AxisPointe Employee Benefit Advisors
AssuredPartners COMPLIANCE OBSERVER

4th Quarter 2017

IRS Letter 226J Has Arrived

As we advised in our recent Compliance Observer Alert, the IRS has begun sending IRS Letter 226J informing applicable large employers (ALEs) of their potential employer shared responsibility penalties for 2015.

Some employers have received letters assessing significant penalty amounts. According to a recent article by law firm Alston & Bird, their clients have received assessments exceeding $200,000, while the ACA Times reports some employers are seeing penalties well into the millions.

If you receive a letter, don't be alarmed; the calculations are preliminary and some employers have already reported incorrect assessments. However, whether you agree or disagree with all or part of the assessment, make sure you ***respond within 30 days from the date of the letter***. Failing to respond indicates your agreement with the preliminary assessment and prompts the IRS to issue a Notice and Demand for Payment (Notice CP 220J). You may also want to consider requesting a pre-assessment conference.

If you need more time to respond, request an extension, in writing. The IRS has indicated it may consider such requests if they are reasonable and made within the required 30-day timeframe.

If you haven't received a letter, don't be complacent. The IRS will continue to send out letters in the coming weeks. Gather supporting documentation now so that you can timely and accurately respond. Advance preparation will be key during this already busy holiday season.

Helpful IRS Links:

- Template Letter 226-J
- Form 14764
- Form 14765
- Understanding Your Letter 226-J
- Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act (See Q/A 55-58)

Related articles:
https://www.alston.com/en/insights/publications/2017/11/irs-begins-assessing-employer-mandate-penalties
https://acatimes.com/more-suggestions-on-responding-to-irs-letter-226j/

ACA Reporting – Publication 5223

IRS Publication 5223 sets the rules and specifications for preparing and submitting substitute Forms 1094-B, 1094-C, 1095-B, and 1095-C.

In particular, Publication 5223 addresses the 2017 requirements for:

- Using official IRS forms to file Affordable Care Act (ACA) information returns with the IRS;

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- Preparing acceptable substitutes of the official IRS forms to file ACA information returns with the IRS; and
- Using official or acceptable substitute forms to furnish information to recipients.

If you do not use the official IRS form to furnish statements to recipients, you must furnish an acceptable substitute statement. Failure to produce acceptable substitutes of the forms and schedules listed in this publication may result in penalties and delays in processing.

You may wish to review IRS Publication 5223 in its entirety for additional details on the rules and specifications for preparing substitute Forms 1094-B, 1095-B, 1094-C, and 1095-C.

Solicitation of Social Security Numbers for ACA Reporting

Employers sponsoring self-funded plans, who want to show they made a "reasonable effort" to obtain the Social Security numbers of dependents enrolled in their plans, must make their third request for numbers by **December 31, 2017**, if they made the ***initial request*** in 2016. By doing so, such employers will not be subject to penalties for failure to report a Social Security number. See IRS Notice 2015-68.

Advance Copies of Form 5500 for 2017

The U.S. Department of Labor's Employee Benefits Security Administration (EBSA), the IRS, and the Pension Benefit Guaranty Corporation (PBGC) have released advance informational copies of the 2017 Form 5500 annual return/report and related instructions. The "Changes to Note" section on page 1 of the instructions highlights important modifications, including the following:

- **IRS-Only Questions**. IRS-only questions that filers were not required to complete on the 2016 Form 5500 have been removed from the Form 5500, Form 5500-SF and Schedules.
- **Authorized Service Provider Signatures**. The instructions for authorized service provider signatures have been updated to reflect the ability for service providers to sign electronic filings on the plan sponsor and Direct Filing Entity (DFE) lines, where applicable, in addition to signing on behalf of plan administrators.
- **Administrative Penalties.** The instructions have been updated to reflect an increase in the maximum civil penalty amount assessable under ERISA section 502(c)(2). Department regulations published on Jan. 18, 2017, increased the maximum penalty to $2,097 a day for a plan administrator who fails or refuses to file a complete or accurate Form 5500 report. The increased penalty under section 502(c)(2) is applicable for civil penalties assessed after Jan. 13, 2017, whose associated violation(s) occurred after Nov. 2, 2015 – the date of enactment of the 2015 Inflation Adjustment Act.
- **Form 5500/5500-SF-Plan Name Change**. Line 4 of the Form 5500 and Form 5500-SF have been changed to provide a field for filers to indicate the name of the plan has changed. The instructions for line 4 have been updated to reflect the change. The instructions for line 1a have

also been updated to advise filers that if the plan changed its name from the prior year filing(s), complete line 4 to indicate that the plan was previously identified by a different name.

