Milliman

Health & Group Benefits

AN EMPLOYER BENEFITS UPDATE

JULY 2018

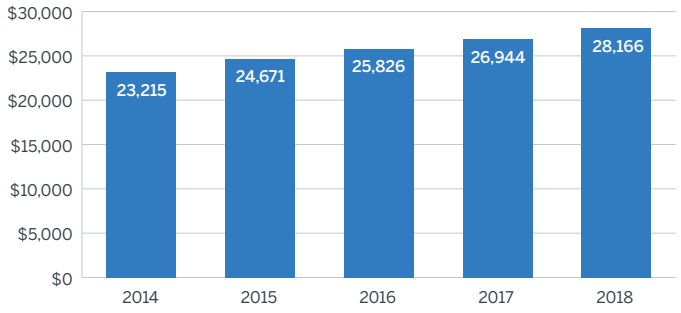
2018 Milliman Medical Index: Healthcare Costs for the Typical American Family exceed $28,000

Chris Girod, FSA, MAAA | Sue Hart, FSA, MAAA | Scott Weltz, FSA, MAAA

Milliman's annual report of healthcare costs for the typical American family, released on May 21, revealed some positive news. The 2018 rate of increase is 4.5% which is nearly the lowest in 18 years.

For many Americans, it is probably difficult to share in this positivity. Unfortunately, the cost of healthcare for the typical American family continues to grow (2018 saw an increase of $1,222 from 2017). In addition, employees still pay close to 44% of these record-high healthcare costs, and their share of the total cost continues to increase. In 2018, employee expenses increased by 5.9%, while employer expenses increased by only 3.5%.

The 2018 Milliman Medical Index outlines several driving forces behind the trend toward slower growth, including provider engagement, plan designs and consumer participation, prescription drug cost reductions, and more.



You can read the full report at www.milliman.com/mmi.

CONTACT

Chris Girod
chris.girod@milliman.com

Sue Hart
sue.hart@milliman.com

Scott Weltz
scott.weltz@milliman.com

Health and welfare trusts seek increased guidance regarding continuation value

Sean Silva, FSA, MAAA, CEBS

One of the primary purposes of a health and welfare trust is to develop strategies to share risk and leverage group purchasing power for the provision of health and welfare benefits to its participants. Examples of health and welfare trusts are multiple employer trusts (METs) and Taft-Hartley multiemployer trusts.

In most instances, benefits provided under health and welfare trusts usually include medical and prescription drug coverage to participants. They also frequently include other ancillary benefits such as dental, vision, life, accidental death and dismemberment, disability, and other welfare-related options. Dependent upon the size and structure of the trust, benefits are typically provided on a fully insured basis, a self-insured basis, or a combination of both.

Due to the continued rise of healthcare costs and uncertainties about the future landscape of healthcare, plan sponsors and fiduciaries are keeping a close eye and seeking increased guidance regarding the financial status of their trusts. A variety of methods can be utilized to assess the financial status of a health and welfare trust. One of the most common methods is to estimate continuation value, or the amount of time that the trust can continue to cover the cost of benefits to its participants and pay for associated administrative, operating, and professional expenses, assuming no future income.

Continuation value can be expressed in many different ways, one of the most common being reserve months. But what level of continuation value should a health and welfare trust target? While the question is common, the answer is complex and requires assessment and understanding of a variety of factors:

- How might deviations from projected experience impact actual results? Estimated months of reserves are developed from financial projections of future experience, which are based on a set of assumptions. It is important to have a full understanding of the assumptions used and how the reserve estimates would be impacted if actual experience differs from projected experience. Sensitivity analyses can help illustrate the impact of changes to assumptions.
- Months of reserves can be expressed on a gross or net basis. Gross reserves are based on total trust assets, while net reserves are based on total trust assets net of liabilities. Trust liabilities can include amounts for premium payments, incurred but not reported (IBNR) claims, accumulated eligibility credits, and hour bank or dollar bank benefits, among others. It is important to understand the basis for which reserves are reported, as well as the impact of trust liabilities on total reserves and how that may change over time.
- How is the future number of participants expected to change? Months of reserves are impacted by participant growth or reduction. For example, a trust with declining participation will experience trust assets being spread over fewer people, thus increasing the months of reserves. Conversely, a trust with increasing participation will experience trust assets being spread over more people, thus reducing the months of reserves.
- Are benefits provided on a fully insured or a self-insured basis? Fully insured trusts tend to have more predictable expenses, and are typically more comfortable holding fewer months of reserves, all else being equal. For self-insured trusts, the level of susceptibility to large fluctuations in claims experience is dependent upon participant size. Because of this, self-insured trusts tend to target a higher level of reserve months than fully insured trusts. Some self-insured trusts may have stop-loss coverage in place to protect against unexpected spikes in claims experience, especially for catastrophic claims.
- How is the trust funded? The primary source of funding is typically through employer contributions, for which the structure can vary among a flat monthly contribution rate per participant, hourly contribution rates, percentage of participant earnings, etc. It is important to understand the structure under which employer contributions are paid, and how economic changes such as variations to employment levels might impact future employer contributions. Other sources of trust income may include participant contributions, investment income, and rebates and subsidies.
- How frequently are employer contribution rates updated? Some trusts update employer contribution rates annually, while other trusts may set employer contribution rates in advance for several years due to multiyear agreements. Trusts for which employer contribution rates are static for numerous reasons (unfavorable economic conditions or political sensitivities for collectively bargained trusts) may wish to retain higher numbers of reserve months to protect against adverse experience.

