CBP
Creative Benefit Plans
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2018: First Quarter

# Compliance Digest

Compliance Bulletins Released January-March

# 2018 Compliance Bulletins

## January



## February



## March



This document is designed to highlight various employee benefit matters of general interest to our readers. It is not intended to interpret laws or regulations, or to address specific client situations. You should not act or rely on any information contained herein without seeking the advice of an attorney or tax professional.

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# Short-Term Spending Bill Delays Cadillac Plan Tax and Extends CHIP

Published: January 30, 2018

On January 22, 2018, Congress approved a short-term spending bill (the "Bill") that will fund the government until February 8, 2018. The Bill was signed into law the same day. During its annual appropriation exercise, Congress provides funding for the agencies and programs it has authorized. Because Congress failed to adopt a regular appropriation bill, a continuing resolution was adopted on December 22, 2017 to continue government funding until January 19, 2018. The current Bill secures temporary funding to allow agencies and programs to continue to function, but a regular appropriations bill is required to secure funding for the entire year
(until September 30, 2018).

Notable to employers sponsoring group health plan coverage, the Bill will further delay the effective date of the Cadillac Plan Tax until January 1, 2022. The Bill also suspends other health care related taxes and extends the Children's Health Insurance Program ("CHIP").

## Suspension of Health-Related Taxes

Several taxes were included as part of the Affordable Care Act ("ACA") to increase health insurance coverage (e.g., individual and employer mandates), reduce health care costs (e.g., Cadillac Plan Tax) and finance health care reform (e.g., PCOR fee). While some taxes have been in effect for several years, others have been delayed or suspended by congressional action.

The Bill delays or suspends the following ACA taxes:

- **High Cost Employer-Sponsored Health Coverage** ("Cadillac Plan Tax;"). This is a 40% excise tax on the value of coverage above $10,200 for self-only coverage and $27,500 for coverage other than self-only. Originally scheduled to take effect January 1, 2018, subsequent legislation delayed the effective date until January 1, 2020. This Bill once again delays the effective date until January 1, 2022.

- **Medical Device Tax.** This is a tax equal to 2.3% of the price of the product, imposed on the sale of any taxable medical device by the manufacturer, producer, or importer. It was previously suspended and is further delayed until January 1, 2020.

- **Annual Fee on Health Insurance Providers.** This fee is assessed on health insurance carriers. Carriers generally build the cost into premiums (3% to 4%) of insured medical, dental, and vision plans. The tax took effect in 2014, was suspended for 2017 and will again be suspended for calendar year 2019. The tax will be collected for 2018.

## The Healthy Kids Act

The Bill expands coverage for children under CHIP and the Public Health Funding Extension Act for a period of six years. CHIP provides health coverage to eligible children who are ineligible for Medicaid, but cannot afford health insurance. Under the program, the federal government matches state funds to expand health insurance coverage for children.

In addition, the Bill expands funding for the following programs:

- **Childhood Obesity Demonstration Project** a comprehensive model used to reduce childhood obesity by awarding grants to eligible entities.

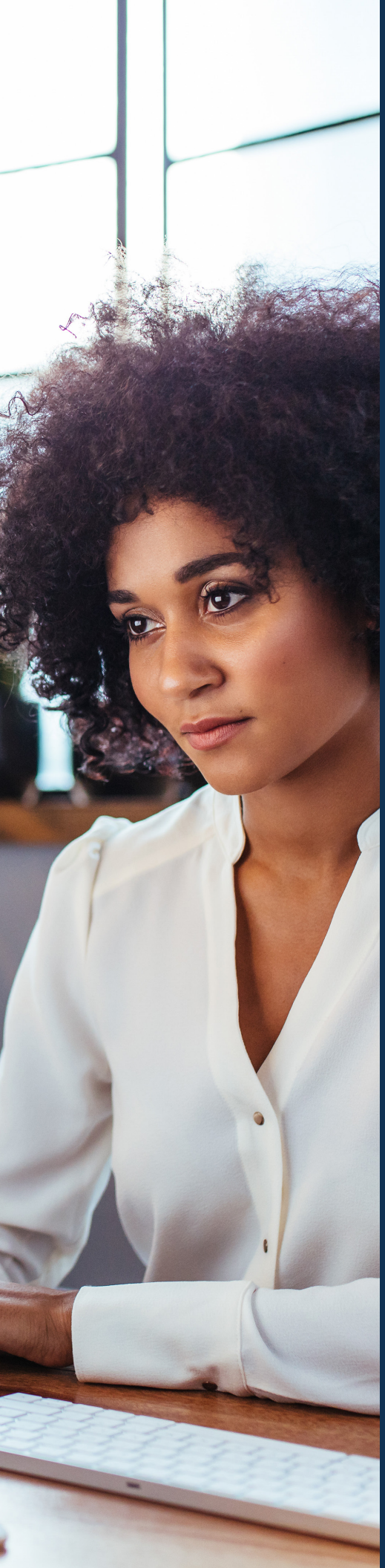
- **Pediatric Quality Measures Program** aims at improving and strengthening core child health.

