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2017: Second Quarter

Compliance Digest

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2017 Compliance Bulletins

May

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House Passes Bill to Repeal Obamacare

Published: May 5, 2017

Just six weeks after the House leaders failed to muster the votes to pass an earlier version of the American Health Care Act (AHCA), the House Republicans narrowly passed their health care bill to repeal and replace Obamacare with a 217 to 213 vote on Thursday. All but 20 Republicans voted for the bill, and the Democrats were unanimous in opposition.

What changed in the Bill?

The earlier version of the AHCA did not satisfy the conservative Freedom Caucus bloc of the Republican party and Speaker Ryan pulled the bill from the floor immediately before the scheduled vote on March 24 when it became clear that there were not 216 votes in the House. Several tweaks were made to the bill to win over support from the Freedom Caucus members who balked and refused to support that version of the bill. These modifications include a state waiver provision and additional protections for pre-existing conditions.

State Waivers

An amendment was made to the bill that allows states to waive certain ACA requirements that are likely to cause increased premium costs. Under the current House bill, states could apply for waivers, which are effective for 10 years, from some of the ACA's consumer protections. There are three types of waivers available:

- **Age Rating Ratio**
  allows states to increase the permitted age rating to a ratio greater than 5:1.

- **Essential Health Benefits**
  allows states to define their own lists of essential health benefits without regard to the ACA list.

- **Health Status Underwriting**
  allows states to permit insurers to include health status as a legal factor when underwriting for individuals who did not maintain continuous coverage, subject to a number of limitations and safeguards.

State waiver requests will be granted by default unless the Secretary of HHS notifies the state within 60 days that the request failed to meet requirements.

Pre-existing Condition Protections

In addition to the state waivers, a further amendment was made to the House bill to help it pass. This amendment provides an additional $8 billion in high-risk pool funding over five years for waiver states for individuals with pre-existing conditions who fail to maintain continuous coverage and may be subject to health status underwriting.

Under this amendment, states could also allow insurers to charge higher premiums to people with pre-existing conditions if they've had a gap in coverage as long as the state provides people priced out of commercial insurance with assistance, like a high-risk pool.

Provisions of the AHCA Affecting Employers

Below is a brief summary of the provisions of the House bill affecting employers:

- Elimination of the Employer Mandate penalties. The penalties are reduced to zero, essentially, repealing the mandate to offer minimum essential coverage to full-time employees that is affordable and provides minimum value.

- Elimination of the Individual Mandate penalties. Penalties are reduced to zero, essentially repealing the requirement for individuals to maintain minimum essential coverage to avoid a tax penalty.

- Further delay of the Cadillac Plan Tax. The effective date of the Cadillac Tax is delayed until 2026.

- ACA Reporting. The ACA reporting rules have not been removed, so it is still not clear whether 2017 ACA reporting would be required.

- Cost-sharing Subsidies. The AHCA repeals the cost-sharing subsidy program under the ACA and replaces it with a new refundable tax credit which would be effective in 2020. The credit would vary from $2,000/year to $4,000/year depending on age, with a family overall cap at $14,000.

- Pre-Existing Conditions. The bill removes the ACA's blanket prohibition on pre-existing condition exclusions. The AHCA imposes a premium surcharge of 30% for 12 months for an individual enrolling after a break in coverage of 63 or more days in the prior year. The revised bill allows states to permit additional premium costs and health status underwriting. There will also be high-risk pool funding over five years for waiver states for individuals with pre-existing conditions who fail to maintain continuous coverage.

- Metal Tiers and Age Banding. The AHCA repeals the actuarial value standards, essentially eliminating the bronze, silver, gold and platinum tiers and allows more plan options, presumably at below bronze levels. It also changes small group medical insurance age-rating from 3:1 to 5:1 (which can be increased under a state waiver).

- HSAs. Alignment of the annual HSA maximum contribution to the maximum out-of-pocket limits on qualified HDHPs.

- OTC and FSA. The AHCA repeals the ACA tax on OTC drugs and medicines and again permits tax favored accounts. Also, it removes the annual cap of $2,500 on employee health FSA contributions.

- Medicaid Expansion. The AHCA gradually rolls back Medicaid expansion by cutting federal reimbursement to states if they leave the expansion in place.

What's next?

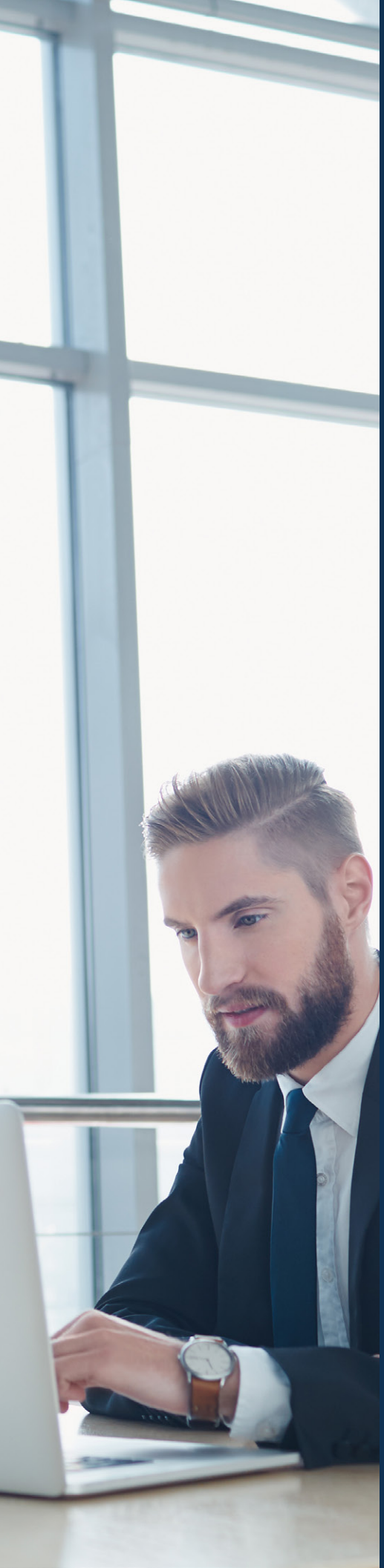
The focus will now shift to the Senate, where the House bill has little chance of being passed in its current form. We may very well see the Senate propose its own version of the bill. In any event, it is likely the Senate will consider the bill at a much slower pace, with a vote not happening until July at the earliest.

