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INSURANCE BRIEF

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The ACA Six Years Later

Open enrollment for the 2016 benefit year concluded with about 12.7 million people actively selecting a plan or being auto re-enrolled for 2016. The first employer reporting deadline has passed and now some employers can move on with the business of amending returns, while others can look ahead.

Correcting Reporting Errors. The instructions for the Forms identify the types of errors that applicable large employers (ALEs) must correct. For Forms 1094-C, ALEs must be sure to correct errors that involve: (i) the name and/or EIN of the ALE; (ii) the total number of Forms 1095-C filed by or for the ALE; (iii) whether the ALE is a member of an aggregated ALE group; (iv) certifications of eligibility; (v) the Minimum Essential Coverage Indicator; (vi) full-time employee count for an ALE member; (vii) the Aggregated Group Indicator; and (viii) the Section 4098H Transition Relief Indicator.

For Forms 1095-C, ALEs must be sure to correct errors regarding: (i) the employees' or enrollees' names and Social Security Numbers; (ii) the ALE's name and/or EIN; (iii) specifications regarding the offer of coverage; and (iv) the premium amount of the least expensive option for self-only coverage.

2017 Benefit and Payment Parameters Finalized

We reported on the proposed benefit and payment parameters for 2017 in the January *Insurance Brief.* On February 29th they were finalized by the Department of Health and Human Services (HHS). The regulations, which also address some Exchange-related items, primarily impact individuals, insurers, Exchanges, and navigators and brokers providing Exchange support—but some of the provisions apply to employers and advisors. Here are highlights:

Out-of-Pocket Maximums. The proposed 2017 annual out-of-pocket maximums are $7,150 for individual coverage and $14,300 for family coverage.

Annual Enrollment. The annual open enrollment period for Exchange coverage will be November 1, 2016 through January 31, 2017 for 2017 coverage; and November 1, 2017 to January 31, 2018 for 2018 coverage. This period will change to November 1 to December 15, 2018 beginning for 2019 coverage.

Small Employer Definition. Consistent with the Protecting Affordable Coverage for Employees Act, the final regulations define a small employer as one with at least one and not more than 50 employees on business days in the preceding calendar year, with an option for states to expand the cutoff to 100 employees. This definition applies for small/large group market delineations and also establishes eligibility for the Small business Health Options Program (SHOP). Consistent with Code § 4980H, if an employer was not in existence throughout the

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preceding calendar year, employer size is based on the average number of employees expected to be employed during the current calendar year.

Notice of Employee Enrollment in Subsidized Exchange Coverage. Under the final regulations, Exchanges are only required to notify employers when their employees actually enroll in Exchange coverage and have been determined eligible to receive a premium tax credit. The Exchange may either send notices employee-by-employee, or in batches, so long as notice is provided within a reasonable time. This is an improvement over the current rule, which requires a notice from the Exchange whenever an employee is determined to be eligible for the premium tax credit—whether or not the employee enrolls. Because employer shared responsibility penalties under Code § 4980H may be triggered only when a full-time employee actually receives a premium tax credit, being notified of mere eligibility for the credit doesn't provide employers with all the information they need and generates unnecessary notices.

The Federally Facilitated Exchanges intend to publish a sample notice. The first batch of federal Exchange notices is expected to be sent in spring 2016. The preamble includes a reminder that the Exchange notice does not establish Code § 4980H liability; only the IRS can assess these penalties. Under the appeals regulations, employers receiving a notification may appeal the Exchange's determination by submitting an appeal request by telephone, mail, or Internet (or in person, if the entity handling the appeal is capable of receiving in-person requests). This guidance allows entities conducting appeals to delay accepting employers' appeal requests via the Internet until January 1, 2017. If an employee is determined eligible for advance payment of premium tax credits, an appeal is an opportunity for the employer to correct any misinformation about employer-sponsored coverage offered to the employee. An employer appeal request form is now available on Healthcare.gov. Employers subject to Code § 4980H should familiarize themselves with the Exchange notification and appeals process since appealing an incorrect eligibility determination can provide an opportunity to "head off" a potential excise tax liability that may be assessed by the IRS at a later date.

