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January 2019

Benefit Plan Developments

Great Lakes Employers Association
Group Marketing Services, Inc.

• Group Insurance That Benefits Small Business.

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Michigan HICA Tax Officially Repealed!

by Tripp VanderWal, Miller Johnson Attorneys

As explained in our previous client alert (which can be found here), Michigan officially repealed the Health Insurance Claims Assessment (HICA) tax on June 11, 2018. However, that repeal was conditioned on the approval of its replacement—the Investment Provider Assessment (IPA)—by the Centers for Medicare & Medicaid Services (CMS).

On December 11, 2018, CMS notified the Michigan Department of Health and Human Services (MDHHS) that it had approved the IPA. As a result, the HICA tax is officially repealed effective as of October 1, 2018. Under the legislation that repealed the HICA tax, the effective date of the repeal was the later of the following dates: (1) the first day of the calendar quarter during which MDHHS was notified that the IPA was approved; and (2) October 1, 2018. Since October 1, 2018 is the first day of the calendar quarter containing December 11, 2018—the date of CMS's approval—the effective date of the repeal is October 1, 2018.

The HICA tax repeal should be welcome news to plan sponsors of self-funded group health plans (and those plans' third-party administrators) because self-funded group health plans are not subject to the IPA.

On the other hand, fully insured group health plans are subject to the IPA. (Technically, the insurers of fully insured group health plans are subject to the IPA. But, like the HICA tax, insurers are sure to pass the cost of the IPA on to their fully insured customers.) Because of the complexity of how the IPA is calculated, it is difficult to tell (at this time) whether the IPA will be more or less expensive to plan sponsors of fully insured group health plans. So, this is probably less exciting news to these plan sponsors (and their plans' insurers).

If you have any questions about the repeal of the HICA tax, the IPA, or how either of these will affect your group health plan, please contact the author (or any member of the Employee Benefits Practice Group) at Miller Johnson, Kalamazoo office: 269-226-2950, Grand Rapids office: 616-831-1700 or www.millerjohnson.com.

Lakeland Health Joined Spectrum Health on October 1st

The boards of directors of Spectrum Health of Grand Rapids, Michigan and Lakeland Health of St. Joseph, Michigan have each approved resolutions to integrate Lakeland Health into Spectrum Health. Lakeland Health became a division of Spectrum Health, effective October 1, 2018.

Lakeland Health will continue to be governed by a local board of directors that will oversee operations and ensure capital investment and philanthropic efforts on a local level. The new entity will be known as Spectrum Health Lakeland.

The two health systems announced their intention to affiliate on July 11, 2018. After months of due diligence, both Spectrum and Lakeland committed to an agreement allowing the organizations to collaborate on high quality care to improve the health of the communities they serve.

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For more information, please contact:

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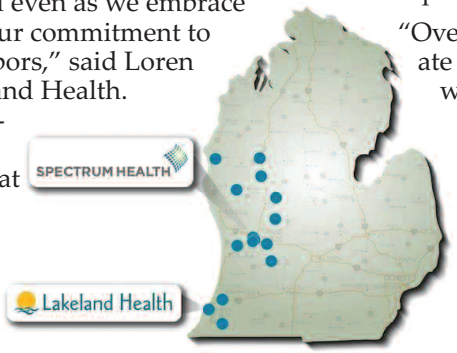
"Lakeland Health is an exceptional organization and we are thrilled they are part of Spectrum Health," said Tina Freese Decker, Spectrum Health President & CEO. "Lakeland's focus on serving the community, high quality care practices and including and engaging patients in their care aligns well with Spectrum Health's culture."

"Health care is constantly changing, and even as we embrace those changes, what hasn't changed is our commitment to take great care of our friends and neighbors," said Loren B. Hamel, MD, President & CEO, Lakeland Health. "Being part of the Spectrum Health family is an exciting new chapter for us and will only enhance our efforts to fulfill that commitment."



Spectrum Health and Lakeland Health will continue to build on the pediatric and specialty care connections already established and expand the opportunities to share best practices across the entire Spectrum Health system. Another benefit of this partnership will be Spectrum Health MedNow, a telehealth service that allows anyone in the State of Michigan quick and convenient access to low-acuity primary care on their mobile device.

