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INSURANCE BRIEF

INSIDE THIS ISSUE:

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Medicare Part D Notice Reminder

It's that time of year again!! The Centers for Medicare and Medicaid Services (CMS) requires entities to provide an annual notice to Part D eligible individuals before October 15 indicating whether its plan's coverage is creditable or non-creditable. The Disclosure Notice requirement applies to Part D eligible individuals who are *active or retired* employees, as well as those who are covered as spouses or dependents under active or retiree coverage.

If your plan data does not include dependent data in the detail necessary to identify eligible dependents who may be Medicare Beneficiaries, you may choose to provide the notice to all eligible employees to assure proper notice to all Medicare Beneficiaries. Notice to the employee will constitute notice to dependents unless you have a separate address for a non-resident spouse/dependent.

Plan Sponsors must also provide a Medicare Part-D notice:

a. Prior to an individual's Initial Enrollment Period for Part-D;
b. Prior to the effective date of coverage for any Medicare eligible individual that joins the Plan;
c. Whenever the entity no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes creditable; and,
d. Upon the request by the individual.

"Prior to" means that the individual must have received the Disclosure Notice within the past twelve months. So, plans that issue the Part-D notice at time of policy renewals do not need to provide another notice.

The notices have not changed since April 2011. Therefore, if the status of your plans is the same you can use last year's notice. The notices are provided in English and Spanish at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html

You can also contact your SML Account Team to request a copy be emailed to you.

Delivery. Plan Sponsors may mail the notice as a stand-alone mailing or choose to incorporate the notice into other documents or disclosures, so long as there is prominent first-page, 14-point reference to the incorporated notice language.

Plan Sponsors may also deliver the notice electronically to plan participants who have the ability to access the Plan Sponsor's electronic information system on a daily basis as a part of their work duties. Plan Sponsors should inform participants that they are to share the electronic notice with all family members who are covered under the group health plan.

Cont'd on Page 2

Reinsurance Fee: Updates and Reminders

The Department of Health and Human Services (HHS) set the 2016 reinsurance fee at $27 per participant.

Deadlines: November 15, 2016 This is the deadline for the second installment of 2015 fees if an employer chose to pay in two installments
November 16, 2016. Self-funded employers must report the number of covered lives to HHS through www.Pay.gov.
January 15, 2017. The first installment of $21.60 per covered life is due. If an employer chooses the combined payment method, both parts are due.
November 15, 2017. The second installment of $5.40 per covered life is due.

The Center for Medicare and Medicaid Services (CMS) has conducted training sessions. Please register at https://www.regtap.info/ to receive notices regarding upcoming trainings. You can also view the webinar presentations once they have been posted to the REGTAP library.

Counting Methods: HHS provides the same methods permitted under the Comparative Effective Research (CER) fee provision, modified to allow for an annual count determined in the fourth quarter. The sponsor of a self-insured plan is allowed to use a different counting method for purposes of the reinsurance contribution from that used for purposes of the CER fee. If an employer sponsors both self-insured and insured options, then they are only permitted to use the actual count or snapshot count method.

HRA rule. If the HRA is integrated with a medical benefit that provides minimum value then the reinsurance requirement does not apply.

Actual Count Method: Calculate the sum of the lives covered for each day of the first nine months of the plan year and divide that sum by the number of days in those nine months.

Snapshot Count Method: Add the totals of lives covered on a date (or more dates if an equal number of dates is used for each quarter) during the same corresponding month in each of the first three quarters of the benefit year. The dates used for the second and third quarters must be within the same week of the quarter as the date used for the first quarter. Divide the total by the number of dates on which a count was made.

Snapshot Factor Method: Add the total lives covered on any date (or more dates if an equal number of dates is used for each quarter) during the same corresponding month in each of the first three quarters of the benefit year, and divide that total by the number of dates on which a count was made. The number of lives is calculated by adding the number of participants with self-only coverage to the product of the number of participants with coverage other than self-only and a factor of 2.35. Self-only coverage + (other than self-only x 2.35) = total number of covered lives.

Form 5500 Method : For a plan that offers self-only coverage and coverage other than self-only coverage, add the total participants covered at the beginning and end of the benefit year, as reported on the Form 5500 for the last applicable plan year.

Medicare Part D *cont'd*

Disclosure to CMS Form. Don't forget that you must also disclose to CMS whether your plans' coverage is creditable or non-creditable. This is done online at www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp

This disclosure must be made within 60 days following the start of the plan year, within 30 days after termination of a prescription drug plan, and within 30 days after any change in the plan's creditable coverage status.

IRS Forms 1094 and 1095

The IRS has released the draft 2016 1094 and 1095 forms and instructions.

Section 6055 - Forms 1094-B and 1095-B and their Instructions.
Section 6056 - Forms 1094-C and 1095-C and their Instructions.

Background: The "B Forms" (1094-B and 1095-B) are filed by providers of health coverage (insurers for fully-insured and employers for self-insured), and the "C Forms" (1094-C and 1095-C) are filed by applicable large employers (ALEs). There are only a few changes from the final 2015 forms and instructions, with the highlights below.

Key Provisions:

The 1094-B Form. There were no changes to the transmittal form.

The 1095-B Form. The instructions to the recipient on page 2 now explain that individuals receiving coverage under an employer sponsored plan may have coverage reported on Form 1095-C rather than 1095-B. It is also explained that information about employer sponsored coverage may be left blank even if the recipient had employer sponsored coverage.

The 1094-C Form. The box for "Qualifying Offer Method Transition Relief" has been removed because that relief was only available for the 2015 filing.

The 1095-C Form. The form is the same. There are changes in how to complete Part II, line 14 which are explained in the Instructions. The field for the Plan Start Month will remain optional for 2016.

