WELLS FARGO INSURANCE

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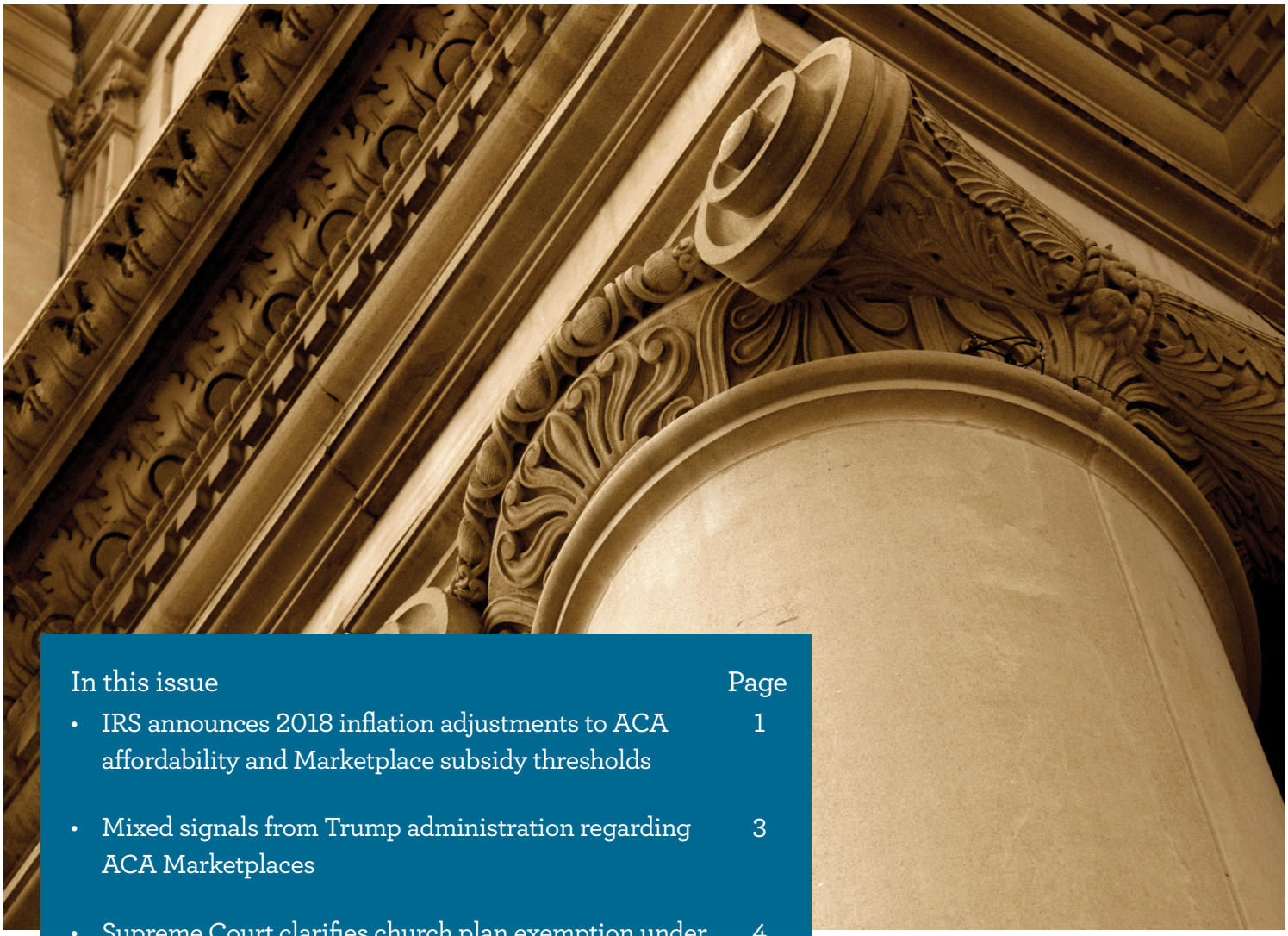
Employee Benefits Compliance Update

Wells Fargo Insurance Employee Benefits Compliance Practice



In this issue

Together we'll go far

IRS announces 2018 inflation adjustments to ACA affordability and Marketplace subsidy thresholds

In brief:

- For 2018, an employee has been offered "affordable" employer-sponsored coverage under the ACA if the required contribution for self-only coverage is no more than 9.56% of household income (a decrease from 9.69% in 2017).
- For 2018, the applicable percentage under the three affordability safe harbors available to employers has decreased to 9.56% (from 9.69% in 2017).
- For 2018, an individual is exempt from the ACA individual mandate to obtain coverage or pay a penalty if available minimum essential coverage costs more than 8.05% of household income (a decrease from 8.16% in 2017).
- The parameters that determine the amount of an eligible individual's premium subsidies for Marketplace coverage have been adjusted for 2018.

