begin on or after January 1, 2017.
- Offers additional clarification on "Qualified Small Employer Health Reimbursement Arrangements" (QSEHRA) pursuant to the Cures Act.

Special Enrollment for Group Health Plans

Under HIPAA, group health plans are required to provide special enrollment opportunities to employees and dependents during which otherwise eligible individuals who previously declined health coverage have the option to enroll under the terms of the plan (regardless of any open enrollment period). Generally, a special enrollment period must be offered for circumstances in which an employee or dependents lose eligibility for any group health plan or health insurance coverage in which the employee or their dependents were previously enrolled, and upon certain life events such as when a person becomes a dependent of an eligible employee by birth, marriage, or adoption.

New Guidance

The FAQ clarifies that if an individual loses eligibility for coverage in the individual market, including coverage purchased through a Marketplace, that individual is entitled to special enrollment in group health plan coverage for which he or she is otherwise eligible. This clarification permits otherwise eligible employees and their dependents who have Marketplace policies cancelled to have a special enrollment right onto the group health plan outside of open enrollment and regardless of whether the employees and dependents remain eligible for other Marketplace coverage (assuming the requirements for special enrollment are met).

It is not clear what constitutes losing eligibility for coverage. For example, is it triggered by a canceled policy number, an offer of different covered benefits, an offer of different limits such as deductibles, only having a different carrier as a remaining option, or only having an HMO option and no longer a PPO option?

It is clear that a special enrollment right is not available when the individual loses eligibility for coverage due to failure to pay premiums on a timely basis or if coverage is terminated for cause (e.g., making a fraudulent claim or an intentional misrepresentation of a material fact).

Updated Preventive Care Guidelines

Non-grandfathered group health plans must cover certain preventive care items and services without cost-sharing.

New Guidelines

The recommendations and guidelines for certain women's preventive care and services have been updated. The changes will take effect for plan years that begin on or after December 20, 2017. As a result, plans years beginning on or after January 1, 2018 will need to comply with the updated recommendations. Some of the changes affect contraceptives and certain women's cancer screenings. For the complete list of the recommendations, visit https://www.hrsa.gov/womensguidelines2016.

Qualified Small Employer HRA

The FAQ discusses and incorporates guidance pursuant to the Cures Act. The Cures Act establishes "Qualified Small Employer Health Reimbursement Arrangements" ("QSEHRAs") effective January 1, 2017 and retroactively extends through 2016 certain relief from penalties for small employers that reimbursed individual health insurance premiums for employees through an HRA or employer payment plan as long as those arrangements would qualify as a QSEHRA.

A QSEHRA is an arrangement offered by an eligible employer and the arrangement:

- is funded solely by an eligible employer, and no salary reduction contributions may be made under the arrangement;
- provides, after the employee provides proof of coverage, for the payment to, or reimbursement of, an eligible employee for expenses for medical care (as defined in Code section 213(d)) incurred by the eligible employee or the eligible employee's family members (as determined under the terms of the arrangement);
- does not permit payment or reimbursements that exceed $4,950 ($10,000 in the case of an arrangement that also provides for payments or reimbursements for family members of the employee) (with amounts to be indexed for increases in cost of living); and
- is provided on the same terms to all eligible employees of the eligible employer.

An eligible employer means and employer that:

- does not offer a group health plan to any of its employees; and
- employed fewer than 50 full-time employees (including full-time equivalent employees) in the preceding calendar year and the arrangement.

For plan years beginning before January 1, 2017, the Cures Act extends earlier relief from the excise tax penalty for small employers that pay or reimburse employees for individual health insurance premiums. This relief does not extend to stand-alone HRAs or employer payment plans that reimburse employees for medical expenses other than individual health insurance premiums.

Additionally, prior regulations and guidance continue to apply to HRAs and employer payment plans that do not qualify as QSEHRAs, including arrangements offered by employers that do not meet the definition of an eligible employer. In other words, a large employer is not permitted to offer a QSEHRA.

Employer Actions

- Consider a loss of individual health insurance coverage (including a carrier cancellation of a policy) as a Special Enrollment opportunity for otherwise eligible individuals in the employer's group health plan.

- For non-grandfathered plans, the employer should prepare to follow the recommendations announced for women's preventive care effective with the first plan year that begins on or after January 1, 2018.

- Eligible small employers should familiarize themselves with the concept of a QSEHRA to determine whether this is an option to pursue as opposed a traditional group health plan or forgoing all medical benefits. Large employers should understand such an arrangement remains prohibited.

Trump's First Executive Order Addresses the ACA

Published: January 25, 2017

On January 20, 2017, President Trump issued an Executive Order to minimize the economic burden of the Affordable Care Act ("ACA"). This Order identifies the new administration's policy for addressing and enforcing the ACA while Congressional Republicans craft legislation to repeal and replace it.