Guaranteed Availability/Guaranteed Renewability. Health care reform generally requires insurers to guarantee availability and renewability of coverage, subject to limited exceptions. HHS had proposed changes to certain exceptions, but the proposals were not included in these final regulations. More specifically, HHS decided not to add an exception to guaranteed availability under which insurers would have been permitted to deny coverage to new individuals or groups during the 90- or 180-day notice period applicable to product discontinuance or market withdrawal. It also decided to retain exceptions to guaranteed renewability when employers cease to be members of an association or violate insurers' minimum participation or employer contribution rules. Based on comments to the proposed regula-

Transit Parity

We were all glad to see the restoration of transit parity for 2016. What may have gone unnoticed is the fact that in December the Protecting Americans from Tax Hike (PATH) Act made this permanent. Then on January 11th the IRS issued Notice 2016-6 to provide guidance related to the law. Section 105 of the act amended Section 132(f)(2) of the Internal Revenue Code to permanently create parity between the transit benefit tax exclusion and the exclusion for qualified parking benefits. Notice 2016-6 explained how to correct 2015 FICA tax overpayments and report income and tax on Forms 941, 941-X and W-2, similar to the retroactive increase for 2014. I for one am glad we won't have retroactive adjustments again!

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tions, HHS acknowledged that employers' rights are different under guaranteed availability and guaranteed renewability and decided not to adopt the proposed changes.

SBC Revisions

The Department of Labor (DOL) issued on February 26th proposed revisions to the template and related materials for the summary of benefits and coverage (SBC), and then on April 6th the final regulations. At the time the agencies issued final SBC regulations in June 2015 they indicated that they would issue revised materials to apply to plan or policy years beginning on or after January 1, 2017.

The revised materials propose further changes to the versions initially proposed in December 2014. The new proposed template (like the earlier proposal) comprises 2-1/2 double-sided pages of prescribed content, making it shorter than the template currently in use. Here are some highlights:

- "Important Questions" Revised. As with the earlier proposal, the new proposed template would eliminate, from the "Important Questions" section, the question about annual limits (as they are no longer permitted) and the question about what is not covered (the SBC would still address non-covered services elsewhere). The new proposed template also presents questions about deductibles, out-of-pocket limits, and network providers differently—for example, asking "Will you pay less if you use a network provider?" rather than "Does this plan use a network of providers?"
- Disclosures Modified. Revised disclosures about continuation coverage and grievance and appeals rights would be required to appear as shown on the template, with additional language (specified in the instructions) required based on factors such as whether the plan is subject to ERISA. The new proposed template also includes disclosures indicating whether the plan provides minimum essential coverage (MEC) and meets the minimum value (MV) standards. Along with a yes or no answer, specific language addressing potential tax consequences (individual shared responsibility), exemptions, and the premium tax credit would be required. Until the template and related materials are finalized and applicable, information regarding MEC and MV may be provided in a separate document.
- Coverage Examples Changed. The new proposed template includes the third coverage example involving a simple fracture, which also appeared in the earlier proposal. Additional proposed revisions to the coverage examples would provide clearer information about the plan's deductibles and coinsurance, and eliminate hypothetical costs for specific services under each scenario such as hospital charges, lab tests, and prescriptions. The coverage example calculators would remain available to use in completing the examples, along with proposed narratives and guides to the calculations. As in the earlier proposal, the SBC template page that explains assumptions and other information about the coverage examples would be eliminated.
- New Instructions Added. The revised instructions for completing the SBC would include some new elements, such as information about addressing coverage or exclusion of abortion services on the SBC. Other proposed revisions to the instructions incorporate previously issued guidance on issues such as combining information for different cost-sharing options and explaining the effect of "add-ons" like a health FSA, HRA, HSA, or wellness program.