A number of Republicans in the Senate have expressed significant concern over the House plan for a number of reasons, including concern over steep spending cuts and the effect on states that expanded Medicaid. In addition, there is also concern that some of the provisions of the bill will not comply with special budget rules that Republicans must follow in order to skirt a Senate filibuster. Several GOP senators also expressed concerns with the rushed process in the House, which voted on the revised bill less than 24 hours after posting it. Members also voted on the bill before receiving a new Congressional Budget Office estimate of its cost and effects.

The Republicans' slight majority (just 52 votes) means they can only lose two senators and still push a repeal through. Since the House passed the bill under budget reconciliation rules, the Senate can pass this bill by a simple majority (50 votes with Vice President Pence as the tiebreaker rather than the usual 60-vote threshold), without the threat of filibuster through the reconciliation process. Keep in mind that any legislation that gets through the Senate will again have to clear the House and its conservative majority.

What should employers do? Continue to comply with the ACA.Remember, despite the passage of the bill in the House, the ACA remains the law of the land for now.

We will continue to keep you apprised of new developments as they occur.



2018 Inflation Adjusted Amounts for HSAs

Published: May 12, 2017

The IRS released the inflation adjustments for health savings accounts (HSAs) and their accompanying high deductible health plans (HDHPs) effective for calendar year 2018. All limits increased from 2017 amounts.

Annual Contribution Limitation

For calendar year 2018, the limitation on deductions for an individual with **self-only coverage** under a high deductible health plan is **$3,450**. For calendar year 2018, the limitation on deductions for an individual with **family coverage** under a high deductible health plan is **$6,900**.

High Deductible Health Plan

For calendar year 2018, a "high deductible health plan" is defined as a health plan with an **annual deductible that is not less than $1,350 for self-only coverage** or **$2,700 for family coverage**, and the **annual out-of-pocket expenses** (deductibles, co-payments, and other amounts, but not premiums) **do not exceed $6,650 for self-only coverage** or **$13,300 for family coverage**.

Non-calendar year plans: In cases where the HDHP renewal date is after the beginning of the calendar year (i.e., a fiscal year HDHP), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date.

Catch-Up Contribution

Individuals who are age 55 or older and covered by a qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined by the statute, is $1,000 for 2009 and thereafter.

Recent Developments Regarding the Employer Mandate

Published: May 19, 2017

Applicable large employers (ALEs) may be resting easy, having had no notification from the IRS of 2015 or 2016 assessments under the Employer Mandate of the Affordable Care Act (the ACA) and having reasonably expected that the Republican-led administration would limit or choose not to enforce this mandate.

With the status of health care reform uncertain, the IRS has taken additional steps regarding the mandate, once again updating its website with FAQs on Employer Mandate penalties that build on information released in January (before the change in administration). Briefly, the guidance:

- Announced the 2017 inflation adjustments with respect to the annual Employer Mandate penalties: $2,260 for the "A" penalty and $3,390 for the "B" penalty.
- Provided examples of how the penalty assessment is calculated.
- Highlighted the process the IRS will use to notify employers of a penalty assessment and to collect the penalty.
- Reminded employers that any Employer Mandate assessment is not deductible for federal income tax purposes.

Recently, the Inspector General for Tax Administration in the Treasury Department issued an assessment of the agency's efforts to implement the Employer Mandate. Results from this report include the following:

- As of October 28, 2016, the IRS processed 439,201 Forms 1094-C and 110 million Forms 1095-C.
- Some of the information contained in these reports did not process as intended, resulting in inaccurate and incomplete data.
- Reports submitted on paper were not processed timely and/or accurately due to system errors.

- Criteria used to validate errors in the submissions did not always work. For example, some error codes mistakenly generated when no error existed and, when errors did exist, codes reflecting the error did not generate.

- Systems needed to identify noncompliant employers subject to a penalty have been delayed as opposed to being initiated or cancelled. Specifically, a post-filing compliance validation system that was scheduled for release in January 2017 has been delayed until May 2017.

Finally, the IRS issued guidance lowering the 2018 safe harbor percentage for affordability to 9.56% versus 9.69% in 2017.

While the IRS made a general announcement that it is currently reviewing President Trump's Executive Order to determine implications for ACA compliance, this new information at least points in the direction that the government may begin enforcing the Employer Mandate.

The following provides additional detail.

The "A" Penalty

In general, an ALE member will owe this first type of Employer Mandate payment ("A" penalty) if, for any month, it does not offer minimum essential coverage (MEC) to at least 95% of its full-time employees (FTEs) (and their dependents), and if at least one FTE receives the premium tax credit for purchasing coverage through the Marketplace.

How is the payment calculated?

If an ALE member is subject to the "A" penalty, the annual payment is $2,000 for each FTE (without regard to whether each employee received a premium tax credit), after excluding the first 30 FTEs from the calculation.

If the ALE includes multiple ALE members (i.e., multiple entities under common ownership), the 30-FTE reduction is distributed ratably across the controlled group based on each ALE member's number of FTEs.

The $2,000 amount is indexed for inflation. The adjusted amounts are:

- For calendar year 2015, $2,080
- For calendar year 2016, $2,160
- For calendar year 2017, $2,260

Even though the announced amounts are annualized, the IRS will determine whether an ALE member owes this payment on a month-by-month basis.

All FTEs except those in a waiting period factor into the payment calculation. Generally, part-time employees will not be counted.

Example 1. Employer is liable for the whole year.

Based on its number of FTEs in 2016, Company K is an ALE for 2017. Company K has 70 FTEs for each month of 2017. Company K does not offer MEC to its FTEs (and their dependents) for any month of 2017. One FTE obtains health insurance through the Marketplace and receives the premium tax credit for each month of 2017.

Because Company K does not offer MEC to at least 95% of its FTEs (and their dependents) for each month of 2017 and at least one FTE received the premium tax credit, Company K is subject to the "A" penalty.

For 2017, Company K is subject to an Employer Mandate payment of $90,400, calculated as follows:

Number of FTEs less 30: (70 – 30) x $2,260= $90,400.

Example 2. Employer is liable for certain months.

Same facts as Example 1, except Company K does not offer MEC to its FTEs (and their dependents) for the first nine months of 2017. One FTE obtains health insurance through the Marketplace and receives the premium tax credit for each of those nine months. For the last three months of 2017, Company K does offer MEC to its 70 FTEs (and their dependents). No FTE receives the premium tax credit for the last three months of 2017.

