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2018:Compliance, Year In Review

Misty Baker, Director of Compliance and Legislative Affairs
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Delay in the ACA Taxes.

January 28th President signed H.R. 195 into law. This bill was to fund the government thru 2/8/2018 but also included provisions to further delay the Cadillac Tax for 2 years (now slated for 2022) and the Health Insurance Tax for another year. Cadillac Tax is anticipated to raise $100 billion in revenue from 2022-2027

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Health Insurance Tax

Originally initiated in 2014, the HIT tax was first suspended in 2017 because of the Consolidated Appropriations Act of 2016. It was reinstituted for 2018 and will be suspended again in 2019. It had been costing families about $500 per year or 2.7% of additional premium. On May 24th, 2018 another bill was introduced to further delay the HIT tax until 2021.

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Medical Device Tax

H.R. 195 also called for a two-year delay of the Medical Device Tax, now scheduled to start January 1st, 2020. This tax would have imposed a 2.3% excise tax on the sale of medical devices paid by manufacturers and importers. The delay will cost the government $3.7 billion in revenue in 2018 and 2019.

Individual Mandate

With the passage of the tax reform bill on December 20th, 2017, the individual mandate was repealed (in actuality, the penalty was "zeroed out" for 2019. the actual mandate is still in force) Many pundits claim this will result in 13 million people losing or dropping coverage.

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Cost Sharing Subsidies

The decision made in late 2017 to end the cost sharing reduction subsidies by the federal government to the insurance carriers led to increased premiums in the individual market and in many cases, carriers pulling out of states leaving “bare counties.” Attempts were made to come up with funding in the March 23rd continuing resolution but in the end, proposal to fund was not included.

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2018 Introduced Legislation

S2303/H.R. 4575 – Access to Independent Health Insurance Advisors Act of 2018. This bill advocated for the continued use licensed insurance advisors by the consumer. The bill calls for the fair remuneration for these insurance professionals and in addition the proposed legislation calls for agent compensation to be removed from the MLR calculation.

2018 Introduced Legislation

H.R. 5138 – Bipartisan HSA Improvement Act of 2018. This bill advocates improved access to health care through modernized health saving accounts. Some of the modernizing efforts included but were not limited to:

Using H.S.A. money for gym memberships up to $1,000

Using H.S.A. money for Direct Primary Care

Raising the contribution limit to equal out of pocket

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Executive Orders

- Executive Order 13813. This order gave rise to proposed regulations concerning Association Health Plans as another method of lowering the cost of insurance and getting more people covered. It allowed employers to band together for the “sole” purpose of obtaining health insurance if there was another business purpose to the group. Preventing AHPs from charging higher premium based on health factors.
- Employer definition is changed to allow for certain self-employed individuals to be included.
- Short Term Health Plans - Proposed regulations will make it easier to obtain coverage through short-term health insurance plans. These plans don't have to adhere to the Affordable Care Act's consumer protections.
- Insurers can sell policies that last just under a year as opposed to the 90-day rule set forth during the Obama administration. This is aimed at giving consumers more choices, boosting competition and lowering premiums.

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Regulatory Changes

Internal Revenue Bulletin 2018-10 - This bulletin was released on March 5th, 2018. The bulletin changed and clarified contribution limits because of the passage of the Tax Cuts and Jobs Act.

For HSAs, the annual tax-deductible contribution limit for tax year 2018 will stay at $3,450 for HSA account holders with self-only coverage but was decreased by $50 to $6,850 for account holders with family coverage through a high-deductible plan. It was changed back to $6,900 a few days later.

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Regulatory Changes

226J Letters - initial letter issued to Applicable Large Employers (ALEs) to notify them that they may be liable for an Employer Shared Responsibility Payment (ESRP). The determination of whether an ALE may be liable for an ESRP and the amount of the proposed ESRP in Letter 226-J are based on information from Forms 1094-C and 1095-C filed by the ALE and the individual income tax returns filed by the ALE's employees.

- 318,296 ALEs filed ACA information returns for 2015
- 49,259 were identified by the IRS as potentially owing an ESRP penalty
- IRS has issued more than 30,000 Letters 226J amounting to $4.4 billion in penalty assessments
- The first 2016 audit letter was received last week of August

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Regulatory Changes

Employer Mandate - Applicable large employers (ALE) must report to the IRS information about the health care coverage, if any, they offered to full-time employees. The IRS will use this information to administer the employer shared responsibility provisions and the premium tax credit.

Single Payer Initiatives

Medicare Extra for All – Center for American Progress. Medicare Extra for All would guarantee universal coverage and eliminate underinsurance. It would guarantee that all Americans can enroll in the same high-quality plan, modeled after the highly popular Medicare program. At the same time, it would preserve employer-based coverage as an option for millions of Americans who are satisfied with their coverage. Employers would have the option to sponsor Medicare Extra and employees would have the option to choose Medicare Extra over their employer coverage. For families with income up to 150 percent of the federal poverty level (FPL), premiums would be zero.

For families with income between 150 percent and 500 percent of FPL, caps on premiums would range from 0 percent to 10 percent of income.

For families with income above 500 percent of FPL, premiums would be capped at 10 percent of income.

Single Payer Initiatives

Medicare For All Act of 2017 - For families with income up to 150 percent of the federal poverty level (FPL), premiums would be zero. For families with income between 150 percent and 500 percent of FPL, caps on premiums would range from 0 percent to 10 percent of income. For families with income above 500 percent of FPL, premiums would be capped at 10 percent of income.

Medicaid Buy-In – A Public Option Plan Anywhere from 10 to 20 states are considering Medicaid buy-in, and at least six states have proposals out in their legislatures. Hospitals do not like the idea as they will out on commercial payments for the individual market patients who opt for Medicaid instead.
Folks who earn too much to be included in the expanded Medicare program would be allowed to buy in to a managed care program.

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Questions?

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