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Wells Fargo Insurance Employee Benefits Compliance Practice

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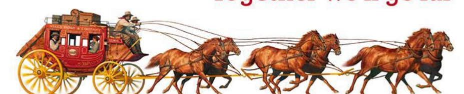

Senate efforts to repeal and replace (or just repeal) the ACA fall short

In brief:

- The Senate failed to pass legislation that would repeal and replace the ACA, as well as legislation that would just repeal a portion of the ACA to keep the legislation activity moving forward.
- Despite the prospects of his long term health after his recent diagnosis of brain cancer, Sen. John McCain (R-AZ) played a critical role in the Senate's actions.
- Due to the current lack of political consensus in Congress to address health care reform, look for the Administration and state insurance regulators to take the lead in determining the success or failure of the Marketplace exchanges in various parts of the U.S. in 2018.

Following several days of maneuvering early in the week of July 24, 2017, the U.S. Senate rejected multiple efforts to repeal and replace the Affordable Care Act (ACA). In the early morning hours of July 28, 2017, the Senate surprisingly was also unable to pass a slimmed-down repeal-only bill. Thus, the ACA remains the law of the land, notwithstanding the fragile Marketplace exchanges that continue to weaken in various areas across the country.

Background

In an eerie similarity to events surrounding the passage of the ACA back in 2010, a prominent senator suffering from brain cancer played a critical role in the health care reform drama in the Senate. Sen. John McCain (R-AZ) returned to Washington after recently announcing his diagnosis of brain cancer. He cast a critical vote needed to pass a motion to start the debate in the Senate concerning passage of ACA repeal and replace legislation. Thereafter, the Senate failed to overcome complaints from various moderate and conservative Republicans. First, a modified version of the Senate's primary "repeal and replace" bill, the Better Care Reconciliation Act, did not pass (see our July 2017 Employee Benefits Compliance Update for a detailed description of the initial and modified versions of this legislation).

Then, a "repeal and delay" bill, the Obamacare Repeal Reconciliation Act, similar to legislation passed by Congress in late 2015 but vetoed by then-President Obama, also failed to pass.

"Skinny repeal" effort fails

In an effort to keep the process going, the Senate leadership's fallback strategy was to put forth a "skinny repeal" bill, the Health Care Freedom Act. The final version of the "skinny repeal" bill included (i) repealing the individual and employer mandate penalties, (ii) delaying the tax on medical devices, (iii) cutting off federal funding for Planned Parenthood for one year, (iv) increasing federal grants to community health centers but decreasing funding for certain other ACA prevention and public health programs, (v) increasing the contributions limits to HSAs, and (vi) relaxing the rules for states to obtain ACA section 1332 waivers to avoid various ACA-related market reform mandates. This bill left untouched the ACA's controversial Medicaid expansion provision and changes to future Medicaid funding. It also did not include any sort of replacement for the individual mandate to encourage individuals to maintain health coverage even though employers and insurers would still have to offer coverage on a guaranteed issue basis.

The hope was that a more robust repeal and replace bill would emerge from a House-Senate conference committee that would be formed to reconcile the differences between the Senate bill and the House's bill, the American Health Care Act (AHCA). However, there were fears that no comprehensive compromise would emerge from the conference committee and that the House would just vote to approve the Senate's bill as is. In the end, however, Sen. McCain provided the decisive vote against the Senate's skinny repeal bill.

What is next?

Although the White House and certain members of Congress continue to call for immediate action to repeal the ACA, Congress is in recess until September 5, 2017. Thereafter, there is currently no clear path in the Senate to move forward with such legislation. In addition, there are other pressing issues that will crowd the legislative agenda this fall, such as considering tax reform, raising the federal debt ceiling, and approving federal spending for 2018.

However, similar to what happened after the House's first effort to pass repeal and replace legislation failed, it is

likely that closed door negotiations will continue within the Republican caucus. In addition, there have been some discussions of bipartisan negotiations and Congressional hearings to address certain limited areas of the ACA, especially to stabilize the Marketplace exchanges. Nevertheless, the prospects of the passage of any sort of bipartisan health reform legislation in the near future are limited.