Lakeland Health is a comprehensive health system serving southwestern Michigan with more than 4,000 employees, 450 providers and hospitals in St. Joseph, Watervliet and Niles. Spectrum Health is the largest employer in West Michigan with 26,000 employees. Spectrum Health offers a full continuum of care through the 12 hospitals of the Spectrum Health Hospital Group, 180 ambulatory and service sites, 3,600 physicians and advanced practice providers, and Priority Health, a health plan that served one million members in 2018.

"Over the past decade, our Board has been deliberate about looking at where health care is going and what it will take to succeed," said Dan Hopp, Chairman of the Board of Directors of Lakeland Health. "Our many years of collaboration with Spectrum Health have set the stage for a great partnership."

"From our perspective, any potential affiliation must be a good cultural, strategic, geographic and financial fit, with health services that complement one another," said Dick DeVos, Chairman, Spectrum Health System Board of Directors. "Spectrum's Board of Directors has spent a full year focused on its growth and partnership strategy. In today's dynamic and ever-changing health care landscape, it is fulfilling when two organizations have a shared vision that will improve them both as well as the health outcomes of the communities they serve."

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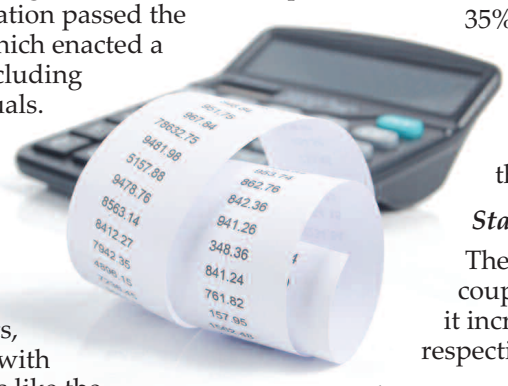
Automatic Extension to Provide Individuals Forms 1095-B, 1095-C

Insurers, self-insuring employers, other coverage providers, and applicable large employers now have an automatic extension until March 4, 2019, to provide individuals with Forms 1095-B, Health Coverage, or Forms 1095-C, Employer-Provided Health Insurance Offer and Coverage. This is an extension from the original due date of January 31. The due dates for employers and insurers to file 2018 information returns with the IRS are not extended. They are still due Feb. 28, 2019 for paper and April 1, 2019 for electronic filing.

New Tax Brackets for 2019

The Internal Revenue Service recently issued the finalized tax brackets for the 2019 tax season, after adjusting rates to account for inflation. The Trump administration passed the Tax Cuts and Jobs Act at the end of 2017, which enacted a number of reforms to the U.S. tax code—including lowering income brackets for most individuals.



The IRS adjusts tax rates for inflation each year– and these changes will generally apply to tax returns filed in 2020 (the 2019 tax season). As previously reported by FOX Business, the agency's new method for gauging inflation–a condition of the tax reform law– will actually raise tax payments, and government revenue, when compared with the measure previously used because things like the standard deduction will increase more slowly.

Here's what rates look like for 2019:

0%: Individuals with incomes of $9,700 or less/Married couples with $19,400 or less

12%: Individuals with incomes over $9,700/Married couples with more than $19,400

22%: Individuals with incomes over $39,475/Married couples with more than $78,950

24%: Individuals with incomes over $84,200/Married couples with more than $168,400

32%: Individuals with incomes over $160,725/Married couples with more than $321,450

35%: Individuals with incomes over $204,100/Married couples with more than $408,200

37%: Individuals with incomes over $510,300/Married couples with more than $612,350

Standard deduction:

The standard deduction for married couples rises to $24,400, for individuals it increases to $12,200, up $400 and $200, respectively.

Alternative Minimum Tax:

For individuals, the exemption amount for tax year 2019 is $71,700 and it phases out at $510,300.

For married couples the exemption is $111,700 and phases out at $1,020,600.

Earned income credit:

For taxpayers filing jointly with at least three children in the 2019 tax season the earned income tax credit rises to $6,557.

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FSA and DCAP Claims Review/Payment Guidelines

Every claim (Expense) that is submitted under an Employer's cafeteria plan's health, Sec. 1.25 arrangement (Flexible Spending Arrangement) FSA and (Dependent Child and Parent) DCAP must be reviewed for proper payment before providing reimbursement.

