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The Fringe Benefit Bulletin

A discussion of news and information for Individual, Group and Medicare insurances



Employee Benefits

New Legislation Takes Aim at the Employer Mandate

AFTER JETTISONING the individual mandate requiring adults to carry health coverage, efforts are afoot in Congress to do away with the Affordable Care Act employer mandate.

One bill, HR 4616, is currently in the House Ways and Means Committee awaiting further amendments before a vote can be made on it. The measure would suspend penalties for the employer mandate for 2015 through 2019, as well as postpone implementation of the "Cadillac tax" on high-cost employer-sponsored health plans for one more year, until 2022.

The employer mandate requires applicable large employers (or ALEs, which are firms with 50 or more full-time or full-time equivalent workers) to offer affordable health coverage that also covers certain minimum essential benefits as required by the ACA.

Employers that fail to offer health insurance can be fined up to $2,300 for every employee that wasn't offered coverage and even more for employees who are eligible for an ACA exchange premium tax credit because they did not have access to affordable employer-sponsored health coverage.

This being an election year, though, pundits have told trade publications they don't think the legislation will be brought to vote in 2018.

For now, if you are an ALE you still have a number of obligations under the ACA. There has been no legislation that rolls back any requirements on employers in regards to securing coverage for their employees.

What should you do?

If you're an ALE you need to keep the following top of mind:

The IRS is assessing penalties for ACA infractions – Employers that are flagged for possibly not providing affordable coverage that covers the minimum essential benefits, or have made filing errors, may receive a 226-J letter from the IRS.

The letters explain that the employer may be liable for a penalty, based on information obtained by the IRS from Forms 1095-C filed by the employer for a specific coverage year, and tax returns filed by the employer's employees. If you receive a letter, you have 30 days to respond.

If you fail to respond within 30 days it will result in assessment of the penalty.

You must still file Forms 1094-C and 1095-C, or risk a penalty for not doing so.

The IRS uses information on Forms 1095-C in applying the ESRP (employer shared responsibility payment) rules and deciding whether to assess penalties against the reporting employer. If you're an ALE, you are required to file Form 1095-C annually with the IRS and send it to your employees. You must provide the forms to employees by Jan. 31, and to the IRS by March 31 of every year.

Failure to submit the forms to the IRS or provide them to employees as required can result in penalties. The penalties can be doubled if the IRS finds that an employer intentionally flouted the filing requirement.

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CONTACT US

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New Regulations

Short-term Plans Can Now Last up to Three Years

THE TRUMP administration has taken another step in its effort to roll out short-term health insurance plans by extending the amount of time such plans can be in effect.

Under the new rule, which was issued August 1, short-term plans can be purchased for up to 12 months and policyholders can renew coverage for a maximum of 36 months.

These controversial plans, though, do not have to comport with the Affordable Care Act, like not covering 10 essential benefits and not having to cover pre-existing conditions – and they can even exclude coverage for medications.

As a result of the changes, the Centers for Medicare and Medicaid Services predicts that an additional 600,000 people will enroll in short-term plans in 2019, jumping to 1.6 million individuals by 2021. Part of that will include some 200,000 people who drop their plans in the individual market and sign up for short-term coverage.

That's compared with about 122,500 people enrolled in short-term plans in 2017, according to the National Association of Insurance Commissioners. But enrollment is expected to surge now that the individual mandate penalty has been eliminated.

That said, CMS predicts that premiums for 2019 ACA exchange plans will rise 1%, while net premiums will decrease 6%.

The final rule goes into effect 60 days after it is posted, but state regulators would still need to approve any new plans that come to market. Health insurers may start selling short-term plans that last up to a year in a few months. The new regulation, however, does not require insurers to renew the policies.

Health insurers and consumer advocates have assailed the plans, saying they provide limited coverage.

However, the plans provide a much lower cost option for anyone – young or older – that does not want to pay for the government mandated 10 essential benefits they do not need or choose not to have.

For example, someone who does not take any medications may not want drug benefits. Also, they may want to have a higher deductible to save on premium.

New rules change the game

The renewability portion of the new regulations was modeled on COBRA plans, which allow people who leave a job to continue on the same plans they had while on the job, but they have to foot the bill themselves.

Plans will be able to exclude someone based on pre-existing conditions.

The plans also do not have to cover the ACA's 10 essential health benefit categories, such as maternity care or prescription drugs, for example.

Insurers that sell these plans will be required to:

- Prominently display wording in the contract that the plans are exempt from some ACA provisions.
- List coverage exclusions and limitations for pre-existing conditions.
- List what health benefits are covered.
- Explain if the plans have lifetime or annual dollar limits on health benefits.

States will be able to regulate these plans as they see fit. For example, some states limit the time someone can be enrolled in a short-term plan, and they may bar renewals. ❖

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ALEs Must Continue Complying Fully with the Law

Summary of Benefits and Coverage forms are still required – Not only are they still required, but the Centers for Medicare and Medicaid Services has, on occasion, rolled out new language and information that it requires all SBCs to include.

The SBC is designed so that your employees can easily compare plans, so they can make an informed decision about which health plan they should choose from your offerings.

If you fail to provide an SBC to your staff, it can result in penalties of $1,128 per employee.

The takeaway

While machinations continue in Washington, the full spectrum of employer-related rules of the ACA still applies.

The administration has introduced new rules that would allow for "association" plans to be sold, but as of now no such plans have hit the market. Due to the complexities of the ACA and the difficulty in having unlike employers band together for coverage, the marketplace may be slow to come up with products that are ACA-compliant.

