SUBJECT: **1) Delay of Certain ACA Taxes and Fees; 2) Benefit and Payment Parameters for 2019; and 3) Extended Transition Period for ACA Compliant Policies**
DATE: May 7, 2018 *(revised May 24, 2018)*

DELAY OF CERTAIN ACA TAXES AND FEES

On January 22, 2018, President Trump signed H.R. 195. Along with providing short-term government funding, it also extends funding of the Children's Health insurance Program (CHIP) for six years through 2023. This program provides low-cost health coverage to children in families who do not qualify for Medicaid, as well as for pregnant women residing in certain states.

In addition, the law amends three provisions of the Affordable Care Act. Specifically, the law:

- Delays, for two years, the imposition of Code Section 4980I, popularly known as the **Cadillac tax.** The Cadillac tax would be assessed on the amount paid for high cost employer-sponsored health insurance coverage exceeding certain threshold levels ($10,200 for individuals; $27,500 for family, subject to indexing). The type of coverage subject to this tax would generally include all health coverage, whether insured or self-funded. It was to take effect in 2020; the new law delays the effective date until 2022.
- Places a one-year moratorium for the 2019 tax year on the **annual fee** required to be paid by 'covered entities' (insurers) who engage in providing health insurance for U.S. health risks. As described below, this fee had been suspended for the 2017 year, was reinstated for the 2018 year, and now suspended again for the 2019 year.
- Places a two-year moratorium on the 2.3% **medical device excise tax** for 2018 and 2019.

As background, a law enacted in 2015 placed similar extensions and moratoriums (see HRB 116, *Year-end Wrap Up,* 12/29/15). That law extended the effective date of the Cadillac tax from 2018 to 2020, as well as changed the status of the tax from an excise tax to a deductible tax. In addition, it placed a one-year moratorium for the 2017 tax year on the annual health insurer fee, and placed a two-year moratorium on the medical device excise tax for 2016 and 2017.

2019 BENEFIT AND PAYMENT PARAMETERS

On April 9, 2018, the Department of Health and Human Services (HHS) released its finalized Benefit and Payment Parameters for 2019, together with a Fact Sheet. These uniform standards, as required under the Affordable Care Act (ACA) are intended for health insurers and the marketplace to ensure health coverage options for consumers, as well as provide planning guidance for insurers and employers.

These final rules, in large part, mirror some of the proposed parameters released last year (see *Proposed 2019 Benefit and Payment Parameters,* HRB 134, 11/17/17). Following are highlights of these rules that may be of interest to employers.

HHS Inflationary Percentage for 2019. The Secretary of Health and Human Services is charged with determining an annual premium adjustment percentage that is used to set the rate of increase for three parameters detailed in the law. For 2019, the premium adjustment percentage is 1.2516634051, or approximately 25% (approximately 16.17% for 2018). This percentage is calculated based on the projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditures Accounts, as calculated by the CMS Office of the Actuary.

The percentage adjustment is applicable to the following three parameters:

1. *The* ***maximum annual limitation on cost sharing***. The ACA imposes certain cost-sharing restrictions, such as deductible and out-of-pocket limits on health plans. These annual out of pocket limits apply to insured plans offered through the marketplace, and insured and self-funded plans offered outside marketplace. Below are cost sharing limitations for 2017 through 2019:

	Self-only Coverage (Individual)	Other than Self-only Coverage (Family)
2017	$7,150	$14,300
2018	$7,350	$14,700
2019	$7,900	$15,800

As a reminder, the out-of-pocket (OOP) limits applicable to high deductible health plans (HDHP) used in conjunction with health savings accounts (HSA) differ from these ACA-imposed cost sharing limits. For 2018, the OOP limits for HDHP plans are $6,650 for single coverage; $13,300 for family coverage. For 2019, the OOP limit for HDHP plans will increase to $6,750 for single coverage; $13,500 for family coverage.

2. The ***assessable payment amounts under IRC Section 4980H(a) and (b)*** relating to employer shared responsibility. Thus far, the Section 4980H(a) and (b) penalty amounts for 2019 have not been issued by the IRS. Based on the HHS inflationary percentage for 2019 contained in the final benefit and payment parameter standards, the estimated 'no coverage' excise tax (IRC Section 4980H(a) is $2,500, and the estimated 'inadequate or unaffordable' excise tax (IRC Section 4980H(b) is $3,750. However, it is important to note that until these inflationary adjusted penalty amounts are officially released by IRS, these are estimated amounts only. The chart below reflects these excise tax penalty amounts for 2017 through 2019.

'No Coverage' Excise Tax IRC § 4980H(a)		'Inadequate or Unaffordable' Excise Tax IRC § 4980H(b)	
2017	$2,260	2017	$3,390
2018	$2,320	2018	$3,480
2019 *(estimated)*	$2,500	2019	$3,750

3. The required contribution percentage by individuals for minimum essential health coverage (MEC) for purposes of determining eligibility for a ***hardship exemption*** under the individual shared responsibility requirement (IRC Section 5000A). One of these exemptions occurs if the cost to the individual to purchase coverage exceeds 8.30% in 2019 (up from 8.05% in 2018) of household earnings.