The Order directs the agencies responsible for administration and enforcement of the ACA to exercise the authority and discretion available to them:

> To the maximum extent permitted by law…waive, defer, grant exemptions from, or delay the implementation of any provision or requirement that would impose a cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications.

This Order serves as a policy statement and the applicable agencies are not likely to take immediate action on this directive. However, once the Department heads for Health and Human Services, the Treasury, and Labor are confirmed and in place, we may see guidance as to how they intend to enforce (or not enforce) certain provisions of the law.

What Should Employers Do?

For now, employers should continue to follow the requirements of the ACA until (and unless) further guidance from the applicable administrative agency is issued.

Specifically, employers should:

- Continue to prepare and provide 2016 Forms 1094-C and 1095-C. The Form 1095-C is due to ACA full-time employees and, for self-insured plans all covered individuals, by March 2, 2017. Form 1094-C and all Forms 1095-Cs are due to the IRS by March 31, 2017 (unless filing by paper, then February 28, 2017).

- Continue to correct incorrect 2015 1094-C and 1095-C returns.

- If applicable (generally employers that file at least 250 Forms W-2 in the prior calendar year), report the value of health insurance coverage on the Form W-2 (box 12, code DD).

- Prepare for enforcement of the employer mandate penalties, if applicable, for the 2015 and 2016 calendar years. As last announced through FAQs, the IRS intends to issue notices for 2015 penalty assessments in the first part of 2017. If the administration decides not to enforce these penalties (to the extent permissible by law), the IRS will provide direction in future guidance.

- Prepare for calendar year 2017 reporting on Forms 1094-C and 1095-C.

- Continue to comply with the following mandates as to group health plans:
  - No lifetime or annual dollar limits on Essential Health Benefits ("EHBs").
  - Cover children to age 26.
  - No retroactive cancellation of health plan coverage, except due to fraud or intentional misrepresentation of a material fact.
  - No preexisting condition exclusion clauses.
  - No waiting periods in excess of 90 days.

- Continue to comply with the following additional mandates for non-grandfathered plans:
  - Cover preventive items and services without cost-sharing.
  - Treat emergency services as covered in-network even if received out of network; no prior authorization requirements on such services.
  - If a primary care provider must be designated, allow for any available in-network physician to be designated and no authorization or referral requirements on OBGYN care.
  - Follow enhanced claims, appeal and external review procedures.
  - Cover routine costs associated with certain approved clinical trials.
  - Out-of-pocket cost sharing cannot exceed prescribed levels (for 2017, $7,150 for individual coverage and $14,300 for family coverage).
  - The small group non-grandfathered insured market must offer EHBs and provide at least a Bronze level of coverage.

- Provide ACA-related notices, including the SBC and Notice of Coverage Options. Remember, a new (and shorter) version of the SBC should be used in connection with enrollment for plan years that begin on or after April 1, 2017.

- Pay fees, as applicable. Specifically, self-insured group health plans should have paid the reinsurance fee for 2016 on January 17, 2017. If paying in two installments, the second payment remains due November 15, 2017. Additionally, employers with self-insured health plans or Health Reimbursement Arrangements (HRAs) should be prepared to pay the PCORI fee by July 31, 2017.

- Keep health FSA maximum employee contributions to no more than $2,600 for 2017 and continue to exclude over-the-counter medicines and drugs unless prescribed.

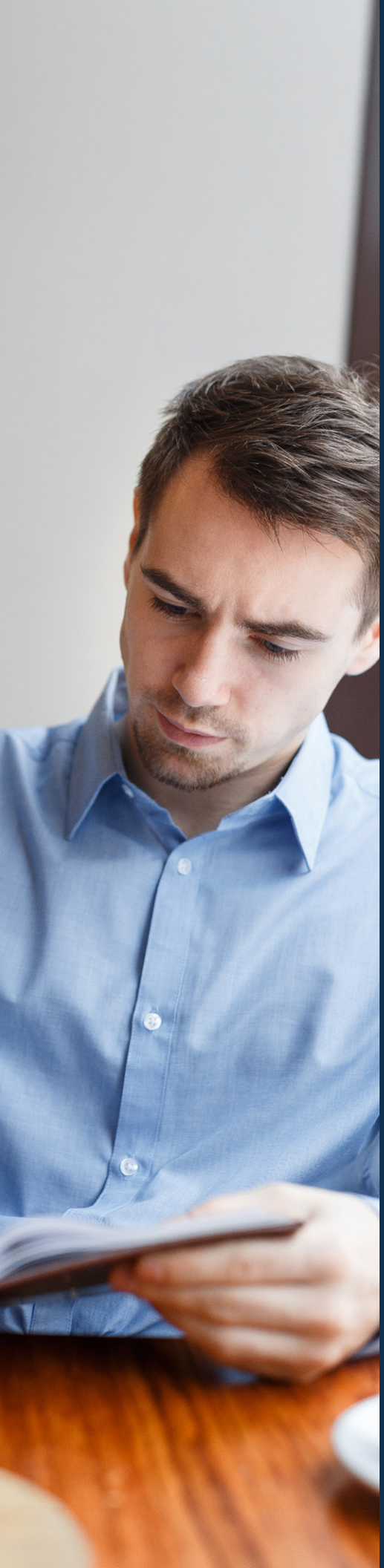
What is the Impact to Employees?