Because Company K does not offer MEC to at least 95% of its FTEs (and their dependents) for the first nine months of 2017

and at least one FTE received the premium tax credit for those months, Company K is subject to the "A" penalty for the first nine months of 2017.

Because Company K does offer MEC to at least 95% of its FTEs (and their dependents) for the last three months of 2017, Company K is not subject to the "A" penalty for the last three months of 2017. Company K also is not subject to the "B" penalty for the last three months of 2017 because no FTE receives the premium tax credit for the last three months of 2017.

For 2017, Company K is subject to an Employer Mandate payment of $67,800, calculated as follows:

Number of FTEs less 30: (70 – 30) x 9/12 of $2,260= $67,800.

The "B" Penalty

Even if an ALE member offers MEC to a sufficient number of FTEs (and their dependents) to avoid the "A" penalty, the ALE may still owe the second type of Employer Mandate payment for each FTE (if any) who receives the premium tax credit for purchasing coverage through the Marketplace ("B" penalty).

An FTE could receive a premium tax credit if the:

1. MEC the ALE offers to the FTE is not affordable; or
2. MEC the ALE offers to the FTE does not provide minimum value; or
3. FTE is one of the 5% of FTEs not offered MEC.

How is the payment calculated?

If an ALE owes the "B" penalty, the annual payment is $3,000 for each FTE who received the premium tax credit.

The $3,000 amount is indexed for inflation. The adjusted amounts are:

- For calendar year 2015, $3,120
- For calendar year 2016, $3,240
- For calendar year 2017, $3,390

Even though the announced amounts are annualized, the IRS will determine whether an ALE member owes this payment on a month-by-month basis.

The total amount of the "B" penalty cannot exceed the amount that the employer would have owed had it been liable for the "A" penalty.

Example 3. Employer is liable for employer mandate payment for failure to offer minimum essential coverage that provides minimum value.

Based on its number of FTEs in 2016, Company M is an ALE for 2017. Company M has 125 FTEs for each month of 2017. For 2017, it offers MEC to its FTEs (and their dependents), but the MEC is not affordable for all of the FTEs.

Fourteen of its FTEs obtain health insurance through the Marketplace and receive the premium tax credit for each month of the year.

Because Company M offers MEC to its FTEs (and their dependents), it is not subject to the "A" penalty for any month of the 2017.

Company M is subject to the "B" penalty for each month of the year because for each month of the year, at least one FTE received the premium tax credit. Company M is subject to an Employer Mandate payment of $47,460, calculated as follows:

Number of FTEs who received the premium tax credit for each month of the year (14) x $3,390= $47,460.

The basic calculation amount of $47,460 is the Employer Mandate payment amount for Company M for 2017.

Assessment and Collection of the Employer Mandate Payment

Employers do not automatically report or pay an Employer Mandate payment they owe. Instead, based on information from the employer and from employees' tax returns, the IRS will calculate the potential Employer Mandate payment and contact the employer to inform it of any potential liability. The employer will then have an opportunity to respond before any assessment or demand for payment is made.

An employer will not be contacted by the IRS regarding any penalty assessment until after its employees' individual income tax returns are due for that year which would show any claims for the premium tax credit.

If, after the employer has had an opportunity to respond to the initial IRS contact, the IRS determines that an employer is liable for a payment, the IRS will send a notice and demand for payment to the employer. That notice will instruct the employer how to make the payment.

The IRS will adopt procedures to ensure that employers receive certification when one or more employees receive the premium tax credit for purchasing coverage through the Marketplace.

Employer Action

ALEs should:

- Prepare to address notifications of a potential penalty assessment from the IRS. Likely, any notices associated with the 2015 calendar year would be issued first, with 2016 notices coming after tax filing season closes.
- Continue to comply for the 2017 calendar year, including continuing to identify and track offers of coverage to FTEs for calendar year 2017 and preparing for reporting on Forms 1094-C and 1095-C.
- Monitor political developments as Republicans in the House passed health care reform legislation which, among other things, zeroed out penalties associated with the Employer Mandate from 2016 forward. The Senate leadership indicates that they will craft their own solution, so further uncertainties with regard to penalties remain.

PCOR Fee Filing Reminder for Self-Insured Plans

Published: May 30, 2017

The PCOR filing deadline is July 31, 2017 for all self-funded medical plans and HRAs for plan years ending in 2016.

The plan years and associated amounts are as follows:

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2015 – January 31, 2016	$2.17/covered life/year	July 31, 2017
March 1, 2015 – February 29, 2016	$2.17/covered life/year	July 31, 2017
April 1, 2015 – March 31, 2016	$2.17/covered life/year	July 31, 2017
May 1, 2015 – April 30, 2016	$2.17/covered life/year	July 31, 2017
June 1, 2015 – May 31, 2016	$2.17/covered life/year	July 31, 2017
July 1, 2015 – June 30, 2016	$2.17/covered life/year	July 31, 2017
August 1, 2015 – July 31, 2016	$2.17/covered life/year	July 31, 2017
September 1, 2015 – August 31, 2016	$2.17/covered life/year	July 31, 2017
October 1, 2015 – September 30, 2016	$2.17/covered life/year	July 31, 2017
November 1, 2015 – October 31, 2016	$2.26/covered life/year	July 31, 2017
December 1, 2015 – November 30, 2016	$2.26/covered life/year	July 31, 2017
January 1, 2016 – December 31, 2016	$2.26/covered life/year	July 31, 2017

For the Form 720 and Instructions, visit: https://www.irs.gov/uac/form-720-quarterly-federal-excise-tax-return.

The information is reported in Part II.

Please note that Form 720 is a tax form (not an informational return form such as Form 5500). As such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third party administrators and USI, cannot report or pay the fee.

Short Plan Years

The IRS issued FAQs that address how the PCOR fee works with a self-insured health plan on a short plan year.

- **Does the PCOR fee apply to an applicable self-insured health plan that has a short plan year?**
  Yes, the PCOR fee applies to a short plan year of an applicable self-insured health plan. A short plan year is a plan year that spans fewer than 12 months and may occur for a number of reasons. For example, a newly established applicable self-insured health plan that operates using a calendar year has a short plan year as its first year if it was established and began operating beginning on a day other than Jan. 1. Similarly, a plan that operates with a fiscal plan year experiences a short plan year when its plan year is changed to a calendar year plan year.

