Employee Benefits Report

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How Could the New Tax Law Affect Your Company's Benefits?

The Tax Cuts and Jobs Act will have a big effect on the way the government taxes employer-sponsored benefit programs. Some of the changes will make it easier for you to offer benefits, while others will make it harder.

President Donald Trump signed the act into law Dec. 22, 2017. It is officially called "An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018." The law is the most sweeping reform of the U.S. tax code in more than 30 years, lowering most business and individual tax rates and modernizing U.S. international tax rules. Most of the provisions were effective Jan. 1, 2018, but some are not permanent and are scheduled to sunset after Dec. 31, 2025, unless a future Congress extends those provisions.

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Family HSA Contribution Limits Lowered

If you offer a Health Savings Account (HSA), you must alert your employees who contribute to a family HSA that the annual maximum contribution limit has decreased for 2018.

An HSA allows employees who have qualified high-deductible health insurance plans to save for out-of-pocket medical expenses using pretax dollars. Unlike a flexible spending account, an employee's HSA balance rolls over from year to year.

Effective this year, the maximum employees can save in their family HSA is $6,850 instead of $6,900. There is no change to the contribution limit to individual

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Here's an overview of some changes that will affect your or your employees' taxes on fringe benefits.

Transportation Benefit Programs

Then: Employees used pretax dollars to pay for transportation or parking expenses, and employers deducted the costs.

Now: Employees still can use pretax dollars to pay for transit expenses, but employers can no longer get a deduction. The exception is if the benefit is necessary to ensure the safety of the employee. In that situation, the employer can deduct the cost. The law's implementation is complicated because local laws in New York City, Washington, DC, and the San Francisco Bay area require certain employers to maintain qualified transportation fringe benefit programs.

In 2018, employees can set aside up to $260 per month pretax for transportation and parking expenses if their employer maintains a transportation benefit program. The exclusion for biking expenses stays at $20 per month.

The rules are different for employees who bike to work. In the past, they could receive $20 monthly from their employer to defray the costs of cycling and the benefit was tax-free. That benefit is no longer tax-free.

Employee Achievement Awards

Then: Employers could give employees tax-free "tangible awards" for achievement, such as the traditional gold watch.

Now: Employees can still exclude and employers can still deduct the value of tangible property and gift certificates *but only when offered from a limited range of items pre-selected by the employer*. Otherwise employee exclusions and employer deductions from taxation will no longer apply to cash or any other gift coupons/certificates, vacations, meals, lodging, tickets to sporting or theater events, securities, or "other similar items."

Family and Medical Leave Tax Credit

Then: The Family and Medical Leave Act guaranteed that employees at large companies received up to 12 weeks of leave each year, although employers were not required to pay workers during the leave.

Now: The act is still in effect, but the new tax law provides employers an incentive to pay for some or all of the leave. Employers that provide paid family and medical leave to their employees can claim a business tax credit for a portion of the wages paid during qualified leave. The paid leave must be an official benefit program offered by the company to all eligible full-time employees. Full-time employees must be allowed to take at least two weeks of annual paid family and medical leave if necessary, and part-time employees must be provided a commensurate amount of leave on a pro rata basis. Employers that pay at least 50 percent of an employee's wages can claim a 12.5 percent credit of the wages paid for up to 12 weeks of family and medical leave per year. The employer's credit is increased by 0.25 percentage points, up to a maximum of 25 percent, for every percentage point when the rate of payment exceeds 50 percent.

HSAs, which remains at $3,450, or for flexible spending accounts. HSA plans continue to allow those who are 55 or older to contribute a catch-up contribution of an additional $1,000 per year.

The Internal Revenue Service made the change after the U.S. House and Senate passed the Tax Cuts and Jobs Act in December 2017. The law applies the "chained consumer price index" to the HSA contribution limits, which is how contributions are linked to the rate of inflation.