On May 4, 2017, the Internal Revenue Service (IRS) issued Revenue Procedure 2017-36, announcing changes to several inflation-adjusted indexes under the Affordable Care Act (ACA) for 2018.

Affordability of employer-sponsored coverage for purposes of individual eligibility for Marketplace subsidies

An employee does not qualify for premium tax credits or cost-sharing subsidies under Marketplace coverage if the employee has been offered employer-sponsored minimum essential coverage (MEC) that is at least 60% actuarial value (minimum value) and "affordable." The coverage is considered "affordable" for this purpose if the employee's required contribution for self-only coverage does not exceed a threshold percentage of household income.

Effective January 1, 2018, the required contribution threshold percentage will be 9.56% of household income, decreased from 9.69% in 2017.

Affordability safe harbors under the employer shared responsibility mandate ("play or pay")

An employer can protect itself from the risk of an IRC §4980H(b) penalty if it offers minimum value MEC to full-time employees, and the cost of self-only coverage meets one of three affordability safe harbors (federal poverty level, rate of pay, or Box 1 of W-2). Each of these affordability safe harbors uses the same threshold percentage, which is indexed for inflation. For more detailed information on the affordability safe harbors, see our April 2015 Employee Benefits Compliance Update.

Effective for plan years beginning in 2018, the applicable threshold percentage is 9.56%, which is a decrease from the 2017 threshold percentage of 9.69%. 2018 is the first year that the threshold percentage has decreased since the ACA was enacted.

An employer that intends to qualify for an affordability safe harbor will need to keep this percentage in mind when setting employee contribution amounts for self-only coverage for the 2018 plan year. For example, if an employer relies on the rate of pay affordability safe harbor by setting the self-only premium for hourly employees as the maximum possible percentage multiplied by 130 times each employee's hourly rate of pay at the beginning of the coverage period, it will have to decrease that percentage from 9.69% in the plan year beginning in 2017 to 9.56% in the plan year beginning in 2018.

For a plan year that begins in 2018, the federal poverty level (FPL) affordability safe harbor will be met if an employee's cost for self-only coverage is no greater than 9.56% of the applicable FPL for a single individual. A calendar-year plan must use the prior calendar year's FPL. A non-calendar-year plan will generally use the current calendar year's FPL (usually released near the end of January of the current calendar year).

Even though the applicable percentage has decreased, an employer with a calendar-year plan that relies on the FPL affordability safe harbor will be able to have a maximum premium in 2018 that is slightly higher than the 2017 maximum premium. This is because the applicable FPL for a single individual has increased enough to offset the

decrease in the applicable percentage. To illustrate, for 2017, a calendar-year plan could meet the FPL safe harbor with a maximum premium set at 9.69% of the 2016 FPL rate of $11,880, resulting in a maximum premium of **$95.93**/month.* For 2018, a calendar-year plan will use 9.56% of the 2017 FPL rate of $12,060, which results in a maximum premium of **$96.07**/month* to meet the FPL safe harbor.

*In all states except Alaska and Hawaii, where the maximum premiums are higher based on the higher FPLs that apply to those states

Exemption from individual mandate penalty

Under the ACA's individual shared responsibility mandate, U.S. citizens and legal residents who do not obtain medical coverage may have to pay a penalty, unless an exemption applies.

An employee eligible for, but not covered under, an employer-sponsored plan is exempt from penalties under the individual mandate if self-only coverage under the plan costs more than a specified threshold percentage of household income. Related individuals (such as a spouse or child) are exempt if the cost of family coverage under the plan exceeds that same threshold percentage of household income.

An individual who is not eligible for employer-sponsored coverage is exempt from penalties under the individual mandate if the cost of coverage under the lowest-cost Exchange plan (reduced by any allowable premium tax credits) available to the individual and family would exceed the threshold percentage of household income.