Individuals should still continue to act as though the individual mandate will be enforced (have minimum essential coverage, qualify for an exemption, or pay a penalty). For the immediate future, it appears subsidies remain available to assist certain low and middle income individuals to purchase coverage in the Marketplace if coverage is not available elsewhere (e.g., employer-sponsored, Medicare, or Medicaid).

There is a significant question as to whether the Trump administration will continue to enforce the individual mandate. It is a crucial component of the ACA in that it operates to keep the risk pool large enough to reduce adverse selection. Not enforcing the coverage requirement could lead to an exodus of healthy individuals from Marketplace insurance and creating an unstable risk pool.

There is also question around the continued availability of subsidies during this transition period. As of right now, they remain available. However, this will be an area to be closely monitored as the leadership at HHS takes shape.

We will continue to monitor and report developments.



DOL Penalties Increase for 2017

Published: February 1, 2017

In 2015, Congress passed the Federal Civil Penalties Inflation Adjustment Act of 2015 (the "Inflation Adjustment Act") to direct federal agencies to adjust the civil monetary penalties for inflation every year. Civil penalties ensure compliance with federal regulation by incentivizing employers not to violate federal regulation and providing federal agencies the power to ensure compliance. However, when penalties are too low, or have failed to be increased for inflation, compliance with federal regulation remains stagnant.

The Department of Labor (DOL) recently published the final rule to adjust for inflation the civil monetary penalties assessed or enforced in its regulations, and the annual adjustments for 2017 that increases certain penalties applicable to employee benefit plans.

The updated penalties went into effect on January 13, 2017 and apply to penalties assessed after the effective date.

Annual Penalty Adjustments for 2017

The following updated penalties are applicable to health and welfare plans subject to ERISA.

Description	Current Penalty	Updated Penalty
Failure to file **Form 5500**	Up to $2,063 per day	Up to $2,097 per day
Failure of a **MEWA** to file reports	Up to $1,502 per day	Up to $1,527 per day
Failure to provide **CHIP Notice**	Up to $110 per day per employee	Up to $112 per day per employee

Failure to disclose CHIP/Medicare Coordination to the State	$110 per day per violation (per participant/beneficiary)	$112 per day per violation (per participant/beneficiary)
Failure to provide **SBCs**	Up to $1,087 per failure	Up to $1,105 per failure
Failure to furnish **plan documents** (including SPDs/SMMs)	$147 per day $1,472 cap per request	$149 per day $1,496 cap per request
Genetic information failures	$100 per day	$112 per day
De minimis failures to meet genetic information requirements (Minimum)	$2,500 minimum	$2,790 minimum
Failure to meet genetic information requirements - not de minimis failures (Minimum)	$15,000 minimum	$16,742 minimum
Cap on unintentional failures to meet genetic information requirements (Maximum)	$500,000 maximum	$558,078 maximum

Employer Action

Private employers, including non-profits, should ensure employees receive required notices timely (SBC, CHIP, SPD, etc.) to prevent civil penalty assessments. In addition, employers should ensure Form 5500s are properly and timely filed. Finally, employers facing document requests from EBSA should ensure documents are provided timely, as requested.

Medicare Part D
CMS Notification Reminder

Published: February 14, 2017

Employers sponsoring a group health plan need to report information on the creditable status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services (CMS). In order to provide this information, employers must access CMS's online reporting system at:

https://www.cms.gov/Medicare/Prescription-Drug-coverage/CreditableCoverage/CCDisclosureForm.html.

As a reminder, notice must be provided by the following deadlines:

- Within 60 days after the beginning date of the plan year;
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status.

An employer with a calendar year plan (January 1 – December 31, 2017) must complete this reporting no later than March 1, 2017.

Additional guidance on completing the form, including screen shots, is available at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure.html.

A Help Line is also available, should you experience technical issues or an error message when submitting the online disclosure form. The Help Line can be reached at (877) 243-1285 (note, you may be directed to a different phone number for further assistance.)

House Republicans Unveil ACA Repeal and Replace Legislation

Published: March 9, 2017

On March 6, 2017, the House Ways and Means Committee and the House Energy and Commerce Committee (the "Committees") released legislation as part of House Republicans' effort to repeal and replace the Affordable Care Act ("ACA") through a budget process known as reconciliation. The legislation, part of House Republicans' American Health Care Act, repeals many of the ACA's taxes and mandates while relaxing Health Savings Account ("HSA") rules and replacing Marketplace subsidies (premium tax credits and cost-sharing subsidies) with refundable tax credits. The Committees have scheduled a markup of this legislation for March 8.

