HEALTH CARE REFORM NEWS

…From the Employer Perspective
June 16, 2016

ACA Checklist for Employers – Countdown to 2017

Although it's been six years since the Affordable Care Act (ACA) became law, the complexity and fluidity of regulations implementing the law's many provisions keeps ACA compliance high on the list of priorities for employers in 2016. In particular, implementation of the annual information reporting requirements for applicable large employers and self-insured plan sponsors kept employers especially busy in late 2015 and early 2016.

As the dust begins to settle on information reporting, employers should return focus to the ACA-related administrative and strategic considerations on the horizon for the last half of 2016 and for 2017. To assist employers with ensuring all their near-term ACA responsibilities are met, we have compiled the following checklist of ACA items that may impact employers between now and the end of 2017.

☐ ANNUAL EMPLOYER INFORMATION REPORTING

Applicable large employers (50+ full-time and/or full-time equivalent employees) must submit 2015 Section 6056 reporting and self-insured employer health plan sponsors must submit 2015 Section 6055 reporting to the IRS by 5/31/16 if filing by mail or by 6/30/16 if filing electronically (electronic filing via the IRS AIR system is required if filing 250 or more forms). For calendar year 2016 information reporting, individual statements must be issued by 1/31/17 and IRS reporting is due 2/28/17 if filing by mail or 3/31/17 if filing electronically. For more information, refer to Trion's 12/29/15 HCR*Alert!* on this topic.

☐ PATIENT-CENTERED OUTCOMES RESEARCH INSTITUTE (PCORI) FEE

Health plans must pay fees related to the ACA PCORI research program for each plan year ending between 10/1/12 and 9/30/19. Self-insured health plan sponsors must pay the fee by filing IRS Form 720, Quarterly Federal Excise Tax Return (insurers are responsible for paying the fees for insured health plans). Applicable fees and due dates for payments due in 2016 and 2017 are:

If Plan Year Ends Between	Due Date	Fee Per Covered Life
1/1/15 and 9/30/15	8/1/16	$2.08
10/1/15 and 12/31/15	8/1/16	$2.17
1/1/16 and 9/30/16	7/31/17	$2.17
10/1/16 and 12/31/16	7/31/17	TBD

The applicable number of covered lives may be determined using the Actual Count, Snapshot Count, Snapshot Factor, or Form 5500 Methods. Plan sponsors are not required to use the same method each year and should therefore evaluate the various methods to determine the least costly before finalizing and submitting fees due in 2016 or 2017. For more information, refer to Trion's 6/9/16 HCR*Alert!* on this topic.

MINIMUM LOSS RATIO (MLR) REBATES

Insurers that do not spend a certain portion of insured premiums on health care services and quality initiatives are required to issue premium rebates to policyholders no later than 8/1 of the following year. Unless held in a trust, ERISA health plan sponsors that receive group policy rebates must distribute any portion of the rebate that is a plan asset within 90 days of receiving the rebate from the insurer. In general, ERISA plan sponsors may apply rebates that are plan assets toward refunds, premium holidays or plan enhancements for plan participants. For more information, refer to the DOL web page on MLR rebates.

TRANSITIONAL REINSURANCE PROGRAM FEE

Health plans must pay fees related to the ACA transitional reinsurance program for calendar years 2014-2016. Self-insured health plan sponsors must report enrollment data and schedule payment by ACH debit using Pay.gov (insurers must pay the fees for insured health plans). Payments may be made in 1 or 2 installments, each due in the following calendar year. Applicable fees and due dates for calendar years 2015 and 2016 are:

Calendar Year	Fee Per Covered Life	Reporting Due	1st Payment Installment Due	2nd Payment Installment Due
2015	$44	11/16/15	1/15/16	11/15/16
2016	$27	11/15/16	1/16/17	11/15/17

The applicable number of covered lives may be determined using the Actual Count, Snapshot Count, Snapshot Factor, or Form 5500 Methods. Plan sponsors are not required to use the same method each year and should therefore evaluate the various methods to determine the least costly before finalizing and submitting 2015 and 2016 calendar year fees. For more information, refer to the CMS web page on transitional reinsurance.

GRANDFATHERED HEALTH PLAN STATUS

Sponsors of grandfathered health plans should review plan status annually and confirm that any changes made to the plan design or premium contribution structure since 3/23/10 continue to conform to grandfathering requirements. Sponsors should also ensure statement of grandfathered status is provided in materials that describe plan benefits. For more information, refer to the DOL web page on grandfathered plans.

OUT-OF-POCKET (OOP) COST-SHARING LIMITS

Since 2014, non-grandfathered health plans must limit total participant in-network OOP cost-sharing for essential health benefits. The self-only limit applies to all individuals, even if enrolled in other-than-self-only coverage. While HSA-eligible high deductible health plans (HDHPs) are subject to other OOP limits set by the IRS, the ACA requirement regarding an embedded individual OOP limit does apply to HDHPs. Effective plan years beginning on or after 1/1/17, the limits are:

	Self-Only Coverage OOP Limit	Other Than Self-Only Coverage OOP Limits	
		Embedded Individual Limit	Family Limit
Plans that are not HSA-eligible HDHPs	$7,150	$7,150	$14,300
Plans that are HSA-eligible HDHPs	$6,550	$7,150	$13,100

For more information, refer to Trion's 3/3/16 HCR*Alert!* on this topic.