When determining the optimum number of months of reserves to hold in a health and welfare trust, it is important to speak with your consultant and other trust professionals to address the considerations described above and their respective implications.

CONTACT

Sean Silva
sean.silva@milliman.com

New employer tax credit for paid family and medical leave

Jennifer Fleck, FSA, MAAA

Buried within the new amendment to the tax code, the Tax Cuts and Jobs Act,[1] is a provision to allow employers to take a tax credit for providing paid family and medical leave for their employees. The United States is the only developed nation that does not offer paid leave for employees to care for family members. This new provision is a small step to try to fill that gap.

Starting in 2018, employers can now take an additional tax credit for part of the wages that are paid to employees taking qualified leaves. However, the provision is currently set to terminate at the end of 2019, which may make some employers think twice about whether this is the right time to begin offering paid leave. This article will lay out the provisions of the new credit and provide thoughts on how employers can offer this benefit to their employees. Milliman does not provide tax advice, and the commentary provided in this article should not be construed as such. Companies are encouraged to seek tax or legal counsel before pursuing any particular tax strategy.

Who is covered?

An employer is eligible for a tax credit for eligible paid family and medical leave benefits paid to an employee who has been employed by the employer for one year or more and who earned less than 60% of the "highly compensated employee" limit under § 414(q)(1)(B)[2] in the prior year. That means, for 2018, this credit will only apply to employees who made less than $72,000 in 2017. That doesn't mean that an employer should exclude its higher-paid employees from this benefit, just that the benefits paid to higher-paid employees will not be eligible for the tax credit.

What types of leaves are covered?

In order to receive this tax credit, the program must cover the same types of leaves as those covered under the Family and Medical Leave Act of 1993.[3] These leaves may be taken for the following reasons:

- Birth of a child
- Adoption or fostering of a child
- To care for a spouse, child, or parent with a serious health condition
- The employee's own serious health condition
- A qualifying exigency arising out of the fact that a spouse, child, or parent is on (or called to be on) active duty in the armed forces
- To care for a member of the armed forces or a veteran (with service in the past five years) with a serious injury or illness who is the employee's spouse, child, parent, or next of kin

However, if the leave is provided as vacation leave, personal leave, or medical or sick leave (other than for one of the reasons above), then the leave does not qualify for the paid family and medical leave tax credit.

What amount of benefit needs to be provided?

A benefit amount between 50% and 100% of wages must be provided for at least two weeks in order for the employer to receive the tax credit. The tax credit is only available on the first 12 weeks of benefit paid in a year. Appropriate adjustments are made for part-time employees.

How to determine the amount of the credit?

The amount of the paid family and medical leave tax credit is a sliding scale that increases from 12.5% to 25% of the amount of benefits paid to qualifying employees. The amount varies based on the percentage of the wages that are being replaced. The applicable percentage used to determine the tax credit is 12.5% increased by 0.25% for each percentage point that the rate of payment exceeds 50%. The table in Figure 1 is an example of how the tax credit works for an employee earning $1,000 per week and various options for the percentage of wages being replaced while on leave.

1 The full text of the legislation is available at https://www.congress.gov/bill/115th-congress/house-bill/1/text.

2 Internal Revenue Service. 2018 Limitations Adjusted as Provided in Section 415(d), Etc. Retrieved July 8, 2018, from https://www.irs.gov/pub/irs-drop/n-17-64.pdf.

3 The full text of the legislation is available at https://www.dol.gov/whd/regs/statutes/fmla.htm.

The tax credit increases as the benefit percentage increases, as shown in Figure 1.