Like most complex bills, we anticipate this legislation will undergo significant changes before the full House and Senate attempt a vote to approve it. Democrats and some Republicans have already voiced their concerns.

While the legislation implicates a number of national health reform initiatives, the following highlights the provisions that directly or indirectly apply to, or have an impact on, employer-sponsored group health plans:

- **TAXES IN GENERAL**
  The legislation will repeal most of the taxes and fees contained in the ACA, including the additional Medicare tax on wages above $200,000 and net investment income, taxes on prescription drugs, premium taxes on insurance carriers and medical device manufactures' taxes.

- **INDIVIDUAL AND EMPLOYER MANDATE**
  The bill eliminates the individual and employer mandate penalties effective after December 31, 2015. The penalties are "zeroed-out," but the mandates remain in the law. Further, it appears any penalties associated with the 2015 calendar year could still be applied. Additionally, nothing in the legislation repeals the employer reporting requirements (Forms 1094-C and 1095-C) and penalties associated with failures to file these forms (or to file correct forms) would remain intact.

- **CADILLAC PLAN TAX**
  The excise tax on high cost plans, known informally as the Cadillac Plan Tax, is delayed until 2025 under this bill. Unlike a previous "leaked bill," which fully repealed the Cadillac Plan tax and replaced it with a tax on the top 10% of employer-provided health plans, this version will enforce the Cadillac Plan tax effective January 1, 2025 rather than on January 1, 2020 as currently scheduled.

- **HSA CHANGES**
  The bill would relax certain HSA rules specifically, increasing the maximum annual contribution to align with the maximum out-of-pocket limit for qualified HDHPs (for 2017, $6,550 self / $13,100 family). Additional provisions would reduce the excise tax from 20% back to 10%, create new catch-up provisions for spouses and permit reimbursement for expenses prior to establishment of a HSA.

- **HEALTH FSA CHANGES**
  The bill repeals the federal rules that imposed an annual limit on health flexible spending account (health FSA) contributions ($2,500, as adjusted annually for inflation).

- **RETAIN PRE-EXISTING CONDITION EXCLUSION**
  The prohibition on pre-existing condition exclusions remains in place; however, carriers in the individual and small group market may impose a 30% premium differential for individuals who experience a 63-day or more gap in creditable coverage in the preceding 12 months.

- **REFUNDABLE TAX CREDITS**
  Marketplace premium subsidies end under this legislation after December 31, 2019. The bill proposes a refundable tax credit for low and middle-income families ranging from $2,000 to $14,000 (based on overall household income) to assist in purchasing state approved, major medical health insurance coverage and unsubsidized COBRA coverage subject to eligibility criteria. Availability of such credits would also be determined based on age, with younger individuals qualifying for lower credits than older individuals.

What Should Employers Do?

For now, employers should continue to follow the requirements of the ACA. This bill will work its way through the legislative process and will likely have changes and amendments before it passes the House and is sent on to the Senate for their deliberations. As currently drafted, many of the provisions of the law will go into effect on January 1, 2018.

We will continue to monitor and report developments.

GOP Pulls AHCA Before Vote

Published: March 30, 2017

On Friday, March 24, 2017, the U.S. House of Representatives pulled the American Health Care Act ("AHCA") from consideration after not receiving enough Republican support to pass the bill. The AHCA was President Trump's first attempt to repeal and replace the Affordable Care Act (the "ACA"). The AHCA, among other things, would have eradicated the penalties associated with the individual and employer mandates, and replaced the ACA subsidies with refundable tax credits.

President Trump has stated that he is content to move on from health care reform and will now focus on tax reform. While some Republicans in the House, including Speaker Ryan, are interested in revisiting health care reform, it is not clear a second shot at "repeal and replace" will garner enough votes in a divided Republican party. On the other hand, Democrats appear willing to come to the table to address bi-partisan changes to the ACA if Republicans stop efforts to "repeal and replace" the law.

Therefore, for the foreseeable future, the ACA remains the law of the land. For now, employers must maintain compliance with all ACA mandates. ACA non-compliance penalties and taxes also remain in place. It will be interesting to see whether the regulatory agencies will issue non-enforcement or limited enforcement guidance that may relieve employers from some of the penalties and reporting requirements under the ACA.

We will be monitoring these political developments, including potential changes to the Cadillac Tax and the employee tax exclusion of health care benefits – both of which may be on the table as part of a tax reform package. In addition, we will be monitoring regulatory changes that could impact employer sponsored plans.

28 West Railroad Avenue

Jamesburg, NJ 08831

heatherb@cbplans.com