Generally, all health FSA and DCAP claims must be substantiated with information from an independent third party (i.e., a party independent of the employee and the employee's spouse and dependents) describing the service or product, the date of the service or sale, and the amount of the expense. Original receipts are required by the Group Marketing Services, Inc. FSA Plan administration.

The 2007 proposed cafeteria plan regulations also contemplate independent claims adjudication, meaning that every claim must be reviewed by an independent entity. These requirements are designed to ensure that health FSAs and DCAPs reimburse only legitimate claims found on the IRS allowed listing of Eligible Items. (Other requirements also apply.) IRS rules require that each claim be substantiated and reviewed, including debit card programs.

Because all claims are subject to the claims substantiation requirements, administrators cannot review only a percentage of claims (i.e., sampling) or automatically reimburse claims that are below a "de minimis" dollar threshold or that appear to be from medical providers. These actions jeopardize the income exclusion that would otherwise apply to reimbursements from these arrangements under the Internal Revenue Code and could cause all reimbursements to be taxable for all Plan Participants (not just those approved using the impermissible techniques). The 2007 proposed cafeteria plan regulations also provide that if a health FSA or DCAP fails to comply with applicable substantiation requirements, all employees' elections between taxable and non-taxable benefits under the entire cafeteria plan will result in gross income.

Access your FSA balances and usage 24/7 on our website: https://www.groupmarketingservices.com/logon.html.

Start a Walking Program in 3 Easy Steps

Map out a route, dress appropriately, and follow our quick-start guide to get going.

Exercise is medicine, and walking is a very common and good form of exercise. Regular brisk walks can help lower the risk of high blood pressure, heart disease, stroke, and diabetes. They can also strengthen bones and muscles, burn more calories, and lift mood. So why is it hard for many of us to start a walking program? "With so much at stake, it seems overwhelming," says Dr. Richard Ginsburg, a psychologist with Harvard-affiliated Massachusetts General Hospital. "The best way to begin is to start slowly and gradually increase the number of steps you take each day." Here we offer the first three steps to help you on the path to better health.

1. Get Ready.

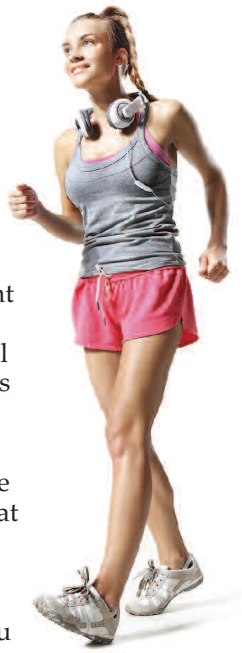
- Make sure your doctor signs off on a walking program, especially if you have heart, hip, or knee problems.
- Map out a route before you go. Your neighborhood or a local park or mall is a good place to start. Avoid places with uneven ground and cracked or crumbling sidewalks.

2. Dress For The Part.

- Wear clothes that suit the weather: cotton shorts and tees in the spring and summer, and sweat pants and long-sleeved layers in the fall and winter. Don't forget a hat and gloves to keep your head and hands warm in winter, and a hat to protect your head from the sun in warmer seasons.
- Wear walking shoes that help cut down on tendon strains. These will have soles that are twice as thick at the heel than at the toe. Look for moisture-resistant insoles, padded tongues, and light, breathable uppers.

3. Start Walking.

- Divide your walk into three parts: a slower pace to warm up, a faster pace to get your heart pumping, then a slower pace to cool down.
- Focus on minutes spent walking, not distance. Your eventual goal will be 150 or more minutes per week.
- Use the guide *below* to help gradually increase your endurance. Start at the beginning if you have been sedentary. Start at a level you're comfortable with if you already exercise.



– Jennifer E. Kaiser, NASM Certified Trainer

Start a Walking Program Using the SCAMPI Approach

The best way to start a Walking Program is to set a **Specific** goal.

This is the SCAMPI approach:

S – Specific goals result in better performance (determine how long the walk will be, what time, how fast, where? How many minutes).

C – Challenging goals tend to accomplish more or less than modest goals. (Do you plan on hiking a great mountain? Or is the goal walking two hours a day?)

A – Approach to goal setting should be on desired ends to move forward.

M – Measurable goals let you know whether the strategy is working.

