WELLS FARGO INSURANCE

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Employee Benefits Compliance Update

Wells Fargo Insurance Employee Benefits Compliance Practice

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Together we'll go far

Senate continues work on its ACA repeal and replace legislation

In brief:

- ACA repeal and replace legislation is progressing through the Senate in a manner similar to the way a comparable bill eventually passed in the House, with the initial draft facing some opposition from different groups of Republicans before being pulled by leadership for more negotiations.
- While there are some similarities between the House and Senate bills, there are also significant differences.
- Various modifications will need to be made to the Senate bill before it can be passed.

News flash

As we go to press, the Senate released a revised discussion draft of its proposed Better Care Reconciliation Act (BCRA). Key modifications include allowing carriers to sell any type of individual health insurance coverage if they also offer at least one option that fully complies with all ACA market reform mandates, adding additional funding to address the opioid crisis and drive state-based reforms, and retaining the existing net investment income tax and additional Medicare tax on high-income individuals. A future Alert will provide further details of whatever bill, if any, that ultimately gets passed by the Senate.

Following the passage of the American Health Care Act (AHCA) by the U.S. House of Representatives earlier this year, the legislative effort by the Republican-controlled Congress to "repeal and replace" the Affordable Care Act (ACA) shifted to the U.S. Senate. Under the leadership of Sen. Mitch McConnell (R-KY), a select group of Republican senators worked in private to develop the Senate version of this ACA repeal and replace legislation, the Better Care Reconciliation Act (BCRA), which was made public on June 22, 2017. While there are some similarities between the AHCA and BCRA, there are also some significant differences (see comparison chart below).

Like the initial draft of the AHCA proposed in the House, the BCRA has received a mixed reception, with various groups of both conservative and moderate Republican senators expressing concern about different aspects of the bill. These concerns lessen the chances that the bill will pass, because there is unanimous opposition by Democratic senators, which means that Republicans can only afford to lose two Republican votes and still be able to pass the bill using the budget reconciliation process, with Vice President Mike Pence breaking the tie.

Also, like the House's initial version of the AHCA, securing the necessary votes to pass the BCRA was made more difficult following the scoring of the bill by the bipartisan Congressional Budget Office (see separate article in this Update concerning this report). As a result, Sen. McConnell chose not to put the BCRA to a vote prior to the Senate's Fourth of July recess, his original target date. Rather, he used this artificial deadline to start clarifying what changes might need to be made to the bill in order to secure the necessary 50 votes, balancing the desire of more conservative Republicans to remove even more of the regulatory structure of the ACA and reduce the federal outlays for healthcare expenditures with the desire of more moderate Republicans to minimize the number of uninsured and address certain specific issues (such as increasing funding for treating opioid addiction). These negotiations will continue for the month of July in an effort to vote on the bill before the month-long summer recess in August.

One of the key modifications purportedly under consideration includes allowing carriers to offer any type of coverage in the individual health insurance market as long as it also offers at least one option that covers all ACA-mandated benefits, which would enable the sale of much lower cost policies for healthy individuals, but at the risk of significantly increasing the cost of coverage for less healthy individuals who need the richer benefits offered under an ACA-approved policy. Other potential modifications include increasing the funding available to address the opioid addiction crisis, and not repealing the net investment tax on high-income individuals to help fund a more generous phase-out of the ACA's Medicaid expansion.

If the Senate Republicans are able to pass the BCRA, it is expected that the House will drop the AHCA and pass the BCRA without any amendments so that it can be signed into law by President Donald Trump. If Republicans are unable

to pass the BCRA, there may be an effort to pass a "repeal" of the ACA without any sort of "replacement," or perhaps even start work on bipartisan legislation to "repair" the individual insurance markets that are in distress in various places across the U.S.