That means ALEs must continue complying with the law fully. ❖

Medicare

Don't Miss These Critical Medicare Deadlines

MISSING A MEDICARE deadline can have important long-term financial consequences. It may mean more money out of pocket for care, or higher penalty premiums for the rest of your life.

Don't miss these important Medicare deadlines:

Initial enrollment period

Your initial enrollment period starts three months before the month in which you turn 65, and lasts until the end of the third month after the month in which you turn age 65. Missing this initial enrollment window may result in late-enrollment penalties, unless you qualify for a special enrollment period.

Enrollment is automatic for Parts A and B, but if you want to enroll in a Medicare Advantage program or a Medicare Part D (prescription drug) plan, it's important to meet this deadline.

But don't wait until the month in which you turn age 65 to enroll. If you wait beyond the end of that month before you turn 65 to enroll, your Part B coverage could be delayed. This would result in a gap in your coverage. If you have a medical event before your Part B coverage kicks in, you could face significant out-of-pocket expenses.

Sign up at a Social Security office, or at *www.SocialSecurity.gov.*

Medicare Supplement (Medigap) deadlines

Medicare Supplement plans, also known as "Medigap" policies, also impose enrollment deadlines. These are additional policies from private carriers that help cover deductibles, copays, and additional services that aren't covered under Medicare.

Typically, you have six months from the time you enroll in Medicare to purchase a Medigap policy and still get guaranteed acceptance, regardless of your medical condition. If you aren't in good health, your carrier could deny coverage altogether.

General enrollment period

If you don't sign up for Part A and Part B during your initial enrollment period, you can do so during the General Enrollment Period, which is between January 1 and March 31 each year. You'll have to pay additional penalty premiums, and your coverage won't begin until July 1.

Special enrollment periods

You may be able to avoid late Medicare enrollment premiums and penalties under certain limited circumstances. You may qualify for a special enrollment period if:

- You or your spouse (or other family member if you're disabled) are working; or
- You're covered by a group health plan (excluding COBRA and retiree health plans).

Switching plans

If you want to join or switch your Medicare Advantage (Part C) or prescription drug (Part D) plan, you generally need to do so during the open enrollment period for these plans. That open enrollment runs from Oct. 15 through Dec.7.

During this period, you can choose to do any of the following:

- Switch from Original Medicare (Part A and B) to Medicare Advantage;
- Switch from Medicare Advantage back to Original Medicare;
- Switch from one Medicare Advantage plan to another;
- Switch from a Medicare Advantage plan that doesn't offer drug coverage to one that does;
- Switch from a Medicare Advantage plan that offers drug coverage to one that doesn't;
- Join a prescription drug (Part D) plan;
- Switch between Part D plans;
- Drop your Medicare prescription drug coverage altogether.

Note: If you want to switch from Medicare Advantage back to Original Medicare, you can do so from January 1 through February 14th. You can also add prescription drug coverage to Original Medicare, but you have to do so before Feb. 14.

Navigating the Medicare system isn't easy.

If you're in doubt, call us. We can help you make sense of the choices, evaluate the pros and cons, and help you make sure you're making the right decision. ❖

Health Plans

Number of Employers Offering Coverage Grows

THE NUMBER of companies offering health insurance to their employees has risen for the first time in a decade, according to new research from the Employee Benefit Research Institute.

In 2017, almost 47% of private-sector employers offered health insurance, up from 45.3% in 2016. The percentage had previously been dropping steadily since 2008, when more than half (56.4%) were providing coverage.

The trend continues that the larger the company, the more likely it is to offer coverage, with 99% of firms with 1,000 or more employees offering health benefits.

Interestingly, the pre-Affordable Care Act numbers are higher than the post-ACA numbers, despite the fact that the law required employers with 50 or more full-time workers to provide most of their staffers with health coverage.

And the fact that numbers started ticking higher in 2017 points not so much to the results of the ACA, but that the labor market is tightening and as competition for talent increases, more employers are adding health coverage to their benefit packages, according the EBRI's analysis.

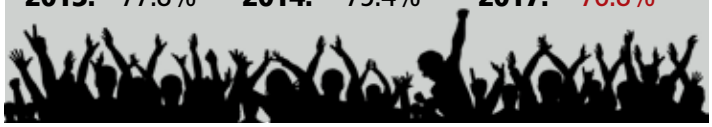
The increases have been across all business sizes.

Percent of Firms with Health Benefits

Employer Size	2017	2015
Fewer than 10 employees	23.5%	22.7%
10-24 employees	49.2%	48.9%
25-99 employees	74.6%	73.5%
100-999 employees	96.3%	95.1%
1,000 and more employees	99.6%	99.3%

Percent of Workers Eligible for Coverage

2013: 77.8% **2014:** 75.4% **2017:** 76.8%



The takeaway: Coverage matters

The EBRI attributes the increases in both the above metrics on the fact that workers have been migrating to jobs that offer health coverage. It also puts the changes down to the strong economy, the tighter job market and the fact that group health insurance rates have been increasing at a moderate clip of about 5% a year.

It also indicates that more employers are offering coverage to recruit and retain talent.

There has been a significant drop-off among small employers offering coverage since the recession hit in 2008 (when 35.6% of firms with fewer than 10 employees offered it, a percentage that dropped to its nadir of 21.7% in 2016).

EBRI analysts cite many factors for the larger decline in coverage offering among the smallest employers, including the effects of the recession on business and the fact that their staff could get coverage on exchanges at relatively low rates thanks to government subsidies.

The overall uptick in 2017 was largely driven by small employers, meaning that they are likely having to step up to compete for talent. As competition for talent will likely continue to grow, it's likely that more employers will continue adding health benefits, in addition to other voluntary benefits, to sweeten the pot.

If you would like to know more about your options, feel free to contact us. ❖