- **What is the PCOR fee for the short plan year?**
  The PCOR fee for the short plan year of an applicable self-insured health plan is equal to the average number of lives covered during that plan year multiplied by the applicable dollar amount for that plan year.

  Thus, for example, the PCOR fee for an applicable self-insured health plan that has a short plan year that starts on April 1, 2016, and ends on Dec. 31, 2016, is equal to the average number of lives covered for April through Dec. 31, 2016, multiplied by $2.26 (the applicable dollar amount for plan years ending on or after Oct. 1, 2016, but before Oct. 1, 2017).

  See FAQ 12 & 13, http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers.

Potential HIPAA Privacy Concerns for Employers Offering Mobile Apps

Published: June 6, 2017

In an effort to help employees lead healthier lives, employers may offer employees access to mobile device applications ("apps") that collect, store, manage, organize, or transmit health information. Nutrition and weight could be logged. Health-tracking "wearables" such as Fitbits might, for example, monitor heart rate, calories burned, sleep quality, and fitness level. Other apps may send information to the employer's health plan for monitoring, continuity of care, or case management purposes in an effort to improve employee health and well-being and potentially reduce health care costs.

App as Part of the Health Plan

Health plans are considered "covered entities" under the Health Insurance Portability and Accountability Act ("HIPAA"). Covered entities must comply with the HIPAA Privacy and Security Rules. If an employer decides to integrate certain apps with the health plan, the employer should be aware of the various HIPAA issues and address them accordingly. Briefly:

- The rules prohibit covered entities and business associates from using or disclosing protected health information ("PHI") when not for treatment, payment, or health care operations purposes without participant authorization. Covered entities are also prohibited from using or disclosing more information than necessary and must keep PHI safe.

- "Business associates" include various third party vendors who create, store, use, transmit, or access PHI on behalf of the group health plan. Wellness vendors and cloud providers that use PHI for functions such as consulting and analyzing health plan data are business associates. As such, the group health plans must have business associate agreements in place with these vendors before PHI may be shared.

- Business associates may delegate responsibilities to subcontractors. In this case, the business associate is responsible for the subcontractor's compliance. For example, a wellness company may be a business associate of a group health plan. The wellness company has a subcontractor agreement with an app developer. The wellness company is responsible for the subcontractor's compliance with HIPAA.

- PHI is health information created or received by a covered entity or employer which relates to the health or payment for health care of an individual and identifies the individual (or the information can be used to identify the individual).

Recently, HHS's Office for Civil Rights, the entity responsible for enforcing HIPAA's privacy and security rules, issued guidance on apps.

Example

A health plan offers a health mobile app that allows participants to download and store their health records, check claim status, and track their progress towards improving their health. The usage data is collected and analyzed by the health plan. The app developer offers a separate version of the app that is available directly to the consumer with the same functionality.

Conclusion

Since the health plan is a covered entity and is contracted directly with the app developer to create, receive, maintain, and transmit PHI on behalf of the plan, the app developer is a business associate and is subject to HIPAA with respect to the app offered by the health plan.

The employer's relationship could instead be with the wellness vendor who purchases the app from the developer. In this case, the wellness vendor would be the business associate. The developer may be considered a subcontractor of the wellness vendor.

App Not Part of the Health Plan

On the other hand, some employers sponsor wellness activities unrelated to their group health plan. For example, an employer could provide employees with step counters and award prizes to employees with the most steps taken during a month. This program likely would not fall within HIPAA's purview.

Employer Action

- Be aware that technology offered to employees that coordinates with the group health plan is likely subject to the HIPAA Privacy and Security Rules.

- Understand the flow of health information. Information could, for example, be transmitted from the user's smartphone to a website. Next, that website may transmit the data to a wellness vendor who collects and analyzes the data on behalf of the group health plan.

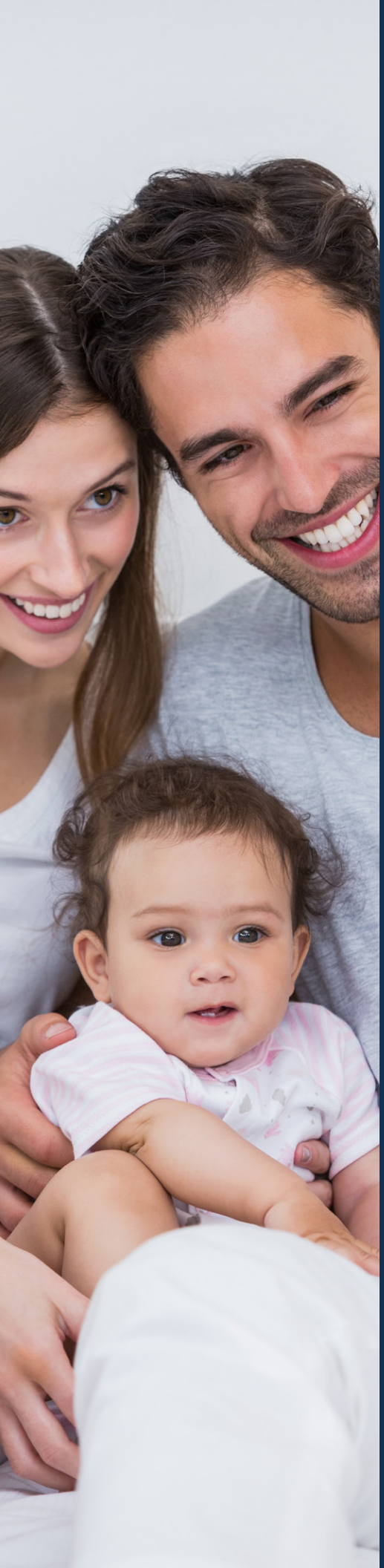
- Ensure the vendors contracting with the health plan understand their responsibilities under the HIPAA Privacy and Security Rules. This includes having safeguards in place to protect users' PHI such as encryption protocols.

- Confirm there are business associate agreements in place with those vendors. The agreements, in part, should make assurances that safeguards are in place and describe the breach notification process. Per OCR guidance, a covered entity must have a business associate agreement must be in place before allowing a business associate access to its PHI.

- Ensure employers do not receive any PHI from a third party vendor. To the extent that an employer wants to analyze information collected from participants' apps, it can receive that information from the vendor on an aggregated and de-identified basis.