Impact on employers

Simply stated, the BCRA (if enacted) will have three primary impacts on employers and employees:

- Employers will benefit from the elimination of the employer shared responsibility "play or pay" mandate – benefits would include:
  - Eliminating the need to comply with the complex full-time employee determination rules;
  - Eliminating the need to offer low-valued group health plan coverage ("skinny MEC") to certain classifications of employees to minimize penalty exposures; and
  - Eventually reducing employer reporting obligations.
- Employees will benefit from certain enhancements to consumer-directed, individual account health options, such as:
  - Increasing the maximum contributions to health spending accounts (HSAs) to the maximum out-of-pocket limits;
  - Eliminating the $2,500 (indexed) cap on before-tax salary reductions to health flexible spending accounts; and
  - Reinstating the rule allowing for the reimbursement of over-the-counter drugs without a prescription from tax-favored health accounts.
- Employers may see lower long-term costs due to minimized cost shifting from placing Medicaid on a more sustainable financial footing, and stabilizing the individual health insurance market.

Comparison of key elements in AHCA and BCHA

Provision	AHCA (House)	BCRA (Senate)
Individual health insurance subsidies	• Replaces the ACA's income-based subsidies with generally less generous age-based, refundable premium tax credits that apply to a broader group of individual health insurance policies, with credits phased out for individuals with income over $75,000 (or $150,000 for joint filers) • Credits are not available to individuals eligible for any type of employer-provided group health plan or governmental coverage	• Replaces the ACA's subsidies with generally less generous, refundable premium tax credits that include some adjustments for income, geography, and age • Limits credits to individuals at 350% of federal poverty level (rather than 400%) and bases subsidies off of a 58% actuarial value plan (rather than the median premium cost of a silver-level (70% actuarial value)) plan • Credits are not available to individuals eligible for any type of employer-provided group health plan or governmental coverage
Individual mandate	• Effectively eliminates by reducing individual mandate penalty to $0 as of 2016 • Instead encourages continuous coverage by imposing a 30% premium surcharge (or permits state waivers to allow carriers to medically underwrite) for individuals with more than a 63 day break-in-coverage	• Effectively eliminates by reducing individual mandate penalty to $0 as of 2016 • Initial version of BCRA contained no continuous coverage incentive, but an amendment was proposed that will impose a 6-month waiting period on individuals with more than a 63-day break-in-coverage
Employer mandate	• Effectively eliminates by reducing employer mandate penalty to $0 as of 2016	• Same as AHCA
Essential health benefits (EHBs)	• Allows states to apply for waivers to establish their own EHB requirements for individual and small group markets	• Does not include EHB waiver rule, but broadens and loosens the ACA's 1332 waiver process, giving states more flexibility to modify various ACA market reforms

Provision	AHCA (House)	BCRA (Senate)
Other key ACA market reforms (such as prohibition of preexisting condition exclusions, dependent coverage up to age 26, prohibition on annual/lifetime dollar caps, cap on out-of-pocket maximums, medical loss ratio (MLR)/rebate rules)	• Generally retains most ACA market reforms, except states can allow waivers to enable carriers to medically underwrite individuals with more than a 63 day break-in-coverage, which undercuts the ACA's prohibition on preexisting conditions • State waiver of ACA's EHB rules may impact prohibitions on annual/lifetime dollar caps and cap on out-of-pocket maximums	• Generally retains most ACA market reforms • Requires states to set their own MLR/rebating rules • Allows for establishment of association health plans that will be exempt from community rating and EHB requirements as large group health plans for small businesses/individuals
Age rating	• Increases the ACA's 3:1 ratio to allow individual market carriers to charge older individuals up to 5 times the cost of coverage to young adults • Allows state waivers to further increase age rating ratio	• Same as AHCA
Consumer-driven account enhancements	• Increases maximum contributions to HSAs to the maximum out-of-pocket limits • Allows spousal catch-up contributions to same HSA • Reduces tax penalty from 20% to 10% for HSA withdrawals for non-medical expenses • Eliminates $2,500 (indexed) cap on before-tax salary reductions to health FSAs • Allows OTC drugs as qualified medical expenses	• Same as AHCA
ACA-related taxes	• Repeals most ACA-related taxes (insurer fee, medical device tax, prescription drug tax, and net investment income tax) beginning in 2017 • Delays Cadillac tax to at least 2026 • Repeals Medicare payroll tax increase as of 2023	• Generally the same as AHCA, except repeal of medical device tax and prescription drug tax not until 2018
Medicaid changes	• Phases out the ACA's Medicaid expansion by 2020 • Allows states to impose work requirements on certain Medicaid enrollees • Changes open-ended federal Medicaid subsidy financing system to per capita model (with per-enrollee caps on federal payments)	• Phases out ACA's Medicaid expansion more slowly between 2021 and 2024, but with deeper cuts thereafter • Allows states to impose work requirements on certain Medicaid enrollees • Changes open-ended federal Medicaid subsidy financing system to per capita model (with per-enrollee caps on federal payments) but with certain modifications from AHCA (such as tying future increases to non-medical inflation rate)

