Benefits BULLETIN

Benefits tips brought to you by
Owen-Dunn Insurance Services

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2019 HSA Limits Announced

The IRS recently announced that limits for health savings account (HSA) contributions will increase for 2019. The high deductible health plan (HDHP) maximum out-of-pocket limits will also increase for 2019. The HSA contribution limits will increase effective Jan. 1, 2019, while the HDHP limits will increase effective for plan years beginning on or after Jan. 1, 2019.

These limits vary based on whether an individual has self-only or family coverage under an HDHP.

Because the cost-sharing limits for HDHPs will change for 2019, employers that sponsor these plans may need to make plan design changes for plan years beginning in 2019.

Also, if an employer communicates the HSA contribution limits to employees as part of the enrollment process, these enrollment materials should be updated to reflect the increased limits that apply for 2019.

New Limits
The following chart shows the HSA and HDHP limits for 2019 as compared to 2018:

2019 HSA Contribution Limit

- **Family -** $7,000 (up $100)
- **Self-only -** $3,500 (up $50)

2019 HSA Catch-up Contributions

- **Age 55+ -** $1,000 (no change)

2019 HDHP Minimum Deductible

- **Family -** $2,700 (no change)
- **Self-only -** $1,350 (no change)

2019 HDHP Maximum Out-of-pocket Expense Limit
(Deductibles, copayments and other amounts, but not premiums)

- **Family -** $13,500 (up $200)
- **Self-only -** $6,750 (up $100)

ACA Affordability Percentages Will Increase for 2019

The IRS recently issued a Revenue Procedure to index the contribution percentages used to determine the affordability of an employer's plan under the Affordable Care Act (ACA).

These updated affordability percentages are effective for taxable years and plan years beginning Jan. 1, 2019. They represent a significant increase from the affordability contribution percentages for 2018.

As a result, some employers may have additional flexibility with respect to their employee contributions for 2019 to meet the adjusted percentage.

Affordable Coverage Test
For plan years beginning in 2019, employer-sponsored coverage will be considered affordable if the employee's required contribution for self-only coverage does not exceed the following percentages:

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2019 Affordability Percentages

- **9.86 percent** of the employee's household income for the year, for purposes of both the pay or play rules and premium tax credit eligibility

- **8.3 percent** of the employee's household income for the year, for purposes of an individual mandate exemption (adjusted under separate guidance)

This adjustment means that employer-sponsored coverage for the 2019 plan year will be considered affordable under the employer shared responsibility rules if the employee's required contribution for self-only coverage does not exceed 9.86 percent of the employee's household income for the tax year.

The 2018 affordability percentage for the pay or play rules and premium tax credit eligibility was 9.56 percent. The 2018 percentage for the individual mandate exemption was 8.05 percent.

For more guidance on this and other compliance topics, contact AP of California, LLC today.

Don't Forget About PCORI Fees

The ACA imposes a fee on health insurance issuers and plan sponsors of self-insured health plans to help fund the Patient-Centered Outcomes Research Institute. The fee, called the Patient-Centered Outcomes Research Institute (PCORI) fee, is calculated based on the average number of lives covered under the policy or plan.

The fee applies to policy or plan years ending on or after Oct. 1, 2012, and before Oct. 1, 2019. The PCORI fee is filed using IRS Form 720, Quarterly Federal Excise Tax Return. Form 720 must be filed annually, by July 31 of each year.

Special Rule for Coverage Under Multiple Applicable Self-insured Health Plans
Generally, separate fees apply for lives covered by each specified health insurance policy or applicable self-insured health plan. However, two or more applicable self-insured health plans may be combined and treated as a single applicable self-insured health plan for purposes of calculating the PCORI fee if the plans have the same plan sponsor and the same plan year.

For example, if amounts in a health reimbursement arrangement (HRA) may be used to pay deductibles and copays under a specified health insurance policy, the HRA and the insurance policy would be subject to separate PCORI fees. However, an HRA that may be used to pay deductibles and copays under an applicable self-insured health plan is not subject to a separate fee if both the HRA and the applicable self-insured health plan have the same plan sponsor and the same plan year.