Effective January 1, 2018, for purposes of this exemption, the required contribution threshold percentage will be 8.05% of household income, decreased from 8.16% in 2017. This percentage was announced late last year in U.S. Department of Health and Human Services regulations, and was restated in Revenue Procedure 2017-36.

Determining individual premium tax credits under Marketplace coverage

The amount of subsidy (premium tax credits) an individual may receive for Marketplace coverage is determined based on the lesser of:

- the cost of the Marketplace plan in which the individual is enrolled, or
- the excess, if any, resulting from:
  - the age-adjusted premium for the second-lowest cost silver plan in the individual's area (reference plan), minus
  - the individual's household income multiplied by an "applicable percentage" based on the household income band. (This determines the maximum contribution an individual would pay before receiving subsidized Marketplace coverage in the form of premium tax credits.)

In Rev. Proc. 2017-36, the IRS updated the "applicable percentage" table from 2017 to 2018, as follows:

Household income as percentage of Federal poverty line	Max premium as % of Household Income in 2017	Max premium as % of Household Income in 2018
Less than 133%	2.04%	2.01%
At least 133% but less than 150%	3.06% to 4.08%	3.02% to 4.03%
At least 150% but less than 200%	4.08% to 6.43%	4.03% to 6.34%
At least 200% but less than 250%	6.43% to 8.21%	6.34% to 8.10%
At least 250% but less than 300%	8.21% to 9.69%	8.10% to 9.56%
At least 300% but not more than 400%	9.69%	9.56%
More than 400%	Unlimited†	Unlimited†

† Not eligible for premium tax credits to help pay for Marketplace coverage

Note that the applicable percentage thresholds for 2018 have decreased, which means individuals who purchase coverage through a Marketplace will pay a smaller percentage of their household income towards premiums than they paid in 2017, assuming their household income remains in the same range.

Mixed signals from Trump administration regarding ACA Marketplaces

In brief:

- As the deadline for insurers to decide whether to participate in the ACA Marketplace approaches, the Trump administration is sending mixed signals about its intentions concerning the future of the ACA Marketplaces.
- HHS has issued final regulations to stabilize the individual health insurance markets to include certain provisions that the insurance industry requested to make selling on the ACA Marketplaces more attractive.
- However, the Trump administration has taken inconsistent actions concerning its willingness to continue to fund cost-sharing reduction payments for low-income individuals purchasing subsidized individual coverage from the ACA Marketplaces.

While Congress continues to consider various legislative efforts to repeal and replace portions of the Affordable Care Act (ACA), the status of the individual health insurance market in various parts of the country continues to deteriorate as different insurers withdraw from the ACA Marketplace for 2018. In selected areas across the country, it appears that there will be no insurers or only one insurer willing to sell individual health insurance products on the ACA Marketplaces. The Trump administration continues to send mixed signals about its intentions concerning the future of the ACA Marketplaces.

On April 13, 2017, the Department of Health and Human Services (HHS) finalized individual health insurance market stabilization regulations. These regulations feature certain provisions that the insurance industry requested to make selling on the ACA Marketplaces more attractive, such as shortening the 2018 enrollment window from three months to six weeks, imposing stricter administrative requirements for individuals attempting to utilize the special enrollment rules to obtain Marketplace coverage off-cycle, and tightening up the premium payment rules to make sure all outstanding premiums from a prior coverage period are paid before an individual can re-enroll with the same insurer for a new policy year.

At the same time, there is significant insurance industry anxiety concerning whether the Trump administration will continue funding cost-sharing reductions (CSRs) for low-income individuals purchasing subsidized individual coverage from the ACA Marketplaces. CSRs lower the out-of-pocket maximums, deductibles, and co-pays for ACA Marketplace coverage. Although insurers are required by the ACA to provide CSRs to silver-tier health plans they sell on ACA Marketplaces, this benefit has been controversial due to questions concerning whether the funding was appropriately authorized by Congress. While this issue worked through the federal court system, the Obama Administration continued to fund CSRs. However, the Trump administration has sent mixed signals concerning its willingness to continue to fund CSRs. For example, while the Trump administration agreed to join a motion by House Republicans to delay the federal appeals court for the District of Columbia from hearing an appeal of the CSR funding case, it did not encourage Congress to clarify the appropriation of the funds in the recently enacted 2017 federal spending bill and has only committed to the funding on a month-to-month basis for the balance of 2017.