CBO issues report on Senate's ACA repeal and replace legislation

In brief:

- The CBO score of the initial draft of the Senate's ACA repeal and replace bill projects a reduction in the federal deficit over the next 10 years of $321 billion, which is $202 billion more than what was projected for the ACA repeal and replace legislation passed earlier this year by the House.
- However, the CBO also projected that the Senate bill would increase the number of uninsured individuals by about 22 million, one million fewer uninsured than what was projected for the House bill.
- Although the CBO health care projections have been questioned by some, they are nevertheless still influential and provide directional insights even if the estimates are difficult to project and imprecise by their nature.

On June 26, 2017, the non-partisan Congressional Budget Office (CBO) released its report on the U.S. Senate's proposed legislation, the Better Care Reconciliation Act (BCRA), to repeal and replace the Affordable Care Act (ACA). While there are numerous similarities between the BCRA and the bill passed by the House of Representatives earlier this year, the American Health Care Act (AHCA), there are some fundamental differences that are reflected in the CBO's report.

For example, the CBO projects that the BCRA will reduce the federal deficit over the period 2017-2026 by $321 billion, which is $202 billion more than its projection for the AHCA. The spending reductions would arise from a reduction in direct spending by $1,022 billion (primarily from a reduction in federal Medicaid funding and funding for premium assistance for non-group coverage by lower income individuals), and net of a reduction of $701 billion in revenues (primarily from a repeal of various ACA-related taxes imposed on high-income individuals, health insurance carriers, and various health care providers, as well as reduction in penalty collections from employers and uninsured individuals).

The BCRA also is projected to increase the number of uninsured individuals by approximately 22 million by 2026 relative to those who would have coverage under the ACA. This coverage loss would be about one million fewer individuals than what was projected for the AHCA.

	AHCA (House)	BCRA (Senate)
Federal deficit reduction over 10-year budget period	$119 billion	$321 billion
Increase in uninsured relative to ACA by 2026	23 million	22 million

The CBO projects that the BCRA would reduce premiums in the individual health insurance market as compared to the ACA due to the ability of carriers to sell policies with less rich benefits. However, the CBO noted that the cost-sharing provisions in these policies would increase out-of-pocket spending to the point that many lower-income individuals would not purchase policies even with the income-based tax credits provided by the BCRA.

While acknowledging that its estimates are based on difficult to predict projections that are subject to change, the CBO indicated that it developed its estimates using the same baseline assumptions for both its AHCA and BCRA reports, and attempted to use estimates in the middle of the distribution of potential outcomes. Nevertheless, certain commentators have questioned the CBO reports, especially in light of the significant impact they attribute to the effective repeal of the ACA's individual mandate provision under the AHCA and BCRA.

Frequently asked question: How do we treat domestic partner health plan coverage for tax purposes?