The advance copies of the 2017 Form 5500 are for informational purposes only and cannot be used to file a 2017 Form 5500 annual return/report. Pension and welfare benefit plans that are required to file an annual return/report regarding their financial conditions, investments and operations each year generally satisfy that requirement by filing electronically the Form 5500 or Form 5500-SF and any required attachments under the all electronic EFAST2 system for submission, receipt, and processing of the Form 5500 and Form 5500-SF.

Information copies of the forms, schedules and instructions are available online at https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/reporting-and-filing/form-5500.

Filers should monitor the EFAST website for the availability of the official electronic versions for filing using EFAST-approved software or directly through the EFAST website.

Source: U.S. Department of Labor

IRS Issues Detailed Guidance on QSEHRAs

On Oct. 31, 2017, the Internal Revenue Service (IRS) issued Notice 2017-67, providing comprehensive guidance, mostly in the form of FAQs, on a variety of topics regarding qualified small employer health reimbursement arrangements (QSEHRAs).

QSEHRAs, a type of health reimbursement arrangement exempt from many ACA reforms, may be offered by small employers that have fewer than 50 full-time equivalent employees and do not offer a group health plan. Employers were able to offer QSEHRAs beginning in January of this year; however, because previous guidance was so limited and vague, many employers were hesitant to implement these arrangements.

Notice 2017-67 provides detailed guidance on a wide range of topics for QSEHRAs, including the criteria for QSEHRAs, the tax consequences of the arrangement, the impact on eligibility for health savings account (HSA) contributions and the written notice requirement. Here are just a few highlights from the 79 FAQs listed in the guidance:

- **Written Notice Deadline**: An employer that provides a QSEHRA during 2017 or 2018 must generally furnish its initial written notice to its eligible employees by the later of (a) February 19, 2018, or (b) 90 days before the first day of the plan year of the QSEHRA. FAQ #38 of the guidance explains what information must be included in the notice. According to the IRS, penalties may apply to any employer that does not timely provide the written notice.
- **"Same Terms" Requirement:** Employers are required to provide the QSEHRA on the same terms to all eligible employees. However, the guidance states that QSEHRA payments or reimbursements may vary based on the age of covered individuals or the number of individuals covered in accordance with the variation in the price of an insurance policy in a relevant individual health insurance market.

- **Employer Eligibility:** Whether an employer is ineligible because it offers group health plan coverage is determined monthly, taking into account all entities treated as a single employer under the Code's controlled and affiliated service group rules (IRC Section 414). Employers become ineligible on the date they acquire ALE status, even if that occurs during the QSEHRA's plan year. However, in that case, a run-out period is permitted for expenses incurred during the period of QSEHRA coverage.
- **Employee Eligibility:** Former employees and non-employee owners cannot participate in a QSEHRA. The "part-time" and "seasonal" employees who can be excluded must be determined using the definition in the Code § 105(h) nondiscrimination regulations. If an employee ceases to be excludable, the QSEHRA benefit must begin no later than the day after the exclusion ends.
- **Maximum Benefit & Reimbursements:** QSEHRAs may use the statutory dollar limits in effect for the preceding year to determine permitted benefits, rather than the dollar limits in effect for the current year. Any carryovers of unused amounts from a prior plan year are taken into account when determining an employee's maximum annual benefit. An employee's total permitted benefit, taking into account both carry-over amounts and newly available amounts, may not exceed the applicable statutory dollar limit.
- **Form W-2 & PCORI Requirements:** An employee's permitted benefit under a QSEHRA must be reported in box 12 of his or her Form W-2 using code FF. In addition, QSEHRA sponsors are subject to the Patient-Centered Outcome Research Institute (PCORI) fee, which generally requires them to file Form 720, Quarterly Federal Excise Tax Return, annually by July 31 of the year following the last day of the plan year.