Other Considerations

Other applicable laws not addressed in this article could include state privacy laws and other federal laws such as those enforced by the Federal Trade Commission. Employers should understand that other types of sensitive information could be collected and transmitted by these apps such as social security numbers and an employee's exact location (e.g., through GPS tracking). This information should also be protected.



New York Paid Family Leave

Published: June 7, 2017

Last year Governor Andrew Cuomo signed the New York Paid Family Leave ("NYPFL") law as part of the 2017 State Budget. On February 22, 2017, the State of New York filed proposed regulations to implement NYPFL. The proposed regulations were subject to a 45-day notice and comment period, which ended April 8, 2017. On May 24, 2017, the State of New York filed revised proposed regulations, which are subject to a 30-day notice and comment period scheduled to end June 22, 2017.

Overview

The NYPFL is a wage replacement program fully funded by employees to bond with a child, care for a close relative with a serious health condition, or ease family obligations when a family member is called into active military service. However, NYPFL is not available to care for the employee's own condition; rather the employee may use leave available under the Family Medical Leave Act ("FMLA"). Both full-time and part-time employees are eligible for the benefits after meeting the eligibility requirements. As proposed, a full-time employee becomes eligible after working 26 weeks and a part-time employee becomes eligible on the 175th day of work. While part-time employees are eligible for the benefits, a part-time employee will receive a prorated percentage of the amount available to full time employees.

Beginning in 2018, an employee will be able to receive benefits at 50% of the average statewide weekly wage. By 2021, an employee will receive 67% of his/her average weekly wages, capped at 67% of the average statewide weekly wage. For 2016, the New York State Average Weekly Wage ("NYSAWW") was approximately $1,305.92 (the amount is determined each year by 3/31).

Paid Leave - Phases		
January 1, 2018	8 weeks	50% of AWW
January 1, 2019	10 weeks	55% of AWW
January 1, 2020	10 weeks	60% of AWW
January 1, 2021	12 weeks	67% of AWW

Employer Requirements

Private employers of any size doing business in the State of New York are required to comply with the NYPFL and public employers are exempt, but may opt into the law. Public employers are defined as the state, any political subdivision of the state, a public authority or any governmental agency or instrumentality. Private employers will not be required to make contributions towards the NYPFL, but are required to withhold employee contributions beginning on or after July 1, 2017. Simultaneously, private employees will be required to make contributions and cannot opt out. The 2018 employee contribution limit will be established by June 30, 2017 and will be updated annually in June.

Administratively, applicable employers will be required to provide a notice relating to NYPFL that includes eligibility and procedure requirements. Furthermore, employers must continue health benefits during NYPFL so long as the employee continues to pay for benefits. Otherwise, health benefits and the employee's job must be reinstated upon return to work. Employers should update leave policies to include NYPFL and properly describe how NYPFL functions with other leave. Finally, employers are required to insure benefits through a carrier or self-insure through the State. Fully insured benefits will be handled by the carrier that administers state-mandated disability benefits. However, employers must contact insurers; the NYPFL coverage will not be automatic. An employer that currently insures the state-mandated disability benefits may self-insure the NYPFL and vice versa.

Leave Coordination

An employee eligible for multiple leave programs may be limited in his/her use of NYPFL, as follows:

- **New York State Disability** - An employee eligible for NYDBL may not concurrently use NYPFL. An employee must choose between NYDBL and NYPFL at any one time. Combined benefits for NYPFL and NYDBL cannot exceed 26 weeks in a 52-consecutive calendar period.
- **Worker's Compensation Claim** - An employee that is receiving disability benefits under a worker's compensation claim is not eligible for NYPFL.
- **Employee not currently employed or on administrative leave** - An employee that is taking unpaid administrative leave is not eligible for NYPFL.
- **Employee working part-time for another employer** - An employee that is working part-time for one employer may not take NYPFL under another employer. The employee cannot be working for either employer.
- **FMLA Leave** - Leave under the NYPFL runs concurrent to FMLA.
- **Sick Pay or PTO** - An employee eligible for NYPFL may be required to take paid leave to supplement NYPFL, at the employer's discretion.

Pending Amendments

The following amendments have been added to clarify requirements and implementation of the NYPFL:

- **Benefit Standards** - defines the benefits that are required for an employer-provided benefit to meet the NYPFL requirements;
- **Definitions** - defines the terms used throughout the regulation;
- **Eligibility and Qualifying Events** - clarifies the qualifying events necessary to take NYPFL; defines the employee eligibility requirements:
  - Part Time - an employee working less than 20 hours per week;
  - Full Time - an employee working 20+ hours per week;
- **Optional Waiver** - provides an optional waiver for employers to permit employees who would not otherwise meet the eligibility requirements to obtain benefits under NYPFL;
- **Employee Notice Requirements** - provides a carrier or self-insurer may partially deny benefits (up to 30 days) if the employee is required to provide advance notice and fails to do so;
- **Medical Certification and HIPAA Authorization Requirements** - provides when each must be provided to the carrier or self-insurer;
- **Substantiation** - proposes the documents required to be provided by an employee to meet NYPFL requirements;
- **Employer Requirements** - enumerates the employer requirements, including the requirement of an individual business owner to maintain NYPFL coverage;
- **Discrimination** - provides the Worker's Compensation Board will schedule a hearing to discuss employee discrimination upon the request of the employee;
- **Dispute Resolution** - provides that any disputes will be resolved through arbitration;
- **Self-Insurance** - provides the requirements an employer must meet to self-insure, including:
  - Employer's responsibility to cover cost of PFL if statutory maximum is exceeded;
  - Security deposit requirement;
  - Employer reporting; and
  - Restriction on third party administrator use.

Employer Next Steps

Employers should expect final regulations or additional delays to be releases in mid-to-late July. In the meantime, employers should determine their obligations related to NYPFL and implement proper policies and procedures to ensure a smooth transition. In addition, employers should contact their NY disability carriers to determine the cost, administrative requirements, and additional information necessary to implement NYPFL. Employers that want to self-insure should review the proposed requirements and contact a Worker's Compensation Board certified third party administrator for additional requirements.

New York Paid Family Leave

Employee Contribution Set!

Published: June 7, 2017

The New York Paid Family Leave law becomes effective January 1, 2018 and, when fully phased in, an employee will receive 67% of his/her average weekly wages, capped at 67% of the average statewide weekly wage. This program will be funded generally through employee payroll deductions.