  Uniform Glossary Definitions Linked in SBC. Proposed changes to the uniform glossary itself are largely similar to those in the earlier proposal. Proposed revisions to the instructions for completing the SBC note that terms defined in the glossary should be underlined in the SBC, and, in electronic versions, may hyperlink directly to the definition.

The final SBC template and instructions maintain material changes proposed to these documents in late February 2016. These changes include:

ACA Updates *cont'd*

Included in IRS Notice 2015-87 are Q & A addressing health FSA carryovers and COBRA. Notice 2013-71 allows for up to $500 of unused amounts remaining at the end of the plan year in a health FSA to be carried over into the following plan year. It has long been the case that qualifying health FSAs need not offer COBRA coverage unless the qualified beneficiary's account is "underspent" when the qualifying event occurs. Q/A-21 explains that health FSA carryovers are included when determining the amount available for reimbursement.

> Example. Facts: An employer maintains a calendar year health FSA that qualifies as an excepted benefit. Under the health FSA, during the open season an employee has elected to reduce salary by $2,500 for the year. In addition, the employee carries over $500 in unused benefits from the prior year. Thus, the maximum benefit that the employee can become entitled to receive under the health FSA for the entire year is $3,000. The employee experiences a qualifying event that is a termination of employment on May 31. As of that date, the employee had submitted $1,100 of reimbursable expenses under the health FSA.
>
> Conclusion: The maximum benefit that the employee could become entitled to receive for the remainder of the year as a benefit under the health FSA is $1,900 (($2,500 plus $500) minus $1,100).

In contrast, Q/A-22 states that carryovers are not included when determining the COBRA premium, which is based solely on the employee's salary reduction election and any additional employer contributions, if applicable.

Q/A-23 provides that, even though qualifying health FSAs are not obligated to provide COBRA beyond the end of the plan year, if a health FSA allows carryovers for non-COBRA beneficiaries, it must allow them on the same terms for similarly situated COBRA beneficiaries. Thus, at the end of the plan year, a qualified beneficiary could potentially carry over up to $500 of unused amounts until the end of the applicable COBRA maximum coverage period, with no premium due. However, health FSAs may also limit carryovers to individuals who have elected to participate in the health FSA in the next plan year (Q/A-24) and may require that carryover amounts be forfeited if not used within a specified period of time, such as one year (Q/A-25).

> Example. Facts: Employer sponsors a cafeteria plan offering a health FSA that permits up to $500 of unused health FSA amounts to be carried over to the next year in compliance with Notice 2013-71, but only if the employee participates in the health FSA during that next year. To participate in the health FSA, an employee must contribute a minimum of $60 ($5 per calendar month). As of December 31, 2016, Employee A and Employee B each have $25 remaining in their health FSA. Employee A elects to participate in the health FSA for 2017, making a $600 salary reduction election. Employee B elects not to participate in the health FSA for 2015. Employee A has $25 carried over to the health FSA for 2017, resulting in $625 available in the health FSA. Employee B forfeits the $25 as of December 31, 2016 and has no funds available in the health FSA thereafter.
>
> Conclusion: This arrangement is a permissible health FSA carryover feature under Notice 2013-71.

What's Next: You can check your Sec. 125 plan documents to see if they reflect the carryover eligibility and duration you want for your active employees and COBRA participants. If they do not, a plan amendment would be necessary to make the desired changes.

ACA Updates *cont'd*

- Removal of Q&A about Coverage Examples
- Updated claims/pricing data for the coverage example calculator
- New minimum essential coverage and minimum value language, as well as new continuation and appeals/grievance rights language
- Revised language for some sections of the template
- An updated Uniform Glossary

The DOL, Health and Human Services (HHS) and the IRS issued a single FAQ on March 11th. According to the FAQ, the agencies expect to review the comments and finalize the new template and related materials "expeditiously" with the intent that plans and insurers will be required to use the revised template and related materials starting with the first day of the first open enrollment period that begins on or after April 1, 2017, with respect to coverage for plan years beginning on or after that date. Thus, for calendar-year plans, the revised SBC template would not apply until the 2017 open enrollment period relating to coverage beginning on or after January 1, 2018. For plans and insurers that do not use an annual open enrollment period, the revised materials would be required beginning on the first day of the first plan year that begins on or after April 1, 2017.