The guidance applies for plan years beginning on or after Nov. 20, 2017, although QSEHRAs established before that date may rely on this guidance. Also, employers that established QSEHRAs for 2017 in accordance with a reasonable good faith interpretation of the law may continue to operate their QSEHRAs based on those terms until the last day of the plan year that began in 2017.

While small employers may see QSEHRAs a great new solution, it is important to consider all of the implications and procedures that will be needed before deciding to establish a QSEHRA. Careful review of this FAQ guidance should be done before establishing a QSEHRA. The IRS has indicated that the rules expressed in the FAQs will become the basis for proposed regulations, and has requested input to help with the drafting of those regulations. Comments should be submitted by January 19, 2018.

PCORI Fee Increase

For plan years ending on or after October 1, 2017 and before October 1, 2018, the fee for an employer sponsoring an applicable self-insured plan has increased to**$2.39** (multiplied by the average number of lives covered under the plan). The fee amount for plan years ending between January 1, 2017 and September 30, 2017 is **$2.26**.

PCORI fees for all plan years ending in 2017 are due to the IRS in July 2018.

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Expansion of Contraceptive Coverage Exemptions

The Trump Administration has issued two new interim final rules expanding certain exemptions from the Affordable Care Act's (ACA) contraceptive coverage mandate. The new regulations, issued in October, are a significant departure from the prior regulations, which only granted an exception to houses of worship.

These new regulations open the door for any employer or college/university with a student health plan with objections to contraceptive coverage based on ***religious*** beliefs to qualify for an exemption. Additionally, the regulations also allow any nonprofit or closely held for-profit employer with ***moral*** objections to contraceptive coverage to qualify for an exemption.

Under prior rules, religiously affiliated nonprofits and closely held for-profit corporations were not eligible for an exemption, but instead could choose an accommodation. To be eligible for an accommodation, an objecting employer was required to self-certify (or notify HHS) of its objection, which many religious non-profit organizations argued infringed on their religious liberties.

Under this new guidance, which is effective immediately, organizations may choose between an exemption or an accommodation. Employers may voluntarily, but are not required to, provide any self-certification or notification to the government.

State Law Impact

Many states have passed contraceptive coverage laws with a provision for exemptions, but the laws vary from state to state and only apply to ***fully insured plans***. This means that there may be a conflict between the state and federal requirements when it comes to religious exemptions. In some states with a contraceptive coverage requirement, employers who are eligible for an exemption under federal law will not qualify for an exemption under state law. Employers in those states will have to meet the standards established by their state even though they may qualify for an exemption based on the new federal regulations.

MLR Rebeates

REMINDER! ERISA plan sponsors who receive a MLR rebate that is considered "plan assets" and who decide to either distribute the rebate in cash to participants or offset the participants' share of premiums must do so ***within three months of the plan's receipt of the rebate*** from the carrier. Failure to distribute the rebate within this timeframe requires the plan sponsor to establish a trust to hold the rebate as plan assets. Carriers had until September 30th to distribute rebates this year.

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DID YOU KNOW?

In October, the IRS reversed a recent policy change in how it monitors compliance with the Affordable Care Act's individual mandate. Individuals should keep the following in mind when filing 2017 tax returns:

- The IRS will not accept electronically filed tax returns where the taxpayer does not certify whether the individual had health insurance for the year.
- Paper returns that do not certify compliance with the individual mandate may be suspended pending receipt of additional information, and any refunds due may be delayed.

To avoid refund and processing delays when filing 2017 individual tax returns in 2018, taxpayers should indicate whether they (and everyone on their return) had health coverage, qualified for an exemption or are paying an individual mandate penalty.

Paid Sick Leave Laws

As a growing trend, states across the country are continuing to enact their own paid sick leave laws. Currently, eight states (AZ, CA, CT, MA, OR, RI, VT & WA) and the District of Columbia have enacted statewide laws that require employers to provide paid sick leave benefits to employees. Employers that are subject to these laws may face compliance challenges as they update their existing leave policies for the new requirements.