Compliance experts recommend that employers reconfigure their payroll system to ensure employees do not contribute too much. If an employee already contributed the maximum amount, you must refund the additional $50; the refund should be treated as normal taxable income. Employees who save too much are subject to a six percent excise tax if the correction is not made.

Moving Expenses

Then: Employees whose job relocation moving expenses were reimbursed by their new employer or their current employer did not have to pay taxes on the amount.

Now: Employees must pay taxes on the reimbursement and they cannot deduct moving expenses that were not paid by their employer. This rule does not apply to active-duty military personnel.

Insurance Terms 101: It Pays to Know Who Does What

If you purchase group health, dental or vision coverage for your company from an agent or a broker, you're aware of the wide range of services they offer. Are you also familiar with the terms used in the insurance industry and what each entity does?

Many of the terms — agency, broker, insurance company/carrier — seem interchangeable, but their meanings are different.

It helps to understand what they do so you can understand what they offer to you and your employees. Here is a quick primer:

Agent/Broker

The terms agent and broker often are used interchangeably, but there are a few differences.

An insurance agent has an ongoing contractual relationship with one or more insurance companies. Some agents, called captive agents, agree to sell only that company's products and their primary duty is to the company.

In comparison, a broker's primary duty is to the client. They can be "appointed" to sell products from a variety of insurance companies and can obtain price quotes and look for the plans that best meet their clients' budgets and needs.

Insurance companies pay both agents and brokers commissions based on their sales. Brokers may also charge fees for their work on behalf of a client.

That's where the differences end. Both agents and brokers need to have a thorough knowledge of the plans they offer so they can give recommendations on what plans best fit their clients' needs and budget. While it could be tempting to simply go with the cheapest option, agents and brokers take your needs into consideration when recommending a plan. They will talk to you about your financial resources, show you policy options, customize a plan to meet your needs, keep your plan current on ever-changing regulations and handle policy renewals.

Agents and brokers must meet the licensing requirements of the states where they sell products. Those requirements generally include successfully completing a written exam, meeting educational requirements and obtaining licenses for each line of insurance they sell. Both agents and brokers must take continuing education courses annually to maintain their licenses.

Most people assume that people who sell insurance are agents, so don't be surprised if your agent actually is a broker.

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Agencies and Brokerages

This can get a little muddy. Remember that agents owe their primary duty to the insurance company or companies they represent and brokers owe their primary duty to their clients. Therefore, a firm that calls itself an agency is technically transacting business as a representative of the company or companies it does business with.

In reality, "agencies" often act as brokers (with their primary duty to the client) as well as agents of certain companies. Many agencies consider it their primary duty to always make the client's interest paramount regardless of their legal status as agents of certain insurance companies. Sometimes it's just a matter of branding. The business may have started out as an agency but later developed brokerage relationships and didn't change its name.

Insurance Company/Carrier

The insurance company is the financial resource for the entire process. In return for charging a specified premium, the insurance company promises to pay certain claims for insured members.

The insurance company, also known as an insurance carrier, issues the policy, charges and collects the premium and is responsible for paying claims. While they make money if a client has a healthy year, they can lose money when a client needs more health care coverage than the carrier estimated. Insurance agents, underwriters, customer service representatives, claims adjusters, marketers and financial experts all work for the carrier. Carriers also are called insurance providers, insurers or insurance companies.

As an insurance broker, we are independent and exist only to serve our clients. If we can help you with your benefit needs, please contact us. ■

Reference-Based Pricing — A New Way of Paying Health Care Providers

Many small employers are turning to self-funding to provide economical group health benefits to employees. A growing number now use reference-based pricing to lower costs.

Reference-based pricing is a way for employers who self-fund their benefits to limit costs by paying a fixed amount for health care. To understand this method of cost control, it helps to understand self-funding .

The Appeal of Self-Funding

Previously, only large corporations could afford to self-fund their employees' group health benefit coverage. With self-funding, the employer pays for employees' claims out of pocket instead of paying a pre-determined premium to an insurance company for a fully insured plan. The employer assumes all risk. Employers can customize a plan to meet the specific health care needs of their workforce. A third-party administrator (TPA) often processes the claims and collects the premiums for the plan.