The uncertainty concerning the funding of CSRs is one of the top reasons that insurers are using to explain why they are proposing higher ACA Marketplace rates for 2018 or are withdrawing from certain geographic markets outright. For example, Blue Cross Blue Shield of North Carolina recently filed a proposed average rate increase of 22.9% for their ACA Marketplace plans in 2018, but noted that the increase would have been 8.8% if there were assurances that CSRs would be funded next year.

Even though none of this individual health insurance market activity directly impacts the group health plan market, it does illustrate the fragility of the individual health insurance market in certain areas in the country for 2018, regardless of whether Congress passes ACA repeal and replace legislation. In addition, the inconsistent actions by the Trump administration make it difficult to determine how much of the instability in the ACA Marketplaces was inherited versus created.

Supreme Court clarifies church plan exemption under ERISA

In brief:

- The U.S. Supreme Court recently ruled that the ERISA church plan exemption applies to church-affiliated organizations that maintain tax-qualified retirement plans, even if a church did not initially establish the plan.
- The Court's decision is important to church-affiliated organizations, especially church-run hospitals that have underfunded defined benefit pension plans and did not want to be subject to various ERISA requirements, including its minimum funding standards.
- In addition, the decision allows church-affiliated organizations to continue to administer their health and welfare plans as they have done in the past without complying with ERISA's reporting and disclosure requirements.

On June 5, 2017, the U.S. Supreme Court ruled 8-0 that the church plan exemption under the Employee Retirement Income Security Act of 1974 (ERISA) applicable to tax-qualified retirement plans established and maintained by a church also applies to plans maintained by an affiliated organization even for plans not initially established by a church. The Court's decision in *Advocate Health Care Network v. Stapleton* reverses lower court decisions holding that such plans were subject to ERISA, and which threatened to upend nearly 30 years of administrative decisions and positions by the Internal Revenue Service (IRS), U.S. Department of Labor (DOL), and the Pension Benefit Guaranty Corporation (PBGC).

The *Advocate Health Care Network* decision allows church-affiliated organizations to continue to administer their health and welfare plans as they have done in the past without complying with ERISA, including its reporting and disclosure rules. In addition, most requirements imposed under the Affordable Care Act on employers and their group health plans apply regardless of whether the plan is subject to ERISA. Nevertheless, this is an important decision for church-affiliated organizations, especially church-run hospitals, which sought to avoid ERISA's minimum funding standards, notice requirements, prohibited transaction provisions, and PBGC premiums for their underfunded defined benefit pension plans. While this decision will likely end a number of similar cases currently pending at different stages within the judicial system, the exposure received by these church plan cases potentially could push Congress or the regulatory agencies to provide greater scrutiny and disclosure to participants with respect to these arrangements.

Overtime pay calculation in Ninth Circuit includes cash-in-lieu of benefit payments

In brief:

- The U.S. Supreme Court recently declined to hear an appeal of the Ninth Circuit's decision in Flores v. City of San Gabriel.
- According to the Ninth Circuit, regular rate of pay for overtime pay purposes includes cash-in-lieu of benefits paid to employees who opt out of the employer's group health plan.
- Even if an employee does not receive cash-in-lieu of benefit payments, the payments must be included in the employee's regular rate of pay for overtime purposes if the aggregate cash payments are not "incidental" to the employer's total contributions on a plan-wide basis.

In a closely-watched case, on May 15, 2017, the U.S. Supreme Court decided against hearing an appeal of the Ninth Circuit decision in *Flores v. City of San Gabriel*. The Ninth Circuit previously decided in the Flores case that cash-in-lieu of benefit payments must be included in an employee's regular rate of pay for purposes of calculating overtime pay in the circumstances described below. As a result of the Supreme Court's decision, the *Flores* case applies to employers throughout the Ninth Circuit, which includes the states of Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon and Washington. It is not clear whether courts elsewhere in the U.S. will follow the Ninth Circuit on this issue.

According to the facts of the case, an employer paid up to $1,305 per month to employees who opted out of the

employer's group health plan with proof of other medical coverage. Many employees elected to receive the cash-in-lieu of benefit payments. For example, in 2010, the employer paid $1,086,203 in cash to employees who opted out of the group health plan, and contributed $1,449,166 to the plan for coverage of employees and family members, for total employer contributions on a plan-wide basis of $2,535,369. During the period 2009 to 2012, the aggregate cash-in-lieu of benefit payments ranged from 42.8% to 46.7% of the employer's total contributions on a plan-wide basis.