- **Outreach and Enrollment Program** designed to increase the enrollment and participation of eligible children.

Finally, the Bill also provides that states may offer a plan that mirrors CHIP benefits for children under the age of 19 that do not qualify for CHIP or Medicaid, a "qualified CHIP look-alike program," that is funded from state funds or through premiums. Thus, the program would allow over-age children to continue to maintain health coverage at reduced costs.

## Resources

For additional information, see:
https://www.congress.gov/115/bills/hr195/BILLS-115hr195enr.pdf



# DOL Penalties Increase for 2018

Published: February 6, 2018

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 annual adjustments for 2018 that increase certain penalties applicable to employee benefit plans.

The updated penalties went into effect on January 2, 2018 and apply to penalties assessed after the effective date.

## Annual Penalty Adjustments for 2018

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

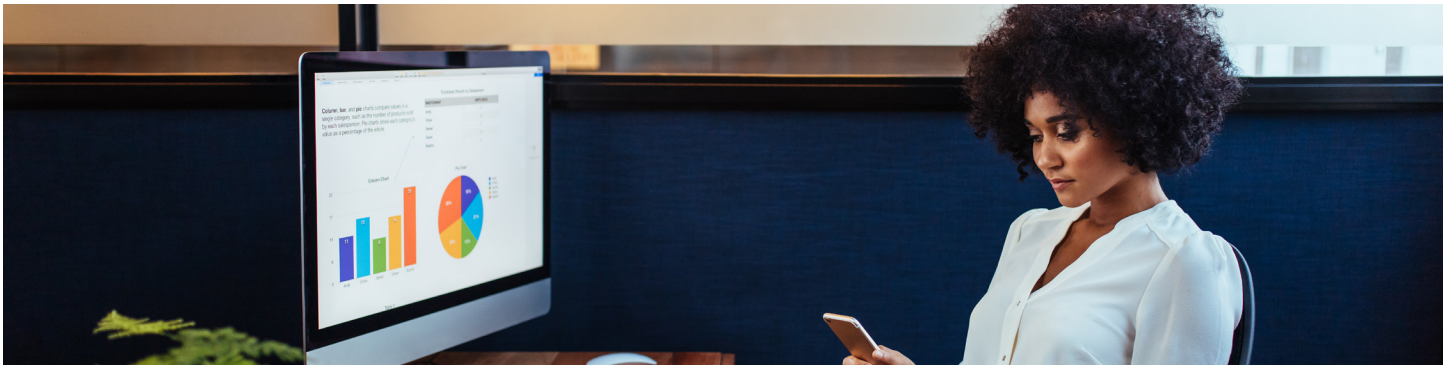
## Annual Penalty Adjustments for 2018

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 $2,097 per day | Up to $2,140 per day |
| Failure of a **MEWA** to file reports | Up to $1,527 per day | Up to $1,558 per day |
| Failure to provide **CHIP Notice** | Up to $112 per day per employee | Up to $114 per day per employee |
| Failure to disclose CHIP/Medicare Coordination to the State | $112 per day per violation (per participant/beneficiary) | $114 per day per violation (per participant/beneficiary) |
| Failure to provide **SBCs** | Up to $1,105 per failure | Up to $1,128 per failure |
| Failure to furnish **plan documents** (including SPDs/SMMs) | $149 per day $1,496 cap per request | $152 per day $1,527 cap per request |
| **Genetic information** failures | $112 per day | $114 per day |
| De minimis failures to meet genetic information requirements | $2,790 minimum | $2,847minimum |
| Failure to meet genetic information requirements – not de minimis failures | $16,742 minimum | $17,084 minimum |
| Cap on unintentional failures to meet genetic information requirements | $558,078 maximum | $569,468 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 12, 2018