The C Form Instructions. *New Codes for Conditional Offers of Spousal Coverage.* There are now a 1J and 1K code for 1095-C Part II, line 14. Code 1K is used if an offer of coverage to the spouse is subject to one or more reasonable, objective conditions. For example, the availability of group coverage under another employer or eligible for Medicare. Code 1J is to be used if no minimum essential coverage is offered to children and conditional offer is available to spouse.

COBRA and Other Post-Employment Coverage. There is clarification on how to report for the month in which an employee terminates with an ALE member, as well as stating that an ALE member is treated as having made an offer to the employee's dependents for an entire plan year if the ALE member provided the employee an effective opportunity to enroll dependents at least once for the plan year, even if the employee declined to enroll their dependents. Any non-COBRA coverage received post-employment should not be reported as an offer of coverage.

Employee Required Contribution. Additional rules apply when an ALE member makes HRA contributions or opt-out payments.

Multiemployer Plan Relief. The relief for multiemployer plans has been extended for another year. This would affect plans sponsored by unions. Employers qualifying for the relief will not need to obtain eligibility and offer information from multiemployer plans for 2016 filings. This can still change for the 2017 filings.

Deadlines: Forms filed in 2017 reporting 2016 coverage on Forms 1094-B, 1095-B, 1094-C and 1095-C are due February 28, 2017, or March 31, 2017, if filing electronically (250+ forms). The penalty relief for incorrect or incomplete returns or statements was limited to filings made for 2015 reporting information.

What's Next: Please contact your SML Account Team if you have any questions.

Benefit Parameters for 2018

On September 6th the Department of Health and Human Services released their Proposed Rule on Benefit and Payment Parameters for 2018.

Most of the provisions are aimed at insurance carriers, but there are of few of interest to employers sponsoring group health plans. Here are the highlights:

Annual Cost-Sharing Limits. The maximum annual limitation on cost-sharing for 2018 would be increased to $7,350 for individual and $14,700 for family coverage. This is compared to $7,150 and $14,300 for 2017.

Insurance Market Rules. In the small group market, revised age-rating bands are proposed for children. One age band for ages 1 through 14, and then single-year age bands for 15 through 20.

Medical Loss Ratio (MLR). Currently newly issued policies with less than 12 months of experience are permitted to defer their MLR reporting until the following year. It is proposed that reporting of policies newly issued with a full 12 months of experience in that MLR reporting year also be permitted to defer reporting.

What's Next: Rules could be finalized before the end of the year. We'll keep you posted!

Proposal to Improve the Form 5500

The Department of Labor (DOL), the Internal Revenue Service (IRS), and the Pension Benefit Guaranty Corporation (PBGC) (the "Agencies") released a Notice of Proposed Forms Revisions to the Form 5500 Annual Return/Report Series. The DOL also published a Notice of Proposed Rulemaking to propose updates to the DOL's reporting regulations to implement the proposed forms revisions. The DOL has provided a Fact Sheet as well.

Currently a Form 5500 is required for health and welfare plans with 100 or more employee participants. Plans with under 100 have a "small plan" exemption. The proposal would require Form 5500 reporting by all ERISA group health plans regardless of size or funding.

A new Schedule J (Group Health Plan Information) would indicate the types of benefits offered, the funding method, employer and employee contributions, COBRA coverage, grandfathered status, whether it is a high-deductible health plan, HRA or health FSA. Most filings would also have to provide financial and claims information and list third-party administrators, stop-loss carriers, and other plan service providers such as mental health or substance abuse benefit managers. There would be questions about compliance with HIPAA, GINA, mental health parity rules, health care reform, summary of benefits and coverages (SBC) and summary plan description (SPD) compliance

Effective Date: The changes are targeted to take effect with 2019 Plan year filings, but some items could be implemented earlier or later.

Wellness Model Notice

The Equal Employment Opportunity Commission (EEOC) has published the Sample Notice for Employer-Sponsored Wellness Programs along with Notice Q&A. This is required as of 1/1/17 for all wellness programs that collect employee health information such as biometric screenings and health risk assessments. If your program is only a smoker surcharge with no blood test for nicotine, the notice is not required. It must be received before the employee provides any health information. We recommend including it with initial and open enrollment materials. For additional information on the EEOC rule requirements please refer to the article in our July 2016 newsletter.

Benefits Eligibility Chart

We hope you find this chart useful in tracking when your employees' benefits should be effective.

Waiting period = First of month following 30 days

Date of Hire	Date of Eligibility
Nov 2 - Dec 2	January 1
Dec 3 – Jan 2	February 1
Jan 3 – Jan 30; Jan 3 – Jan 31 leap years	March 1
Jan 31 – Mar 2; Feb 1 – Mar 2 leap years	April 1
Mar 3 – Apr 1	May 1
Apr 2 – May 2	June 1
May 3 – Jun 1	July 1
Jun 2 – Jul 2	August 1
Jul 3 – Aug 2	September 1
Aug 3 – Sep 1	October 1
Sep 2 – Oct 2	November 1
Oct 3 – Nov 1	December 1

Waiting period = First of month following 60 days

Date of Hire	Date of Eligibility
Oct 3 – Nov 2	January 1
Nov 3 - Dec 3	February 1
Dec 4 – Dec 31; Dec 4 – Jan 1 leap years	March 1
Jan 1 – Jan 31; Jan 2 – Feb 1 leap years	April 1
Feb 1 – Mar 2; Feb 2 – Mar 2 leap years	May 1
Mar 3 – Apr 2	June 1
Apr 3 -May 2	July 1
May 3 - Jun 2	August 1
Jun 3 - Jul 3	September 1
Jul 4 - Aug 2	October 1
Aug 3 – Sep 2	November 1
Sep 3 - Oct 2	December 1