The Superintendant of Financial Services has set the maximum employee contribution at 0.126% of an employee's weekly wage, not to exceed 0.126% of the statewide average weekly wage (currently $1,305.92). Since the premium paid by an employee depends on how much an employee earns, those employees earning less will pay a lower premium, and those earning more will pay a higher premium as they are eligible for higher benefits. For employees who make more than the statewide average weekly wage of $1,305.92, the contribution will be capped at $1.65 per week for 2018. It is likely that the maximum contribution will increase in March of 2018 when the statewide average weekly wage is again calculated.

Employers may begin collecting employee contributions beginning on July 1, 2017.

We will continue to keep you apprised of future developments.

New Fiduciary Rules Impact Some HSAs

Published: June 12, 2017

New rules are effective June 9, 2017 that affect investment advisors with respect to health savings accounts ("HSAs") with investment options (as well as retirement plans and IRAs). The new rules address advisors, not employers specifically, and HSAs are not the primary target of the new rules; however, there a few important items for employers to note.

Background

Both ERISA and the Internal Revenue Code impose strict rules on fiduciaries. Even though HSAs are not generally subject to ERISA, they are subject to the Code's version of the prohibited transaction rules which deem anyone offering investment advice for direct or indirect compensation to be a fiduciary.

The rules, in part, require fiduciaries to act solely in the best interest of plan participants and beneficiaries and to not profit from their positions as fiduciaries.

HSA funds may be placed in conservative investments, although only a small percentage of HSAs are set up to so allow.

Summary

Recent regulations expand the types of advice and circumstances that result in fiduciary status and are intended to better protect participants from questionable advice such as investing in high commission products, calling into question the motives of the person providing the advice.

Fiduciary status arises when a person offers certain investment-related recommendations. The 2016 regulations clarify that fiduciary advice is limited to individualized advice directed to specific parties. It may be delivered by a person who:

A. Represents or acknowledges fiduciary status;

B. Provides the recommendation under a written or verbal agreement, arrangement, or understanding that the advice is based on the "particular investment needs" of the investor (e.g., HSA owner); or

C. Directs the advice to a specific investor about the advisability of a particular investment or management decision.

Along with the 2016 regulations, the DOL finalized two new prohibited transaction exemptions ("PTEs") that allow the now-expanded group of fiduciaries providing investment advice to receive compensation otherwise prohibited under the fiduciary rules.

1. The Best Interest Contract (BIC) exemption

This exemption allows qualifying financial institutions and individual investment advice fiduciaries associated with those institutions to receive compensation despite a potential conflict of interest, if all of the following apply:

- There is a written contract.
- The financial institution and the advisers provide investment advice that is, at the time of the recommendation, in the best interest of the HSA account holder.
- The recommended transaction does not cause the fiduciary to receive, directly or indirectly, compensation for their services that is in excess of "reasonable compensation."
- Statements by the financial institution are not materially misleading at the time they are made.

2. Eligible investment advice arrangement

This exemption applies to an adviser who does not receive any fee or other compensation (including commissions, salary, bonuses, or anything of monetary value) that varies depending on the basis of an account holder's selection of a particular investment option. All of the following must apply to the arrangement:

- It must be authorized by the HSA account holder.
- Either:
  - The adviser's compensation does not vary depending upon the basis of investments (the "level" fee requirement); or
  - The advice is given using a computer model that is certified and provides unbiased allocation advice based on relevant information about the account holder and generally accepted investment theories.
- Certain disclosure obligations are met.
- An annual audit requirement is met.

Potential Impact on Employers

A plan sponsor (or service provider or other party) can provide educational information without becoming a fiduciary. For this purpose, educational information means general communications that a reasonable person would not view as an investment recommendation, general circulation newsletters, remarks, or presentations in widely attended speeches and conferences or general marketing materials. This exclusion covers communications between employees, such as human resources department staff who communicate to other employees about the plan provided they are not registered or licensed advisors under securities or insurance laws and only receive their normal compensation for work performed by the employer.

Employers should ensure they do not:

- Provide information to their employees about HSAs which crosses the line from general investment education to investment advice; or

- Benefit in some way from the advice being given.

San Francisco Paid Parental Leave Ordinance

Published: June 15, 2017

On April 21, 2016, the San Francisco Board of Supervisors passed the Paid Parental Leave for Bonding with New Child Ordinance (PPLO). The law requires employers who have employees working in San Francisco to provide supplemental compensation to employees who are receiving California Paid Family Leave for purposes of bonding with a new child. The PPLO is phased in based on employer size.

- Employers with 50 or more employees must comply beginning January 1, 2017.
- Employers with 35-49 employees must comply beginning July 1, 2017.
- Employers with 20-34 employees must comply beginning January 1, 2018.
- Employers with fewer than 20 employees are exempt.

Background

The California Paid Family Leave program (CPFL) provides eligible employees with up to 55% of their weekly wages for up to six weeks to bond with a newborn, newly adopted, or foster child. The CPFL benefit is administered by the Employment Development Department and funded by payroll taxes on employees. The PPLO will provide benefits to employees that are receiving CPFL so that the employee will receive up to 100% of their weekly wages, subject to a maximum amount and based on a calculation described below.

Covered Employers

An Employer is covered under the PPLO if the employer “regularly employs” the required threshold number of employees listed above. The employee count must include all employees regardless of their status or classification as seasonal, permanent or temporary, full or part time, contracted, leased, commissioned, or any other employee category. This is a very expansive definition and differs from other definitions of employee from the Internal Revenue Code, Affordable Care Act, or other laws. The count must include all employees on paid or unpaid

leave, including protected leave, leaves of absence, disciplinary suspensions, or any other type of leave. The employee count must include all employees of the employer regardless of geographic location and whether they actually work within San Francisco.

The employee count is based on the average number of employees that are employed during the PPLO lookback period. The PPLO lookback period is the 12 weekly pay periods (or other pay period equivalent such as six biweekly pay periods) preceding the start of the first day of an employee's CPFL period but does not include any pay periods during which the employee was on unpaid or partially paid leave. Additionally, all employees employed within a controlled group of companies are included in the count for the employer.

In the event that an employer becomes a covered employer during a covered employee's CPFL period (after the CPFL period has commenced), the covered employer must provide PPLO supplemental compensation only for the period after becoming a covered employer. This is especially important for intermittent leave periods.