Accordingly, focus will shift from Congress to the Administration and state insurance regulators to see what actions they take or not with respect to stabilizing the individual insurance markets. Insurers have repeatedly pointed to the inconsistent actions from the Administration since President Trump's election (such as only committing to fund cost-sharing reduction payments on a month-by-month basis, suggesting that the individual mandate will not be enforced, and cutting back on federal efforts to market the exchanges) as being critical to their decisions to withdraw from certain markets and significantly increase their proposed pricing in the markets where they remain. As a result, some state insurance regulators are taking a more active role in negotiating with insurers to stay in their state and to expand the coverage areas. In addition, some states (such as Alaska, Maine, and Minnesota) are pursuing ACA section 1332 waivers to create high-risk pools and other support mechanisms to stabilize their own individual health insurance markets.

Unless and until comprehensive ACA repeal and replace legislation is enacted, employers need to remain focused on complying with the law, which is the subject of a separate article in this month's Employee Benefits Compliance Update.

Benefit planning for 2018

In brief:

- At least for the time being, the ACA remains the law of the land. Unless and until that changes, health plan sponsors need to remain focused on providing ACA-compliant health benefits to their workforce.
- Benefits compliance requirements should be assessed and evaluated, as there are a number of changes that will need to be made for 2018.

As employers begin to strategize for their 2018 benefit programs, it is important not to lose sight of new and ongoing compliance obligations. Despite what may come of Affordable Care Act (ACA) repeal and replace legislation, there are a number of compliance concerns that may require plan sponsors to make changes in their employee benefit plan design and administration.

Summary of Benefits and Coverage

Health plan sponsors required to provide a Summary of Benefits and Coverage (SBC) and related materials to employees are reminded that the final revised SBC template and related materials should be used for open enrollments that occur on or after April 1, 2017. Please see the article from our April 2017 Employee Benefits Compliance Update for complete details on the new requirements. For calendar year plans, the upcoming 2018 open enrollment is the first open enrollment where the new SBC templates must be used. Employers should review SBCs for the upcoming open enrollment to be sure they have changed to reflect the new rules. Templates, instructions and related materials for the new SBCs can be found on the Department of Labor website (open "Model Notices & Disclosures" – SBC information is at the bottom).

Section 1557 nondiscrimination notice

U.S. Department of Health and Human Services (HHS) regulations require employers that are "covered entities" (generally, those that have a health plan and receive any financial assistance from HHS) to distribute a Section 1557 nondiscrimination notice to avoid potential penalties (see the article in our October 2016 Employee Benefits Compliance Update). The full lengthy Section 1557 notice and numerous language-assistance taglines must be included with all "significant communications" involving the medical plan, such as summary plan descriptions and SBCs.

ACA reporting

Even though an executive order was issued earlier this year directing the federal government agencies to minimize the burdens of the ACA, the Internal Revenue Service (IRS) has confirmed in two letters from the Office of Chief Counsel that the law has not been changed by the executive order. The statutes and regulations implementing the employer shared responsibility "play or pay" and the individual mandate are still in effect and have not been changed.

Likewise, there has been no statutory change removing the employer's obligation to report offers of health coverage to full-time employees, or actual coverage provided to any individuals (for self-insured plans). So, employers subject to the reporting requirements should prepare to comply and report for 2017 on Forms 1095-C and 1094-C, unless reporting relief is enacted.

The IRS recently issued draft Form 1094/1095 information returns for the 2017 tax year. Draft instructions are still pending. The draft forms themselves show few changes from 2016.

- Form 1094-B (used by coverage providers to report health plan enrollment) is unchanged.
- The only change to Form 1094-C (used by applicable large employers (ALEs) to report information relevant to employer shared responsibility penalties) is the removal of the line 22 box for "Section 4980H Transition Relief." This relief was applicable only to the 2015 plan year, but the line 22 box remained on the 2016 form because some non-calendar-year plans qualified for this relief for months of the 2015 plan year that fell into the 2016 calendar year.
- There are no substantive changes to Form 1095-B (used by coverage providers to report health plan enrollment) or Form 1095-C (used by ALEs to report information relevant to employer shared responsibility penalties). A new paragraph in the Instructions for Recipients on the back of the form entitled "Additional information" refers recipients to an IRS webpage that provides an overview of the provisions of the individual shared responsibility, employer shared responsibility, and premium tax credits, along with contact information for the IRS Healthcare Hotline for questions.