FIGURE 1: TAX CREDITS FOR EMPLOYER

WEEKLY WAGES	PERCENTAGE OF WAGES REPLACED	WEEKLY WAGES REPLACED	APPLICABLE PERCENTAGE FOR CREDIT CALCULATION	WEEKLY TAX FOR CREDIT EMPLOYER
$1,000	40%	$400	0.0%	$0.00
$1,000	50%	$500	12.5%	$62.50
$1,000	60%	$600	15.0%	$90.00
$1,000	70%	$700	17.5%	$122.50
$1,000	80%	$800	20.0%	$160.00
$1,000	90%	$900	22.5%	$202.50
$1,000	100%	$1,000	25.0%	$250.00

Does this credit apply to employers in states that mandate paid family leave already?

This tax credit doesn't apply to state-mandated leaves. The regulation says that any leave that is paid by a state or local government or mandated by a state or local government shall not be taken into account when determining the amount of paid family and medical leave provided by the employer. Currently California, New Jersey, New York, and Rhode Island have mandated paid family and medical leave programs in place. In addition, Massachusetts, Washington, and Washington D.C. have passed leave legislations and will have mandated programs in place in the next few years.

Considerations in deciding to offer a paid family and medical leave program

If an employer decides to begin offering paid family and medical leave to its employees, it has a few decisions to make. The first decision is whether to insure the plan with an insurance company or to self-insure the benefit. If it decides to self-insure, it then will also need to decide if it wants to administer the plan on its own or if it wants to use a third party administrator (TPA).

The decision of whether to insure or not depends on the employer's risk tolerance and cash flow availability. Taking into account the employee demographics, an estimate of expected claims costs and expenses can help an employer make the right decision for itself.

Milliman has assisted numerous clients in evaluating whether or not to adopt a paid family and medical leave program for their employees. Claims costs, expenses, and other risk considerations are all important items to review before implementing a new program. The interaction of the new plan with an existing leave program is often an important consideration as well. For example, the way that employees transition from a short-term disability maternity claim to a new child family leave should be carefully thought through from both the employee and the employer perspectives. In our experience, it is not only the cost of the program but also the employee's experience, which are both important considerations.

CONTACT

Jennifer Fleck
jennifer.fleck@milliman.com

Regulatory Roundup

RECENT LEGISLATIVE IMPACT ON EMPLOYER-SPONSORED INSURANCE

Milliman Employee Benefits Research Group

DOL Files Final Rule on Association Health Plans

The Department of Labor issued final regulations and frequently asked questions designed to expand the availability of association health plans (AHPs). The final regulations provide an additional basis for a group or association of employers to be treated as an "employer". Under the new rule, AHPs can serve employers in a city, county, state, or a multi-state metropolitan area, or a particular industry nationwide. Sole proprietors as well as their families will be permitted to join such plans. In addition to providing more choice, the new rule makes insurance more affordable for small businesses. Just like plans for large employers, these plans will be customizable to tailor benefit design to small businesses' needs.

IRS Releases Guidance with 2019 Updates for ACA Applicable Percentage Table and Employer Required Contribution Percentage

The Internal Revenue Service released Revenue Procedure 2018-34, which provides indexing adjustments for certain provisions under section 36B of the Internal Revenue Code. In particular, it updates the Applicable Percentage Table to provide the Applicable Percentage Table for 2019. This table is used to calculate an individual's premium tax credit. The revenue procedure also updates the required contribution percentage for plan years beginning after calendar year 2018. The percentage is used to determine whether an individual is eligible for affordable employer-sponsored minimum essential coverage.

IRS Releases Inflation-Adjusted Amounts for HSAs in 2019

The IRS' Revenue Procedure 2018-30, provides the inflation-adjusted amounts for health savings accounts (HSAs) for calendar year 2019. The updated limits specify the maximum annual contributions to HSAs that may be tax deductible, as well as the minimum deductibles and the maximum out-of-pocket expenses allowed under qualifying high-deductible health plans (HDHPs).

IRS Posts Employer Guidance Regarding Steps Applicable Large Employers Can Take Regarding Letters 227

Many applicable large employers (ALEs) earlier this year received from the Internal Revenue Service Letter 226-J, which imposed an employer-shared responsibility payment (ESRP) on Forms 1094-C and/or 1095-C filed for the 2015 calendar year. Employers were required to respond to Letter 226-J within a short 30-day period, which proved to be difficult due to the collection of data required. The next step in the penalty process was for an employer to receive one of five form letters (Letters 227). The IRS now has created a webpage called "Understanding Your Letter 227", which includes guidance on how to answer the letters.