The employer treated the cash-in-lieu of benefit payments as taxable compensation to those employees who received the cash. However, the payments were not included in the regular rate of pay for overtime pay purposes for either of the following groups of employees:

- Employees who received the cash because they opted-out of the employer's group health plan (with proof of other medical coverage); or
- Employees who did not receive the cash because they were covered under the employer's group health plan.

Both groups of employees sued the employer to have the cash-in-lieu of benefit payments included in their regular rate of pay for overtime pay purposes.

In its decision, the Ninth Circuit examined the overtime pay issue separately for each group of employees. First, the court decided that cash paid to employees who opted out of the employer's group health plan must be included in their regular rate of pay for overtime pay purposes, because the cash was compensation for their hours of employment. Second, the Ninth Circuit decided that cash-in-lieu of benefit payments must be included in an employee's regular rate of pay for overtime pay purposes even if the employee was covered under the plan and did not receive any cash, because the aggregate cash payments were not "incidental" to the employer's total contributions on a plan-wide basis. The court noted that the U.S. Department of Labor had historically used a 20% limitation on cash payments per employee to determine if such payments were more than "incidental," but the Ninth Circuit declined to adopt that approach as the litmus test.

Based on the *Flores* case, employers that make cash-in-lieu of benefit payments should evaluate the overtime pay consequences of those payments with the assistance of their employment law attorney. Employers should also consider (with the assistance of their employment law attorney and labor negotiator, if applicable) whether it is necessary or appropriate from a financial standpoint to make changes to their cash-in-lieu of benefit payments, such as trimming the dollar amount of cash available to employees, or replacing the program with another approach.

PCOR fee reminder

In brief:

- The PCOR fee is due no later than July 31, 2017, for policy or plan years ending in 2016.
- The fee is the average number of covered lives under the plan during the policy or plan year, multiplied by:
  - $2.17 for policy or plan years ending on or between 10/1/15 - 9/30/16; and
  - $2.26 for policy or plan years ending on or between 10/1/16 - 9/30/17.

The annual payment deadline for the Patient-Centered Outcomes Research (PCOR) fee is approaching. PCOR payments for policy or plan years ending in 2016 are due no later than July 31, 2017. The PCOR fee helps fund research that evaluates and compares health outcomes, clinical effectiveness, and the risks and benefits of medical treatments and services. The fee applies to policy and plan years ending after September 30, 2012, and before October 1, 2019.

What plans are subject to the fee?

- All private and public (including governmental and Native American tribal government) group health plans, retiree-only plans, and multiemployer plans. Self-funded HRAs are subject to a separate fee assessment even if provided under a fully-insured medical plan.

Who is required to calculate and pay the fee?

- For self-insured plans, plan sponsors (typically the employer) are responsible.
- For fully-insured plans, the insurance carrier is responsible.

How much is the fee?

Plan Years Ending in 2016	Fee per Covered Life Due by 7/31/2017
Feb 1, 2015 - Jan 31, 2016	$2.17
Mar 1, 2015 - Feb 28, 2016	$2.17
Apr 1, 2015 - Mar 31, 2016	$2.17
May 1, 2015 - Apr 30, 2016	$2.17
Jun 1, 2015 - May 31, 2016	$2.17
July 1, 2015 - Jun 30, 2016	$2.17
Aug 1, 2015 - July 31, 2016	$2.17
Sept 1, 2015 - Aug 31, 2016	$2.17
Oct 1, 2015 - Sept 30, 2016	$2.17
Nov 1, 2015 - Oct 31, 2016	$2.26
Dec 1, 2015 - Nov 30, 2016	$2.26
Jan 1, 2016 - Dec 31, 2016	$2.26

How is the fee reported and paid?

- The PCOR Fee will be paid by filing IRS Form 720 (Quarterly Federal Excise Tax Return).

Summary:

Plan Year Ending	Amount	Due Date
1/1/16 – 9/30/16	$2.17	7/31/17
10/1/16 – 12/31/16	$2.26	7/31/17

For more information on the PCOR fee, please see our Legislative Alert on this issue. If you have any questions or need assistance with the PCOR fee, please contact your Wells Fargo Insurance representative.

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.