Preventive services

Group health plan sponsors need to closely monitor federal recommendations and guidelines on preventive services. Non-grandfathered plans must cover all of the preventive services listed in the various federal recommendations and guidelines for plan years beginning one year or later after the applicable recommendation or guideline is issued. For example, on December 20, 2016, the Health Resources and Services Administration updated its Women's Preventive Services Guidelines. The updated guidelines apply for plan years beginning on or after December 20, 2017. Other required preventive care requirements that will begin January 1, 2018, include screening for depression in adults, low dose aspirin for certain at-risk adults, and syphilis screening for certain asymptomatic non-pregnant adults.

ERISA disability claims procedure

On December 19, 2016, the Department of Labor (DOL) published final changes to the claims and appeals procedures for disability benefits found at 29 CFR §2560.503- 1, which are substantially similar to the proposed changes previously published on November 18, 2015. These final rules apply to any claim for benefits filed on and after January 1, 2018 under a welfare or retirement plan that is conditioned upon a showing of disability where the disability determination is made by the plan. The rules provide greater procedural protections to claimants, and impose additional responsibilities on plan administrators. Please see the article from our February 2017 Employee Benefits Compliance Update for complete details on the new requirements.

Insurer fee

The ACA implemented an annual fee on health insurers starting in 2014. Legislation passed in 2015 included a temporary moratorium on the insurers' fee, but under present law the insurers' fee will be reinstated in 2018, which could result in significant premium increases over 2017 rates. For more detail, please see the separate article in this month's Employee Benefits Compliance Update.

Out-of-pocket maximums

Sponsors of all non-grandfathered group health plans need to confirm that the plan's out-of-pocket maximum complies with the ACA's limits for 2018. The final regulations provide that the limits for 2018 are $7,350 for self-only coverage and $14,700 for tiers other than self-only (with the individual limit of $7,350 still applying separately to each individual covered under tiers other than self-only). For HSA-qualifying high-deductible health plans (HDHPs), plan sponsors also need to confirm that the plan's deductible and out-of-pocket maximum comply with the 2018 limits. Qualifying HDHP coverage for an individual must have an annual deductible of at least $1,350 and the out-of-pocket maximum cannot exceed $6,650 for 2018. Qualifying HDHP family coverage must have a deductible of at least $2,700 and the out-of-pocket maximum cannot exceed $13,300 for 2018 (with a limit of no more than $7,350 applied to any individual to also comply with the ACA, if non-grandfathered).

Cadillac tax

Employers should continue to review their risk of exposure under the "Cadillac tax," the 40% excise tax on high-cost health coverage exceeding certain thresholds. This provision was originally scheduled to become effective in 2018, but subsequent legislation delayed this excise tax to 2020.

The first step is to determine which of the employer's benefits will be included when calculating the tax. The employer can then estimate the exposure to the tax in 2020 and future years. If there is significant exposure, an employer may want to consider options to reduce coverage costs, such as the following:

- reducing benefits to lower the overall value of coverage (e.g., increasing cost-sharing features like deductibles and coinsurance);
- restricting contributions to account-based plans;
- shifting employee contributions from pre-tax to after-tax where after-tax contributions are excluded from the tax's calculation (e.g., for HSAs); and
- limiting or excluding spousal coverage to lower the cost of family coverage.

Tax reform

It's possible that lawmakers could again try to reform the rules governing health savings accounts (HSAs), flexible spending accounts (FSAs), and health reimbursement arrangements (HRAs) as part of the tax reform effort, so employers should consider adding these types of plans to their overall benefits strategy. The House and Senate healthcare proposals both included some changes, such as raising contribution limits for HSAs, which could be renewed in the context of tax reform.