2018 Social Security and Medicare Trustees' Reports Released

The Social Security and Medicare Trustees Board released annual review of the programs. The trustees estimate that by 2034 the combined trust funds for Social Security—the Disability Insurance and the Old Age and Survivors Insurance Programs—will run dry. At that point Social Security will be able to pay only 79% in promised benefits to retirees and disabled beneficiaries. The trust fund for Medicare Part A, which covers hospital and nursing home costs for seniors, would run dry by 2026. Meanwhile, Medicare Part B, which helps seniors pay for doctor's bills and outpatient expenses, is funded by a combination of premium payments and money from general federal revenue. The same is true of Part D, which offers prescription drug coverage. Both will be financed in full indefinitely, but only because the law requires automatic financing of them.

Federal Subsidies for Health Insurance Coverage for People under Age 65 - 2018 to 2028

The Congressional Budget Office (CBO) released Federal Subsidies for Health Insurance Coverage for People under Age 65: 2018 to 2028, which provides CBO and the Joint Committee on Taxation projections on the federal subsidies, taxes, and penalties associated with health insurance coverage for people under age 65 that will result in a net subsidy from the federal government of $685 billion in 2018. According to the report, the most common source of health insurance for

the non institutionalized civilian population under age 65 is a current or former employer—either one's own or a family member's. CBO and JCT estimate that in 2018, a monthly average of about 158 million people (or about 58 percent of the population under age 65) will have employment-based coverage. That number is projected to decline to 154 million, or about 55 percent of the population under age 65, in 2028.

Treasury, Labor, HHS Issue Clarification on Grandfathered Plans, Preexisting Conditions, Lifetime-Annual Limits

In May 2018, the Department of Health and Human Services (HHS) published a notice entitled, Clarification of Final Rules for Grandfathered Plans, Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, Dependent Coverage, Appeals, and Patient Protections under the Affordable Care Act. The notice provides a clarification for grandfathered plans, preexisting condition exclusions, lifetime and annual limits, rescission, dependent coverage, appeals, and patient protections under the Affordable Care Act (ACA) after the American College of Emergency Physicians (ACEP) filed a complaint in the United States District Court of the District of Columbia. The court required the Departments to provide a more thorough explanation of the decision not to adopt the public comments from the ACEP and others.

CONTACT

Maria Saavedra
maria.saavedra@milliman.com

PLAN SPONSOR 2018-2019 COMPLIANCE KEY DATES

JULY 31, 2018
- Send Form 720 to IRS for payment of the Patient-Centered Outcomes Research Institute (PCORI) fee (applies to plan years ending before 10/1/2018)
- 2017 Form 5500 Annual/Return Report for calendar year plans, unless extension applies

SEPTEMBER 1, 2018
- Applicability date of DoL's final rule for fully insured association health plans

SEPTEMBER 30, 2018
- Summary Annual Report (SAR) to employees for calendar year plans, unless extension applies

OCTOBER 14, 2018
- Rx Drug Creditable Coverage Notice to Medicare Part D-eligible individuals

NOVEMBER 1, 2018
- Open enrollment begins for ACA insurance coverage in 2019

DECEMBER 1, 2018
- Summary of Benefits and Coverage (calendar year plans without open enrollment) to employees

DECEMBER 15, 2018
- Open enrollment ends for ACA insurance coverage in 2019
- SAR to employees if Form 5500 filing date was extended

DECEMBER 31, 2018
- Deadline to make discretionary plan amendments for changes implemented during 2018 for calendar year plans

JANUARY 1, 2019
- Penalty for individuals to have health insurance coverage is reduced to $0.
- Applicability date of DoL's final rule for existing self-insured association health plans complying with the agency's pre-rule test

JANUARY 31, 2019
- 2018 Form W-2 to employees and to the Social Security Administration
- 2018 Form 1095-C/1095-B to full-time employees of "applicable large employers" not full-time employees enrolled in self-funded group health plan (Note: Form 1095-C for 2018 has not been released.)

FEBRUARY 28, 2019
- 2018 Forms 1094-C and 1095-C/1094-B and 1095-B (paper) to IRS (Note: Forms have not been released by IRS).

MARCH 1, 2019
- Rx Drug Creditable Coverage Disclosure to CMS for calendar year plans
- Form M-1 filing to DoL by multiple employer welfare arrangements providing health coverage in 2018
- Reporting of small HIPAA breaches occurring in 2018

MARCH 31, 2019
- 2018 Forms 1094-C and 1095-C/1094-B and 1095-B (electronic) to IRS

APRIL 1, 2019
- Applicability of DoL's final rule for newly formed self-insured association health plans

Milliman

IT TAKES VISION