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, 2018) must complete this reporting no later than March 1, 2018.**

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

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

# IRS Decreases Some 2018 Limits

## Including Maximum Family HSA Contribution

Published: March 12, 2018

Due to the new tax reform law, on March 5, 2018, the IRS released Revenue Procedure 2018-18 announcing that it has recalculated some of its previously-released 2018 limits for health saving accounts ("HSAs"), Archer medical savings accounts ("MSAs"), adoption assistance programs, and the small employer health insurance credit.

### HSAs

The 2018 HSA maximum contribution for the family tier is reduced from $6,900 to **$6,850.** The other HSA limits remain the same.

Note that:

1. Although the limit is announced on an annual basis, it is actually determined monthly so individuals who are not HSA-eligible for all of 2018 are generally limited to the number of months they are HSA-eligible and enrolled in family coverage multiplied by $570.83 per month (rather than $575 per month).

2. Individuals who already contributed the full 2018 limit (i.e., who front-loaded) or otherwise end up going over the limit need to contact the HSA trustee/custodian for a taxable distribution ($50 if HSA-eligible all year) by the due date of his or her 2018 tax return to avoid penalty. Additional information:

    - The trustee or custodian of an individual's HSA is not responsible for determining whether contributions to the HSA exceed the maximum annual contribution. This is the responsibility of the account beneficiary who is also responsible for informing the trustee or custodian of any excess contribution and requesting a withdrawal of the excess contribution together with any net income attributable to the excess contribution. In this case, the trustee will make a distribution and report on Form 1099-SA.

- The excess contribution (from the employee or employer) and income are included in the participant's gross income.

- Excess contributions for a year and the income attributable to them should be returned by the due date of the participant's income tax return, including extensions, for that year.

- If not timely returned, the excess contributions will be subject to a 6% penalty.

3. HSA elections can be changed monthly. For HSAs to which employees are able to make pre-tax contributions, the Code Sec. 125 rules generally apply, but because the eligibility requirements and contribution limits for HSAs are determined on a month-by-month basis, an employee may increase or decrease the election at any time (and at least monthly) as long as the change is effective prospectively, without a status change.

   Employers can consider announcing to employees that there is a deemed automatic election to reduce the contribution unless the employee objects. This entails consulting the payroll department or vendor and adjusting the contributions accordingly. For an employer with 26 pay periods, the original maximum per pay HSA contribution for family coverage has been $265.38. However, with the announced reduction, the new amount is $263.46.

   For example, if the contribution for January – March 23 was $1,592.28 ($265.38 X 6 pay periods), the remaining contributions through December would be $262.88 per pay period ($5,257.72 / 20 pay periods), with a small rounding consideration.

4. An announcement should be made to employees about the new limit. There is no particular format required. Any materials printed already should be marked with the new limit, if feasible. Any materials not printed already should be amended, if feasible.

## Archer MSAs

These arrangements are not common as they have generally been replaced by HDHP and HSA programs.

For MSA purposes, the coordinating plan must have:

- for self-only coverage, an annual out-of-pocket maximum (other than for premiums) for covered benefits of $4,550 (was $4,600); and

- for family coverage, an annual deductible of at least $4,550 (was $4,600).

The other limits remain the same.

## Adoption Assistance Programs

For employer adoption assistance programs, the maximum amount that can be excluded from an employee's gross income for qualified adoption expenses is reduced from $13,840 to $13,810. Further, the adjusted gross income threshold after which the adoption exclusion begins to phase out is reduced from $207,580 to $207,140.

The other limits remain the same.

## Small Employer Health Insurance Credit

An eligible small employer may claim, subject to a phaseout, a credit equal to 50% of nonelective contributions for health insurance for its employees. The credit is reduced under certain circumstances, including if the average annual full-time equivalent wages per employee are more than $26,600 (was $26,700).