Fully-insured group health plans may see significant premium increases for 2018 due to end of moratorium on ACA insurers' fee

In brief:

- The ACA implemented the annual fee on health insurers starting in 2014.
- The insurers' fee is generally passed onto group health plans, with estimated annual increases in premiums from 2014 forward of approximately 2% to 4% per year.
- The 2015 year-end omnibus budget bill included a moratorium on the insurers' fee for 2017, resulting in 2017 insured group health plan renewal rates that may have been significantly less than plan sponsors otherwise anticipated.
- Under present law, the insurers' fee will be reinstated in 2018, which, absent other factors, could result in significant premium increases over 2017 rates.

Section 9010 of the Affordable Care Act (ACA) included a new fee on health insurers commencing in 2014, designed to assist in funding new obligations of the federal government under the ACA, including subsidies for certain individuals buying coverage through a public Marketplace. The fee is designed as an "applicable amount," which is the annual amount to be collected from most insurers, in aggregate, as follows:

Year	"Applicable Amount"
2014	$8.0 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018	$14.3 billion
2019 and beyond	Indexed increase

The applicable amount is allocated among insurers based on relative market share. Group health plan insurers generally passed on the allocated fee to employer-sponsors. As a result, for years 2014 through 2016, most insured group health plans saw increases between 2% and 4% per year on a compounded basis such that by 2016, renewal rates perhaps included as much as a 12% fee-based increase relative to 2013, the year before the fee commenced.

As reported in our December 22, 2015 Employee Benefits Compliance Alert, then-President Obama signed into law a

2016 omnibus spending law, which included a moratorium on the insurers' fee for 2017. As a result of the federal government not collecting the anticipated $13.9 billion fee for 2017, affected insurers generally adjusted premiums on group health plans to reflect the savings. Thus, most employer-sponsors saw 2017 rates significantly less than what they may have otherwise anticipated after taking into account other factors such as medical cost trend.

While various proposals by the House and Senate include eliminating the insurers' fee, no bill has yet been enacted to do so. Unless and until such bill is enacted, sponsors of insured group health plans should assume that the fee will apply for 2018 and that insurers will pass along their allocated share of the 2018 $14.3 billion applicable amount through 2018 premium adjustments. Because the 2018 fee will be implemented relative to a prior year where no fee was collected, rate increases from 2017 attributable to the insurers' fee alone may be significant. Thus, employer-sponsors of insured group health plans should anticipate such increases in upcoming 2018 renewals.

Please contact your Wells Fargo Insurance representative for further information on the ACA insurers' fee.

New EEO-1 form data overlaps with ACA Forms 1094-C and 1095-C information reporting data

In brief:

- Both the EEO-1 Report and Forms 1094-C/1095-C are due in March 2018, and require the collection of overlapping data.
- Employers may want to streamline their systems that collect data for the EEO-1 and 1094-C/1095-C forms to promote efficiency.

The U.S. Equal Employment Opportunity Commission requires designated employers to fill out the EEO-1 Report, which is an annual compliance survey that requests employment data categorized by race/ethnicity, gender, and job category.

In 2017, the EEO-1 Report was revised to request additional detailed information from employers with 100 or more employees. To allow employers extra time to prepare the report, however, the due date for the 2017 report was extended to March 31, 2018 (instead of September 30, 2017). Some of the data required on the new EEO-1 Report overlaps with the data needed to complete the Forms 1094-C and 1095-C required by the Affordable Care Act (ACA). Specifically, the following new data elements are required on the revised EEO-1 Report:

- Summary pay data: Employers must report the total number of full- and part-time employees they had during the reporting year in each of 12 pay bands listed for each EEO-1 job category. Employers will use earnings reported in Box 1 of the W-2 Form.
- Aggregate hours worked data: Employers must count and report the number of hours worked in the year by all the employees accounted for in each pay band.

Both the revised EEO-1 Report and the ACA Forms 1094-C and 1095-C are relatively new mandates that require employers to put more energy and resources into collecting data. It is advisable to consider streamlining systems so that the data for both requirements is coordinated in a way that will save time and avoid duplication of efforts.

How can we help?

To learn more about current benefits compliance issues, please visit us online or contact your local Wells Fargo Insurance Services representative.

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