Employers must also be aware that numerous cities and counties across the country have enacted local ordinances that mandate paid sick leave. For example, New York City, Cook County, Illinois (which includes Chicago), and Montgomery County, Maryland, all have enacted local paid sick leave ordinances. Employers must generally comply with both the statewide paid sick leave law and local ordinance, if applicable.

For more information about paid sick leave laws in your state or local area, contact your AssuredPartners benefit team.

Family Deductibles
What You Need to Know

What is a deductible?
A deductible is the amount you must pay out of pocket for medical care before the insurance company will begin paying. For example, if you have an $800 deductible, you will have to pay for all health care costs until you've reached $800. After that, your insurance will start paying, although you may owe a copay or coinsurance amount. The deductible starts over annually.

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There are two basic types of deductibles for ***family*** coverage, and knowing which one you have and how it works will help you plan for out-of-pocket health care expenses.

Non-embedded Deductibles

A non-embedded, or aggregate, deductible is simpler than an embedded deductible. With a non-embedded deductible, there is only a family deductible. All family members' out-of-pocket expenses count toward the family deductible until it is met, and then they are all covered with the health plan's usual copays or coinsurance. It doesn't matter if one person incurs all the expenses that meet the deductible or if two or more family members contribute toward meeting the family deductible.

Embedded Deductibles

Embedded deductibles have two components: the individual deductibles for each family member and the family deductible. When a family member meets his or her individual deductible, the insurance company will begin paying according to the plan's coverage for that member. If only one person meets an individual deductible, the rest of the family still has to pay their deductibles.

Care must be taken when an embedded deductible is under a High Deductible Health Plan (HDHP). When an individual has family coverage under an HDHP, no benefits can be paid under the HDHP (except for preventive care) until the minimum annual deductible for family coverage has been met. A health plan does not qualify as an HDHP if there is an embedded deductible that is lower than the required minimum annual deductible for family coverage (**$2,700 for 2018**). Also, the HDHP must be designed to ensure that the embedded individual deductibles do not cause the plan to exceed the out-of-pocket maximum expense limits.

Out of Pocket Maximums

To qualify as an HDHP, the sum of the plan's annual deductible and any other annual out-of-pocket expenses that the insured is required to pay, such as copayments and coinsurance (but not premiums), cannot exceed the annual HDHP out-of-pocket maximum (MOOP) (**2018 MOOP: $6,650 Individual/$13,300 Family**).

The Affordable Care Act (ACA) also imposes an annual limit (or out-of-pocket maximum) on total enrollee cost-sharing for essential health benefits. The ACA's cost-sharing limit, which applies to all non-grandfathered health plans, is higher than the out-of-pocket maximum for HDHPs (**2018 ACA MOOP: $7,350 Individual/$14,700 Family**). In order for a health plan to qualify as an HDHP, the plan must comply with the lower out-of-pocket maximum limit for HDHPs.

In addition, the ACA provides that the self-only annual limit on cost-sharing applies to **each individual**, regardless of whether the individual is enrolled in self-only coverage or family coverage. This guidance embeds an individual out-of-pocket maximum in family coverage so that an individual's cost-sharing for essential health benefits (EHBs) cannot exceed the ACA's out-of-pocket maximum for self-only coverage (**$7,350 for 2018**).

Example: If an HDHP's family coverage has a $10,000 out-of-pocket maximum and one individual in the family coverage incurs $20,000 in expenses from a hospital stay, then that individual would only

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be responsible for paying the cost sharing related to the costs of the hospital stay covered as an EHB up to the annual limit on cost sharing for self-only coverage ($7,350 for 2018).

This HHS FAQ explains how this guidance affects HDHPs with family deductibles that are higher than the ACA's cost-sharing limit for self-only coverage.

Source: Zywave

FROM ALL OF US AT ASSURED PARTNERS

Please contact your AxisPointe Benefit Team if you have questions or need assistance with this topic or other compliance matters.

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