Covered Employees

As defined in the PPLO, a Covered Employee is:

- Employed at least 180 days prior to the commencement of the leave period;
- Completes at least eight hours of work per week within San Francisco;
- Works in San Francisco for at least 40% of their weekly hours for the covered employer; and
- Is eligible to receive compensation under the CPFL for bonding with a new child.

If an employee is taking intermittent leave, they need to have commenced employment 180 days prior to each leave increment. Government employees are not considered covered employees. Employers are not required to but may verify that an employee is actually receiving compensation under the CPFL by requesting that the employee provide the employer with their Electronic Benefit Payment Notification (DE 2500E). The DE 2500E is also referred to as the "Notice of Payment" and is provided to the employee by the State EDD.

Benefit Calculation

In order to be eligible for PPLO supplemental compensation, a covered employee must be eligible to receive CPFL benefits. To be clear, employees must have actually applied for CPFL benefits and received a Notice of Computation from the EDD. An employee must then provide the Notice of Computation and the completed PPLO Form to the employer. Further, the covered employer is not required to pay PPLO supplemental compensation if the employee does not actually receive the CPFL benefits. Additionally, the PPLO Form includes a requirement that the employee agree to reimburse the covered employer for the full amount of PPLO supplemental compensation if the employee voluntarily separates from employment within 90 days of the end of the employee's CPFL period.

The PPLO supplemental compensation calculation varies based on whether the employee has more than one employer and whether the employee receives and reports tips. For a Covered Employee of a single employer that does not receive tips:

- Find the employee's CA EDD CPFL weekly benefit amount on the notice of computation or electronic benefit payment notification provided by the employee (this amount is capped at $1,173);

- Determine the employee's current normal gross weekly wages during the PPLO lookback period (this amount is capped at $2,133);

- Subtract the CPFL weekly benefit amount from the normal gross weekly wage;

- This is the amount of PPL supplemental compensation due per week.

An Employer may, but is not required to, apply up to two weeks of an employee's accrued, unused vacation time toward the cost of PPLO supplemental compensation. An Employer may only apply accrued, unused PTO in excess of 72 accrued hours. However, an Employer may not apply an employee's accrued, unused sick time for PPLO supplemental compensation.

On April 11, 2016, legislation was signed by Governor Brown to increase the benefits paid by the CPFL program. Benefits will increase from the current 55% to either 60% or 70% of an employee's average weekly wage changing the employer's contribution from the current 45% to either 40% or 30%.

Employer Action

Employers must post the required notice in all worksites and are encouraged to provide a copy of the PPL Form to all current and new employees. Additionally, if a Covered Employer publishes an employee handbook that describes available types of leave, then they are required to include a description of employee rights under the PPLO in the next edition of their handbook. Employers must provide the PPL Form in any language that is spoken by 5% or more of the employees in any worksite.

Senate Releases Draft Reform Legislation

Published: June 26, 2017

On June 22, 2017, the Senate released draft health care reform legislation, the Better Care Reconciliation Act of 2017 ("BCRA"). It is substantially similar to the America's Health Care Act ("AHCA"), legislation passed by the House last month.

The Senate bill is not without controversy, drawing criticism from Democrats, moderate and far-right Republicans. The Senate Majority Leader has indicated that the bill will be brought for a vote before the 4th of July recess. Because no Democrats will vote in favor of "repeal and replace" legislation, the Republicans will need 51 votes. This means no more than two Republican Senators can vote against the legislation. So far, at least five have announced their opposition to the bill. Further, the Congressional Budget Office is expected to score the bill early this week, which may affect the vote count. There will be a significant amount of negotiation and political maneuvering to determine whether the Republicans can secure the votes to pass one of their major policy initiatives, to repeal and replace the Affordable Care Act ("ACA").

The following chart highlights some of the key aspects of the ACA and how they would be changed by AHCA and BCRA.
This chart is targeted at specific aspects of the law that affect employers sponsoring group health plans. Changes to Medicaid and other government programs are not addressed.

	ACA	AHCA	BCRA
Status	Current law	House introduced 3/6; Withdrawn 3/24/2017; Reintroduced and passed with amendments 5/4/2017; Senate is on the clock	Senate draft bill released 6/22/2017
Individual mandate	Requires all U.S. citizens and legal residents to have qualifying health coverage (unless an exemption applies) Failure to have qualifying coverage may result in a penalty of the greater of $695 (as indexed) or 2.5% of household income (capped at the average national cost of Bronze level coverage)	Eliminates individual mandate penalty ($0) effective January 1, 2016 Uses a 30% surcharge (based on the cost of the insurance premium) on individuals who are without coverage for at least 63 days and then buy coverage • Surcharge would apply for a period of 12 months • States may use health status underwriting as opposed to the 30% surcharge in the individual market	Eliminates individual mandate penalty ($0) effective January 1, 2016 New 6/26/2017. Imposes a 6-month waiting period on individuals buying health insurance in the individual market who, during the prior 12 months, had a break in coverage of at least 63 consecutive days (effective January 1, 2019)
Employer Mandate	Applicable large employers may pay a penalty if full-time employees receive subsidized coverage in the Marketplace Penalties are assessed when there is no offer of minimum essential coverage to the full-time employee and children and when there is an offer of coverage, but the coverage is not affordable or does not meet minimum value Employers must report to the IRS on offers of coverage, affordability and minimum value using Forms 1094-C and 1095-C	Eliminate penalties as of January 1, 2016 ($0) 1094-C and 1095-C remain Efforts may be made to condense reporting to align on Form W-2, making the 1094-C and 1095-Cs obsolete	Eliminate penalties as of January 1, 2016 ($0) 1094-C and 1095-C remain
High Cost Plan Excise Tax	40% excise tax on health insurance coverage that exceeds $10,200 for self-only and $27,500 for coverage other than self-only Effective date is January 1, 2020	Same as ACA except the effective date is pushed out to January 1, 2026	Same as AHCA
Other Taxes and Fees	Introduced a host of new taxes and fees	Repeals most ACA imposed taxes and fees, including: • Additional Medicare tax on wages and investment income • Health insurance carrier tax • Medical device tax and pharmaceutical fee Keeps the PCORI fee Removes $ cap on health FSA contributions	Same as AHCA