P – Proximal, short term goals raise a sense of confidence and determination.

I – Inspirational goals should be consistent with ideals and ambitions.

– Jennifer E. Kaiser, NASM Certified Trainer

Agencies Issue Final Regulations on Contraceptive Coverage Exemptions Based on Religious Beliefs or Moral Convictions

Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 26 CFR Part 54, 29 CFR 2590, 45 CFR Part 147, 83 Fed. Reg. _ (Nov. 15, 2018); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 26 CFR Part 54, 29 CFR 2590, 45 CFR Part 147, 83 Fed. Reg. _ (Nov. 15, 2018).

On November 8, 2018, the IRS, DOL, and HHS released advance copies of two final regulations offering exemptions from aspects of health care reform's preventive health services mandate to certain employers and others with religious or moral objections to health insurance that covers contraceptives. The final regulations were scheduled to be published in the Federal Register on November 15, 2018.

For more information, visit the Federal Register website: https://www.federalregister.gov/documents/2018/11/15/2018-24512/religious-exemptions-and-accommodations.

Leading the Change: A Transformative Moment in Health Care

Aetna / CVS Caremark Merger

The combination of CVS Health and Aetna is a transformative moment for the company and industry, and a continuation of their evolution as a health care innovation company.

The goal is to transform the health care experience by utilizing their combined capabilities to build an innovative health care model that is easier to use, less expensive, and puts consumers at the center of their care. For our pharmacy benefit management clients, the combined organization will deliver greater value and service excellence, while continuing to provide the opportunity to better manage their most expensive health care challenges.

By placing consumers at the center of their health care decisions through a much more connected system, we will make it easier for them to access the information, resources and services they need. By utilizing their neighborhood locations and the expertise of thousands of CVS pharmacists and clinicians, CVS Health to make health care both more personal and easier to navigate.

The combined capabilities of the two companies better positions CVS Health to develop innovative tools and service offerings, new plan designs, and enhanced analytic capabilities as well as an improved health care experience. The goal is to make a complicated system simpler and help people achieve better health at a lower cost.

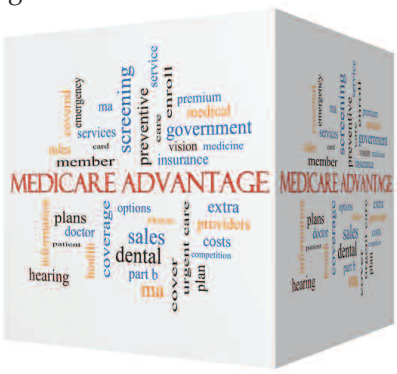
Medicare Advantage Open Enrollment Period Begins January 1, 2019

What You Need to Know

The MA OEP begins January 1, 2019 and runs through March 31, 2019. During this time, beneficiaries who are enrolled in an Medicare Advantage plan or who are newly-MA-eligible may make any of the following one-time changes to their coverage:

- Switch from one MA plan to a different Medicare Advantage plan.
- Drop MA coverage and return to Original Medicare (Part A and Part B).
- Drop MA coverage, return to Original Medicare and add stand-alone Part D coverage.

No other changes can be made during the Medicare Advantage Open Enrollment Period (MA OEP). Enrollment requests will be effective on the first day of the following month. For example, if a beneficiary uses the MA OEP in January, the coverage effective date will be February 1st.



*Important reminders– **What Agents cannot do during OEP:***

- No soliciting – You cannot share materials advertising the ability to make a plan change or referencing the OEP in any way.
- No targeting – Do not purchase a mailing list or do anything else that might help you identify beneficiaries who are in the OEP, or contact any clients you recently submitted applications for during Annual Enrollment Period (AEP).
- No trying to change anyone's mind – You may not contact former enrollees who have selected a new plan during the Annual Enrollment Period (AEP).
- No sales activities – You can not engage in or promote any activities that intend to target the OEP as an opportunity to make further sales

Learn more about the MA OEP at medicare.gov.

Flexible Spending Accounts (FSA)

For the taxable year beginning in 2019, the dollar limitation under IRS Code Sec 125(i) on voluntary employee wage reductions for annual contributions to Health Flexible Spending Account/ arrangements (FSA) is $2,700.00. Don't use it? You may not have to lose it.