There is no similar rule for lives covered by more than one insurance policy subject to the PCORI fee.

Special Counting Rule for HRAs and FSAs
Plan sponsors are permitted to assume one covered life for each employee with an HRA, even if the HRA can reimburse expenses of the employee's family members. Similarly, plan sponsors are permitted to assume one covered life for each employee with a flexible spending account (FSA).

Qualified Small Employer HRA (QSEHRA)
Plan sponsors of applicable self-insured health plans must file Form 720 annually to report and pay the PCORI fee; a QSEHRA is an applicable self-insured health plan for this purpose.

Links and Resources
Please see the following IRS resources for more information on the ACA's PCORI fees:

- PCORI Fee Overview Page
- PCORI Fee: Questions and Answers
- IRS Form 720 and instructions
- PCORI Fee Due Dates and Applicable Rates

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New Resources for Mental Health Parity Compliance

The Department of Labor (DOL) has provided new resources to promote compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). The MHPAEA requires parity between mental health and substance use disorder (MH/SUD) benefits and medical and surgical benefits.

Employers should work with their issuers and benefit administrators to confirm that their health plan's coverage of MH/SUD benefits complies with the MHPAEA, including any nonquantitative treatment limitations (NQTLs). Employers should consider using the DOL's resources to understand the MHPAEA's requirements and review their plan designs.

Mental Health Parity
The MHPAEA is a federal law that generally prevents group health plans and health insurance issuers that provide MH/SUD benefits from imposing less favorable benefit limitations on those benefits than on medical and surgical coverage. The MHPAEA's parity requirements generally apply to group health plans and health insurance issuers that provide coverage for MH/SUD benefits in addition to medical and surgical benefits.

Parity Requirements
Under the MHPAEA, the financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) applicable to MH/SUD benefits cannot be more restrictive than the predominant requirements or limitations applied to substantially all medical and surgical benefits in a benefit classification.

In addition, the MHPAEA imposes parity requirements on the NQTLs that plans may place on MH/SUD benefits. An NQTL is generally a limitation on the scope or duration of benefits for treatment. NQTLs include medical management standards, formulary designs for prescription drugs, plan methods for determining usual, customary and reasonable charges, exclusions based on a failure to complete a course of treatment, and restrictions based on facility type or provider specialty.

The MHPAEA requires group health plans and issuers to disclose certain information to plan participants regarding the plan's coverage of MH/SUD benefits, including the following:

- Upon request, health plan sponsors and issuers must disclose information on medical necessity criteria for both medical and surgical and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical and surgical and MH/SUD benefits. To avoid possible penalties under ERISA, plan sponsors should respond to these requests within 30 calendar days. If a plan sponsor does not respond within 30 calendar days, penalties of up to $110 per day may apply.

- Group health plans that are subject to ERISA must provide the reasons for a denial of MH/SUD benefits in the plan's claim denial notice in accordance with the DOL's claims procedure regulations. Participants in plans that are not subject to ERISA may request this information, and the plan sponsor must respond within a reasonable time and in a reasonable manner.

MHPAEA Enforcement
The DOL, through its Employee Benefits Security Administration (EBSA), enforces the MHPAEA's requirements for private-sector employment-based health plans. Vigorous enforcement of the MHPAEA has been one of the DOL's top enforcement priorities. When the EBSA identifies MHPAEA violations in a specific group health plan, it asks the plan to make necessary changes to any noncompliant plan provision and to re-adjudicate any improperly denied benefit claims.

In fiscal years 2016 and 2017, the EBSA closed 671 health plan investigations, 378 of which included reviews of MHPAEA compliance. These investigations resulted in 136 citations for MHPAEA violations. During the 2017 fiscal year, almost 50 percent of MHPAEA violations involved NQTLs.

More information regarding MHPAEA compliance is available on the DOL's website for MH/SUD parity.