	ACA	AHCA	BCRA
Wellness	Increases available wellness incentives under the HIPAA rules to 30% (50% for tobacco use) Care must be taken to coordinate with other federal rules (ADA and GINA)	Same as ACA	Same as ACA
Benefit Design Reforms	All group health plans must: • Not impose annual or lifetime dollar limits on essential health benefits • Cover children to age 26 • Not retroactively terminate coverage • Not impose waiting periods of more than 90 days • Not include pre-existing condition exclusions In addition, non-grandfathered group health plans must: • Cover preventive care at 100% in-network • No discriminate in favor of highly compensated in insured plans (not currently enforced) • Adopt enhanced claims, appeals and external review procedures • Limit individual out-of-pocket expenses to prescribed thresholds ($7,150 self-only/ $14,300 family for 2017) • Cover routine costs associated with clinical trials • Include certain patient protections and cover emergency services as in-network when provided out-of-network	AHCA retains all of the benefit design reforms of the ACA except in the individual market where a 30% surcharge is permitted on individuals who have a gap in coverage of at least 63 days; the surcharge lasts 12 months Additionally, the AHCA gives power to the states (with approval from HHS) to reduce the essential health benefits currently defined under federal law	Retains all of the ACA benefit design reforms Provides some additional flexibility in waiver process for states to design alternative standards (not clear how far reaching this is) New 6/26/2017. Imposes a 6-month waiting period on individuals buying health insurance in the individual market who, during the prior 12 months, had a break in coverage of at least 63 consecutive days (effective January 1, 2019)
Small Group and Individual Rules	Offer at least a bronze level of coverage (60% plan) with all of the essential health benefits Costs of insurance may only differ based on the following: • Plan and tier of coverage; • Age (3:1); • Geographic location; • Tobacco-status (5:1)	Allows 5:1 age-banded rates Offer coverage below a Bronze level (i.e., 58% plan) Permits states to waive certain federal requirements for state based initiatives: • Age rating above 5:1 • Identify a state's own set of essential health benefits beginning in 2020 • Beginning in 2019, use health status rating (assuming there is a high risk pool) as opposed to the 30% surcharge in the individual market when someone purchases coverage after a 63 day gap in coverage	Allows 5:1 age-banded rates Provides some additional flexibility in waiver process for states to design alternative standards (not clear how far reaching this is) New 6/26/2017. Imposes a 6-month waiting period on individuals buying health insurance in the individual market who, during the prior 12 months, had a break in coverage of at least 63 consecutive days (effective January 1, 2019)

	ACA	AHCA	BCRA
Health Savings Accounts (HSAs)	Eligible individuals may contribute up to the statutory maximum contributions (for 2017, $3,400 self-only and $6,750 for family) Withdrawals from HSAs for non-qualified medical expenses are subject to a 20% penalty No joint HSAs No reimbursement of qualified medical expenses incurred prior to establishment of the HSA	Effective January 1, 2018 increase the maximum HSA contribution for a calendar year to equal the out-of-pocket cost sharing under the QHDHP rules ($6,550 self-only; $13,100 family for 2017) Permit both spouses eligible for a $1,000 catch-up contribution to make the contribution to the same HSA Permit reimbursement of qualified medical expenses from the HSA when they were incurred up to 60 days before the HSA is established Reinstates the 10% penalty for withdrawals from the HSA for non-qualified expenses	Same as AHCA
OTC	Tax favored accounts cannot reimburse OTC medicines and drugs without a prescription	Reinstates pre-ACA rules that permit reimbursement of OTC medicines and drugs without a prescription	Same as AHCA
Certificates of Creditable Coverage	No longer applicable after December 31, 2013	No specific guidance	New 6/26/2017- will require issuance of certificates of creditable coverage to prove continuous coverage over the prior 12-month period
Association Health Plans	Generally limits the ability for unrelated small employers to pool together under a single employer plan and take advantage of large employer underwriting	Creates more flexibility for association medical plans to be established	Creates new small business health plans to allow unrelated employers to purchase large group coverage Incorporated into ERISA – must be insured and receive federal and state approval
Premium tax credits in Marketplace	Makes available premium tax credits for individuals between 100%-400% of FPL without access to affordable MEC Computed based on the second lowest cost silver plan (70% plan) available in the Marketplace Individuals with unaffordable employer based coverage may access premium tax credits	Phases out premium tax credits By 2020 introduce income based tax credits adjusted for age (and reduced for individuals with income over $75,000)	Funds cost-sharing subsidies through 2019 Will make future subsidies available to income between 100%-350% of FPL Amount of credit will be computed based on a 58% plan in the Marketplace Denies access to tax credits to individuals with access to employer coverage
MLR	Requires insurance carriers to meet certain thresholds for insured health plans • At least $0.85/$0.80 (small group) of every $1 must go pay claims or activities to improve health care quality • Rebates must be paid to policy holders when the carrier fails to maintain the appropriate ratio	N/A	Requires states to establish and administer the MLR at the state level for plan years beginning January 1, 2019

Republicans Delay a Vote on BCRA

Published: June 29, 2017

It has been a busy week in Washington. The Congressional Budget Office released its report on the Better Care Reconciliation Act ("BCRA"), the Senate's version of "repeal and replace" legislation. Unfortunately for Republican leadership, the report estimated that, if enacted, 22 million Americans would lose health insurance coverage by 2026. This report, along with conflicting opinions within the party, forced Senate Majority Leader Mitch McConnell to delay a vote on the legislation until sometime after the July 4th recess.

In order to pass BCRA, 50 of the 52 Republican Senators must be in favor of it. At last count, at least 9 senators have stated they would vote against BCRA in its current form. The opposition is from both the Conservatives, who believe the bill does not go far enough to repeal and replace the ACA, and more moderate Republicans who are concerned about the number of Americans losing coverage.

Prior to withdrawing the legislation, the current draft was updated to include a 6-month waiting period for coverage purchased in the individual insurance market when an applicant has more than a 62-day break in coverage during the prior 12-months. The law also requires carriers (and presumably sponsors of a group health plan) to provide documentation of prior coverage in order to offset any waiting period.

Reports are that McConnell is looking to further revise the current draft legislation and send it back to CBO for a new score. It is unclear what revisions the Leader is looking to make and how that may affect the vote tally. Further, any bill (if passed) will need to be reconciled with House legislation and pass that chamber before it can be signed by the President.

We will continue to monitor and report developments.

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