The biggest advantage of a self-funded plan is the potential for employers and employees to save money. Self-funded plans fall under ERISA (Employee Retirement Income Security Act) guidelines and are exempt from many of the Affordable Care Act regulations — especially those that caused premiums on fully insured plans to climb substantially. Employers also do not pay state health insurance premium taxes, which can run two to three percent of the premium.

There are risks. If employers truly self-fund their group health benefits, they assume the risk of paying the health care claims for employees. It's imperative that the company has sufficient financial resources.

However, there is another, less risky option — level funding. Employers who level-fund their healthcare plans pay a regular monthly fee based on what the insurer thinks the company's claims will be. They also buy stop-loss insurance premiums to cover claims above a specified dollar level.

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The Appeal of Reference-Based Pricing

A provider's bill does not necessarily indicate the service's actual cost, nor is it always a true reflection of market value. Reference-based pricing is a way for employers to cap the amount they'll pay to cover claims.

Many employers reimburse providers 150 percent of Medicare's reimbursement. Medicare reimbursement is used as a guide because it is the only universally accepted payment rate. Medicare reimbursement is enough to cover the service with some extra for the doctor or hospital. By pricing reimbursement at 150 percent, providers generally react positively because they typically receive less from Medicare and about the same amount from most insurance carriers.

Some plans only cap the cost of certain medical procedures — procedures that vary greatly in price but not in outcome, such as hip or knee replacements. Employers usually work with a reference-based pricing vendor or third-party administrator to set fixed payment levels.

Employees who have this plan do not have to see doctors in network, since there is no network. They can go anywhere the reimbursement is accepted. Depending on the plan, employees might or might not have to pay a balance bill for the difference in price.

The main advantage of this payment system is that it adds transparency to health plan pricing and saves employers money. It also keeps premiums lower for employees.

On the downside, employees may have to search to find providers who accept the reimbursement level. Employees also may be liable for balance billing if the care provider insists on more than the set price. This is most common with hospital stays. Some plans make it the employer's responsibility to pay for any balance bills they cannot negotiate. A reference-based plan also requires more employee education so they know what to do if they are balance billed.

In general, providers accept the payment or a final negotiated price that is below the cost of traditional payments about 95 percent of the time.

If you are interested in self-funding and reference-based pricing, talk to your agent or broker to learn if these plans and pricing would be good for your workplace.

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Congress Looking at Retirement Savings Plans

Proposed legislation looks to improve retirement savings

Congress is considering making improvements to the Retirement Enhancement and Savings Act (RESA). The proposed changes could make it easier for small employers to offer retirement plans to employees and simpler for all employers to offer 401(k) annuities.

Legislators passed RESA with bipartisan support in 2016. One of its key measures is authorization to start Multiple-Employer Plans (MEPs).

The proposed changes also received bipartisan support in the Senate. AARP, financial service providers and stakeholders also support the changes, arguing small companies have a more difficult time offering retirement benefits, such as 401(k) plans, than large companies.

The proposal encourages small businesses to band together and offer defined contribution plans. These plans would not require businesses to be related to join, as would be the case with a MEP. Instead, companies would form a Pooled-Employer Plan (PEP) to lower plan costs.

Policymakers also want to improve the quality of retirement plans offered through a PEP compared to what was offered with a MEP, including simpler plan administration and less fiduciary liability for small employers.

The proposed legislation also would amend the rules for annuities to make them easier for employers to offer as part of a 401(k). An an-

nuity is a contract between a plan participant and a third party (usually an insurance company),where the participant makes a lump-sum payment in exchange for a guaranteed income for a specified time or for life. Taxes on earnings are deferred until the funds are withdrawn. Annuities can also provide death benefits and long-term care benefits.

If approved, the legislation would require regularly issued statements to 401(k) plan participants to help them better understand how their current account balance translates into a monthly retirement income stream.

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