# Tax Credit Available for Employees on Paid Family or Medical Leave

Published: March 23, 2018

For 2018 and 2019 only, there is a tax credit available to certain employers as to FMLA-qualifying circumstances (whether under FMLA or not) for employees earning $72,000 or less for whom paid family and medical leave is provided. Nothing in the rules requires the employer to be subject to FMLA to receive the tax credit. Thus, it is available to employers with less than 50 employees. Notably, paid leave must be provided to both full-time and part-time employees in order to claim the credit; if part-time employees are excluded from a paid leave policy, this credit is not available.

Additional information follows.

## Amount of Credit

The credit is generally 12.5% of the amount of wages paid to qualifying employees (although it increases by .25% for every percentage point an employee's FMLA wages exceed 50% of their normal wages, capped at 25%).

The credit is also capped with respect to each employee to the normal hourly wage rate of such employee for each hour (or fraction thereof) of actual services performed for the employer multiplied by the number of hours (or fraction thereof) for which family and medical leave is taken. In the case of any employee who is not paid on an hourly wage
rate, the wages of such employee are prorated to an hourly wage rate under regulations to be established by the Secretary of the Treasury.

## Form of Credit

The credit is in the form of a general business credit.

## Eligible Employer

To take the credit, an employer must have in place a written policy that provides not less than 50% of the wages normally paid to such employee and:

- in the case of a qualifying employee who is full-time (customarily employed for at least 30 hours per week), provides not less than 2 weeks of annual paid family and medical leave; and

- in the case of a qualifying employee who is a part-time employee (customarily employed less than 30 hours per week), provides an amount of annual paid family and medical leave that is not less than a prorated amount. Note that many existing programs do not offer paid leave to part-time employees and thus would not qualify for the credit (unless there is no part-time workforce).

If an otherwise eligible employer (whether or not subject to FMLA) provides paid family and medical leave outside of what is required under FMLA to an eligible employee, there are protections it must ensure in order to take advantage of the tax credit. In that case, the otherwise eligible employer must provide paid family and medical leave in compliance with a written policy which ensures that the employer:

- will not interfere with, restrain, or deny the exercise of or the attempt to exercise, any right provided under the policy; and

- will not discharge or in any other manner discriminate against any individual for opposing any practice prohibited by the policy.

All entities in the same controlled group under Code Sec. 52(a) and (b) (more than 50% common ownership) are treated as a single employer.

## Qualifying Employees

An employee for whom a credit is available is any employee who:

- has been employed for at least one year; and

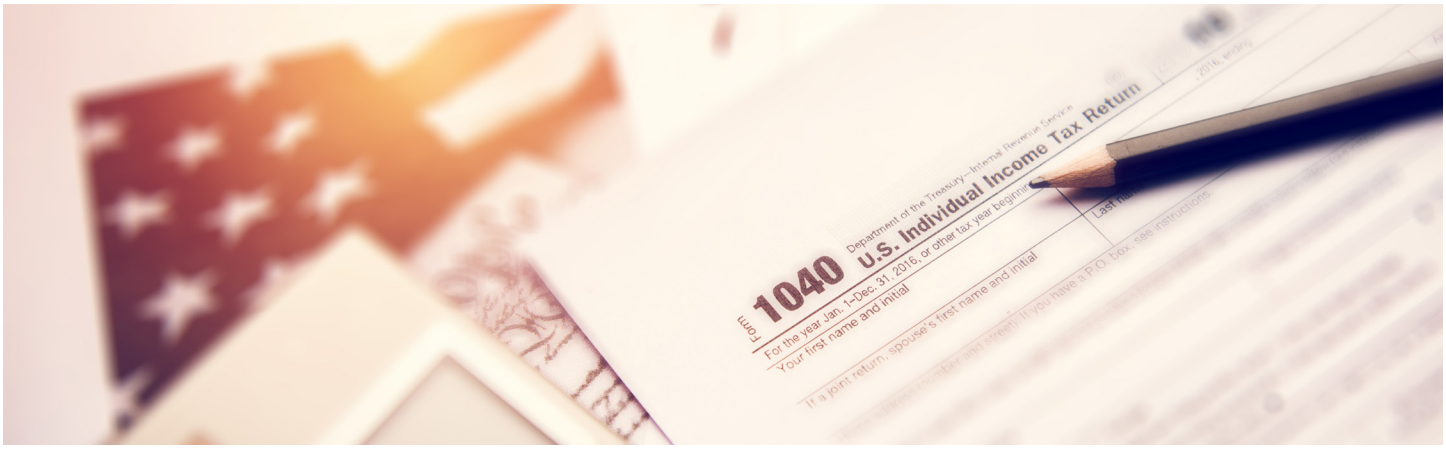
- had compensation of no more than $72,000 for 2018 (to be indexed in 2019).