Same-sex marriage in the United States has been the law of the land for some time now. The generous tax benefits for employer-provided health plans apply to an employee and the employee's legal spouse regardless of gender. However, long-standing tax principles remain in place with respect to taxation of benefits to an employee for health plans covering an employee's domestic partner. A domestic partner still does not have any automatic special status as a dependent for federal tax purposes, and, in general, coverage provided to the domestic partner of an employee under an employer-sponsored health plan does not receive the same favorable tax treatment as spousal coverage. This is true regardless of whether the domestic partner is the same sex or opposite sex of the employee.

However, if a domestic partner (or the child of a domestic partner) can qualify as a "dependent" under the Internal Revenue Code (IRC), it is possible for that individual to receive health coverage tax-free under an employer-provided plan. This means meeting the requirements of IRC §105(b), which takes the definition of a "dependent" under IRC §152 and disregards certain subsections. Ultimately, an employee's domestic partner, as well as a child of a domestic partner, can be an employee's federal tax dependent for health coverage purposes by satisfying all the following criteria:

- Receiving over half of his or her support from the employee;
- Having the same principal place of abode as the employee and being a member of the employee's household (which must not violate local law) for the taxable year of the employee (almost always a full calendar year);
- Not being anyone's qualifying child; and
- Being (1) a citizen or national of the U.S., or (2) a resident of the U.S. or a country contiguous to the U.S. (Canada or Mexico)

For domestic partners, there is often some difficulty in meeting the first requirement above. For children of domestic partners, there may be difficulty in meeting the first three requirements, particularly when there is another parent involved. Because of the administrative challenges in verifying these circumstances, many employers choose to rely on an employee's self-certification as to whether each requirement is met.

If an employee's domestic partner or the domestic partner's children do not meet the above requirements to qualify as a dependent under IRC §105(b), the employer must treat the fair market value of their health plan coverage as taxable income to the employee. This typically means any employer-paid portion of the premiums attributable to health insurance coverage for the employee's non-dependent domestic partner or domestic partner's child must be subject to employment tax withholding and reported as imputed income to the employee on Form W-2, thereby raising both the employee's taxable gross income and the employer's payroll taxes. Additionally, any employee-paid portion of the premiums attributable to the coverage of a non-dependent domestic partner or domestic partner's child must either be taken from the employee's paycheck on an after-tax basis, or taken on a pre-tax basis but imputed back into the employee's taxable income.

There is no specific guidance for how to determine the fair market value of health plan coverage for a domestic partner or a domestic partner's child, although presumably any reasonable method would be acceptable. One approach would be to apply the single-only gross premium rate separately to the domestic partner and each of the domestic partner's children covered through the employee. However, another common method used by employers is an incremental approach that calculates the value of domestic partner coverage as the difference between (a) total gross premiums for employee-plus-spouse coverage (or some similar tier, such as "employee-plus-one"), and (b) total gross premiums for employee-only coverage. For example, if gross premiums for employee-plus-spouse coverage are $850 per month, and gross premiums for employee-only coverage are $400 per month, then the difference of $450 per month would be treated as imputed income to the employee covering a domestic partner, subject to payroll tax withholding.

In some cases there is no additional incremental cost to cover a domestic partner or a domestic partner's child, such

as when the employee already has family coverage covering the employee and multiple children of the employee. In those situations, a best practice would be to make sure some incremental cost approximating fair market value of the coverage is treated as imputed income to the employee. For self-insured plans, the COBRA rate (less the 2% allowable administrative fee, if applicable) could be used for gross premiums. For extra assurance on the acceptability of the method of imputing income, an employer may want to contact its tax counsel.

Note the above discussion only addresses the rules for imputing income for the value of health benefits provided to domestic partners for federal income tax purposes. The corresponding rules for state income tax purposes will differ state by state. If a given state formally recognizes domestic partnerships, it is more likely to have amended its state income tax laws to provide that the value of employer-provided health coverage for domestic partners will not be considered taxable income to the employee for state and local income tax purposes.

Please contact your Wells Fargo Insurance representative for more information on health plan coverage for domestic partners.

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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