Note: This affordability standard is distinct from the employer's shared responsibility affordability standard, and distinct from the affordability standard for being entitled to premium assistance. For 2018, coverage under an employer-sponsored plan is deemed affordable to a particular employee if the employee's required contribution to the plan does not exceed 9.56% (9.86% for 2019) of the employee's household income for the taxable year, based on the cost of single coverage in the employer's least expensive plan.

These parameters, together with separately issued guidance, provide for additional circumstances for claiming a hardship exemption from the requirement to maintain MEC. Even though the Tax Cuts and Jobs Act repealed the individual penalty mandate for tax years beginning January 1, 2019, there may be instances when individuals may still need to seek an exemption to qualify for certain coverages. A hardship exemption is now available for individuals who live in counties or geographical areas where there is zero to one issuer offering qualified health plan coverage to satisfy MEC criteria. Individuals claiming this hardship exemption are still required to follow current marketplace enrollment procedures, including completion of a hardship application.

Benchmark Plan Designs. Under current law, states can utilize one of several plan design categories for defining essential health benefits (EHB). A plan is permitted to use any of the 51 state-based benchmark plans, or the Federal Employee Health Benefit Plan benchmark plan to make its EHB determination. For plan years 2020 and beyond, states will have the following additional options for selecting an EHB-benchmark plan. A state can:

1. Select one of the 50 EHB-benchmark plans used by other states for the 2017 plan year;
2. Replace one or more of the ten required EHB categories of benefits under its own benchmark plan used for the 2017 plan year, with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year; or
3. Select a set of benefits tailored as its own EHB-benchmark plan, as long as it meets the scope of benefits requirements and other specified requirements, as outlined in separate CMS guidance.

While self-funded plans, large group market plans and grandfathered group health plans are not required to provide coverage for EHBs, to the extent that the plan does cover EHBs, it must select a benchmark plan. The selected benchmark plan is used to determine which EHBs the plan offers; this is relevant for a number of ACA purposes including restrictions relating to cost-sharing, annual and lifetime limits and preexisting condition exclusions.

Annual Open Enrollment Period. For the 2019 plan year, the annual open enrollment period for obtaining coverage through the federal marketplace will run from November 1, 2018 through December 15, 2018. State marketplaces may have different open enrollment periods.

Special Enrollment Periods. The final benefit and payment parameter rules make changes to the existing special enrollment period criteria for new dependents enrolling in marketplace coverage due to birth, adoption, foster care placement or court order, as well as for pregnant women who lose Children's Health Insurance Program (CHIP) coverage. In addition, the prior coverage requirement applicable to special enrollment events is waived for those individuals who reside in a service area where there is no qualified health plan coverage available. State marketplaces may provide for different special enrollment periods.

Medical Loss Ratio. The ACA's medical loss ratio (MLR) rules require insurers issuing individual and group health plans to spend a minimum of 85% of premium dollars paid by large group plans (80% in small group and individual markets) on medical care and health care quality improvements. The final benefit and payment parameters, together with two separately issued implementation documents, make certain modifications to the methodology used for calculating these MLR amounts. Specifically, the rules allow for a certain fixed percentage of earned premium that would automatically qualify as quality improvement expenses, and eases the rules for states seeking an MLR rebate adjustment in the individual market.

Federal Exchange User Fees. Insurers participating in the federal marketplace are subject to a user fee to help pay for the operational expenses of the marketplace. For 2019, the user fee rate remains at 3.5% of the monthly premium charged by the insurer. Insurers in state-based exchanges that use the federal exchange platform will be charged 3% (up from 2% in 2018).

Small Business Health Options Program (SHOP). As a means to wind down the Small Business Health Options Program (SHOP) through the Federal marketplace platform, the online enrollment process for employers is eliminated. Employers are permitted to directly enroll in the SHOP through a registered marketplace agent, broker, or insurer. For plan years beginning January 1, 2018, both the federal and state-supported SHOP marketplaces will no longer be required to provide employee eligibility, premium aggregation, and online enrollment functionality services.

EXTENDED TRANSITION PERIOD FOR ACA COMPLIANT POLICIES

Certain so-called 'grand-mothered' policies in the individual and small group markets that are not grandfathered and have enjoyed exemption from certain market provisions since January 1, 2014. The CMS' Center for Consumer Information and Insurance Oversight have extended the exemption several times and released another extension on the same day the final benefit parameters were released. Accordingly, individual and small group health policies renewing prior to October 1, 2018 (but ending by December 31, 2018) can be renewed, free from many of the ACA's market reforms, including:

- Fair health insurance premiums;
- Guaranteed availability of coverage;
- Guaranteed renewability of coverage;
- Prohibition of pre-existing condition exclusions or other discrimination based on health status with respect to adults, except with respect to group coverage;
- Prohibition of discrimination against individual participants and beneficiaries based on health status except with respect to group coverage;
- Non-discrimination in health care;
- Comprehensive health insurance coverage; and
- Approved clinical trials.

Unless extended again, or if changes are made by Congress or the Trump Administration in the interim, beginning January 1, 2019, these policies must be ACA-compliant.

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