## Qualifying Circumstances

"Family and medical leave" means leave for any one or more of the following purposes whether the leave is provided via FMLA or by a policy of the employer:

- Because of the birth of a son or daughter of the employee and in order to care for such son or daughter.

- Because of the placement of a son or daughter with the employee for adoption or foster care.



- In order to care for the spouse, or a son, daughter, or parent, of the employee, if such spouse, son, daughter, or parent has a serious health condition.
- Because of a serious health condition that makes the employee unable to perform the functions of the position of such employee.
- Because of any qualifying exigency arising out of the fact that the spouse, or a son, daughter, or parent of the employee is on covered active duty (or has been notified of an impending call or order to covered active duty) in the Armed Forces.
- To care for a servicemember as to an eligible employee who is the spouse, son, daughter, parent, or next of kin of a covered servicemember.

Vacation leave, personal leave, and medical or sick leave for any other purpose is not counted.

It is not clear whether short-term disability benefits count for this purpose.

Any leave which is paid by a state or local government or required by state or local law is not considered in determining the amount of paid family and medical leave provided by the employer.

## Maximum Amount of Leave

The amount of family and medical leave that may be taken into account is up to 12 weeks.

## Examples

**Example 1:** Employer pays $10,000 of wages to qualifying employees during a period in which those employees are on family and medical leave. This amount is 50% of the wages normally paid to the employees for services rendered to the employer. Employer can claim a paid family and medical leave credit of $1,250 (12.5% of $10,000).

**Example 2:** Employer pays $12,000 of wages to qualifying employees during a period in which those employees are on family and medical leave. This amount is 60% of the wages normally paid to the employees for services rendered to the employer. The 60% rate of payment exceeds 50% by 10%. As the applicable percentage of 12.5% used to determine the credit is increased (but not above 25%) by .25% for each percentage point by which the rate of payment exceeds 50%, Employer's credit is increased by 10 × 0.25%, or 2.5%. Employer can thus claim a paid family and medical leave credit of $1,800 (15% (12.5% plus 2.5%) of $12,000).

## Effective Date

This credit is permitted from January 1, 2018 – December 31, 2019.

A taxpayer may elect to have this section not apply for any taxable year.

## Employer Action

The Treasury Department is expected to issue guidance to better understand the various requirements of the tax credit. Employers should review existing policies to understand whether they are eligible to claim a credit for 2018 and await further guidance.

# San Francisco HCSO
## Calculating Self-Funded Expenditures in 2018

Published: March 26, 2018

Employers sponsoring self-funded health plans with Covered Employees in San Francisco will need to calculate health care expenditures differently beginning with calendar year 2018. Historically, self-funded employers used the COBRA equivalent rate to determine if the health care expenditure was sufficient.

Beginning in 2018, employers will need to adopt a new technique, either the "No Return of Premium" or "Pay-As-You-Go," to determine whether the employer's contributions meet the minimum San Francisco requirements.

For calendar year 2017, employers may still use the COBRA equivalent rate to determine health care expenditures (including on their Annual Reporting Form for 2017 due by April 30, 2018).

### Background

In 2008, San Francisco implemented the Health Care Security Ordinance ("the Ordinance"), a "pay or play" law requiring employers to make health care expenditures on behalf of Covered Employees. Under the Ordinance, the annual expenditure by a covered employer for 2017 may total more than $5,000 per Covered Employee.

Briefly, a Covered Employee is an employee who (1) has been employed at least 90 days and (2) performs at least 8 hours of services a week in San Francisco.