Federal Marketplace Special Enrollment Period Processes

On February 24th the Centers for Medicare & Medicaid Services (CMS) made an announcement and published a Fact Sheet on their new special enrollment confirmation process. Due to concerns about whether current federal Health Insurance Marketplace rules and procedures are sufficient to ensure that only those who are eligible enroll through special enrollment periods (SEP), they have created a new verification process for individuals who apply.

Beginning in the next several months, all consumers who enroll or change plans using a special enrollment period for any of the following triggering events will be directed to submit documentation to verify their eligibility:

- Loss of minimum essential coverage;
- Permanent move;
- Birth, adoption, placement for adoption, placement for foster care or child support or other court order; or
- Marriage.

CMS will provide consumers with lists of qualifying documents, such as a birth or marriage certificate. Consumers will be able to upload documents to their HealthCare.gov accounts or mail them in.

Applicants will be required to attest their understanding of the SEP eligibility requirements, including documentation requirements, and that their statements are truthful. CMS will provide a list of documents that are acceptable for verification of eligibility. Consumers may upload these documents to their account or mail them in. CMS will review the documents and inform the consumer if more information is needed. Consumers who fail to provide appropriate documentation may lose their eligibility.

CMS will modify the Healthcare.gov application process to clarify eligibility requirements for the permanent move and loss of minimum essential coverage SEPs. It will work with assisters, navigators, and brokers, as well as consumer groups, to clarify SEP eligibility requirements. CMS will phase in the documentation process over the next several months.

Please contact your SML Account Team if you have any questions.

2017 Medicare Part D

On April 4th the Centers for Medicare & Medicaid Services (CMS) released the Part D prescription drug program changes for 2107.

- Deductible: $400 (a $40 increase from 2016);
- Initial coverage limit: $3,700 (a $390 increase from 2016);
- Out-of-pocket threshold: $4,950 (a $100 increase from 2016);
- Total covered Part D spending at the out-of-pocket expense threshold for beneficiaries who are not eligible for the coverage gap discount program: $7,425 (a $362.50 increase from 2016);
- Estimated total covered Part D spending at the out-of-pocket expense threshold for beneficiaries who are eligible for the coverage gap discount program: $8,071.16 (a $555.94 increase from 2016); and
- Minimum cost-sharing under the catastrophic coverage portion of the benefit: $3.30 for generic/preferred multi-source drugs (a $.35 increase from 2016), and $8.25 for all other drugs (a $.85 increase from 2016).

These parameters will be used by insurers and group health plan sponsors to determine whether their plans' prescription drug coverage is creditable for 2017.

HCSO Annual Reports

The 2015 Annual Reporting Form is now available online.

Deadline: April 30, 2016. Failure to meet the deadline can result in penalties of $500 per quarter.

We recommend you review the instructions prior to beginning the form. You may also want to view the Annual Reporting Form PDF preview.

As a reminder: you are not a "covered employer" under the HCSO and you should not submit the Form if (1) you are a private employer and you employed fewer than 20 persons, (including those employed outside of San Francisco) in each of the four calendar quarters of 2015; or (2) ; you are a non-profit corporation and you employed fewer than 50 persons (including those employed outside of San Francisco) in each of the four calendar quarters of 2015; or (3) if you did not have any employees in San Francisco in 2015. If you are not required to submit the Form, no further action is required.

2016 Expenditure Rates are $1.68 for medium employers (20-99) and $2.53 for large employers (100+).

If you have any questions please visit the Office of Labor Standards Enforcement's HCSO website to access the text of the HCSO, the implementing regulations, answers to "Frequently Asked Questions," and other helpful forms and notices. You can also contact the OLSE by phone at (415) 554-7892 or by email at hcso@sfgov.org.