To satisfy the spending requirement, a Covered Employer must make health care expenditures on behalf of covered employees at the following rates:

| Employer Size | # of Employees* | 2017 Expenditure Rate | 2018 Expenditure Rate |
|---|---|---|---|
| Large | All employers w/ 100+ employees | $2.64 per hour payable | $2.83 per hour payable |
| Medium | Businesses w/ 20-99 employees<br>Nonprofits w/ 50-99 employees | $1.76 per hour payable | $1.89 per hour payable |
| Small | Businesses w 0-19 employees<br>Nonprofits w/ 0-49 employees | Exempt | Exempt |

** all employees, not just those working in SF*

Generally, the Covered Employer must calculate the required expenditure for each covered employee. However, there are special rules that can be used to determine the expenditure requirement for plans that provide uniform health coverage (meaning coverage in the same health plan) or a self-funded arrangement.

## What's New for a Self-Funded Plan?

Under a rule change effective in 2017, all health care expenditures must be made irrevocably. This change eliminates the possibility that a Covered Employer can recover unused funds allocated to Covered Employees, for example through reimbursement accounts.

Guidance issued October of 2017, describes how the irrevocability rule affects the calculation of health care expenditures made to self-funded health plans. Specifically, amounts that are not irrevocably spent cannot be considered in determining whether a self-funded plan complies with the spending requirement.

Beginning with calendar year 2018, an employer may comply with the spending requirement by providing a self-funded uniform health plan to some or all of its Covered Employees, so long as that plan satisfies one of the following conditions:

1. No return of premium. The employer pays premiums and/or fees to third-party administrator (TPA) to administer the self -funded health plan and:
   a. no portion of those premiums or fees are returned to the employer; and
   b. the premiums and fees paid for a calendar quarter meet or exceed the required expenditure for each Covered Employee for that quarter.
2. Pay as you go. The employer pays claims as they are incurred, and the average hourly expenditures meet or exceed that year's expenditure rate for the employer.
   a. This option is limited to uniform health plans, meaning the plan must have the same benefit design for all covered employees, including co-pay requirements, out-of-pocket maximums, deductibles, coverage tiers, and eligibility criteria.
   b. The average hourly Health Care Expenditure for employees in a uniform health plan is calculated by dividing the total amount of required Health Care Expenditures for employees in the plan by the total number of Hours Payable to each of the employees in the plan during that quarter.
   c. The employer shall receive credit toward the spending requirement in the amount of the average actual expenditures per Covered Employee.

## Pay As You Go

To meet the minimum expenditure requirement under the pay-as-you-go method, the average hourly expenditure for a calendar year must meet or exceed that year's expenditure rate.

For 2018, you will use the actual claims data for the year in determining the average hourly expenditure.

To determine the total spent on the self-insured health plan, only irrevocable employer contributions are counted. Do not include before or after-tax employee contributions.

In the following two examples, assume the employer is considered a Large Employer under HCSO.

| **Example 1** | |
|---|---|
| Covered Employees in 2018 | 100 |
| Total spending on self-insured health plan for those employees in 2018 | $600,000 |
| Total hours payable to covered employees in 2018 | 206,400 |
| Average hourly expenditure | $2.91 ($600,000/206,400) |
| Does the average hourly expenditure equal or exceed $2.83? | Yes |

| **Example 2** | |
|---|---|
| Covered Employees in 2018 | 75 |
| Total spending on self-insured health plan for those employees in 2018 | $350,000 |
| Total hours payable to covered employees in 2018 | 154,800 |
| Average hourly expenditure | $2.26 ($350,000/154,800 |
| Does the average hourly expenditure equal or exceed $2.83? | No-additional employer expenditure needed to satisfy spending requirement |

If the spending requirement is not satisfied (as reflected in Example 2), the employer may "top off" expenditures by February 2019. Options available to the employer to satisfy this requirement include:

- Employer contributions toward premiums for other medical benefits (e.g., dental or vision) or make additional contributions toward a spouse or dependent's coverage.
- Contribute to the City Option.

## Employer Action

Employers sponsoring a self-funded group health plan and planning to use employer contributions to meet the requirements of the HCSO for 2018 will want to carefully review these new calculation options.

While the 2017 expenditures (which are due to be reported by April 30, 2018) may be determined with the COBRA equivalent method, effective 2018, a new method will be use to determine the expenditure amount.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