ESSENTIAL HEALTH BENEFIT (EHB) BENCHMARK PLAN FOR SELF-INSURED PLANS

Since 2014, non-grandfathered self-insured and large market plans are not permitted to apply annual or lifetime dollar limits to EHB covered by the plan. To define which services are EHB (i.e., which services can be subjected to dollar limits and which cannot), self-insured plan sponsors are permitted to select any state's EHB benchmark plan as its reference. States are permitted to adopt new benchmark plans for 2017, so self-insured plan sponsors should review the 2017 plan design for the state EHB benchmark they originally selected and confirm whether there are any changes which might be in conflict with benefit dollar limits imposed by their plans. For more information, refer to Trion's 5/6/16 HCR*Alert!* on this topic.

HEALTH REIMBURSEMENT ARRANGEMENTS (HRA)

Since 2014, HRAs (except retiree-only and limited use HRAs) generally must be integrated with group health plan coverage satisfying ACA market reform rules. Effective plan years beginning on or after 1/1/17, HRAs covering family members cannot be integrated with employee-only coverage (i.e., spouses and dependents must be enrolled in group health plan coverage for the HRA to reimburse their claims). For more information, refer to IRS Notice 2015-87.

HEALTH INDUSTRY TAX (HIT)

Since 2014, health plan insurers must pay fees related to offsetting the government's expense for premium tax credits granted to individuals for Marketplace coverage. The fee, which is set as an aggregate lump sum dollar amount each year, is allocated among insurers based on market share and insurers add this expense to policyholder premium rates. The 2016 Consolidated Appropriations Act placed a 1-year moratorium on this tax for 2017, so sponsors of insured group health plans will not see this expense included in 2017 premium rates.

EMPLOYER SHARED RESPONSIBILITY – AFFORDABILITY SAFE HARBORS

Income threshold: Employer shared responsibility regulations provide that an employer will not be subject to a penalty on the basis of affordability if the employer offer of coverage meets one of 3 affordability safe harbors – required employee cost for self-only coverage in the lowest-cost minimum value plan cannot exceed a fixed percentage of: a) an employee's W-2 Box 1 income, b) a figure calculated using an employee's rate of pay, or c) the mainland U.S. Federal Poverty Level for a single person. The original fixed percentage of income of 9.5% is adjusted to 9.66% for 2016 and 9.69% for 2017. For more information, refer to Trion's 4/18/16 HCR*Alert!* on this topic.

Cafeteria plan flex contributions: Effective plan years beginning on or after 1/1/17, employer cafeteria plan flex credit contributions that are not exclusively limited to use for medical care (e.g., health FSA contribution) or the employer's group health plan premiums are not treated as reducing an employee's required health care coverage contribution for affordability safe harbor purposes (e.g., if employee cost for self-only health plan coverage is $2,400 per year and the employer provides a $600 per year flex plan contribution that can be used to pay for both health and non-health (e.g., dependent care FSA, life, disability, etc.) benefits or received as cash, required employee contribution for ACA affordability purposes is $3,000 per year. For more information, refer to Trion's 1/28/16 HCR*Alert!* on this topic.

WELLNESS PROGRAM INCENTIVES

Since 2014, financial incentives provided by health-contingent wellness programs that are part of employer health plans are limited to 30% of total health plan premium cost if not tobacco-related and 50% of premium cost if tobacco-related (based on self-only premium if incentive is provided for employee only or premium for coverage tier in which employee is enrolled if incentive is also provided for a spouse). Additionally, wellness program participation as a condition for accessing health coverage or a particular benefit option is not prohibited.

Effective plan years beginning on or after 1/1/17, new ADA and GINA regulations apply restrictions on incentives offered by wellness programs that require an employee's completion of medical exam or disability-related inquiries or a spouse's completion of medical exam or inquiries about manifestation of disease or disorder, regardless of whether the program is part of a group health plan and regardless of whether it is participatory or health-contingent. In such cases, employee incentives and spouse incentives are each limited to 30% of the premium cost for self-only coverage. Additionally, access to health coverage or a particular benefit option cannot be contingent upon wellness program participation. For more information, refer to Trion's 5/25/16 HCR*Alert!* on this topic.

NON-DISCRIMINATION IN HEALTH CARE

Effective 7/18/16 (or first day of the 2017 plan year if plan design changes are required in order to comply), generally, health plans sponsored or insured by entities that receive Federal financial assistance administered by HHS or by entities established under Title I of the ACA are subject to Section 1557 regulations prohibiting discrimination in health care on the basis of race, color, national origin, age, disability, and sex (including pregnancy, gender identity and sex stereotyping). Most notably, affected plans are prohibited from categorically excluding or applying discriminatory restrictions on gender transition services and from denying or limiting coverage for sex-specific health services just because a transgender individual identifies as belonging to another gender. The regulations also include provisions to ensure communications with individuals with disabilities or limited English proficiency are as effective as communications with others.

Employer-sponsored health plans subject to the regulations include insured group health policies sold by insurers receiving Marketplace premium tax credit payments and plans offered to the insurers' own employees; plans offered by employers that are health care providers receiving Medicare A, Medicare C, or Medicaid payments; and plans for which an employer receives Medicare D subsidies. Provided a plan sponsor is not otherwise a covered entity, applicability of Section 1557 to self-insured plans is limited to plans administered by TPAs that are also covered insurers and only with regard to complaints resulting from the TPA's administration of the plan (complaints resulting from benefit design of such plans may be referred to

EEOC for review in the context of Title VII of the Civil Rights Act or ADA rather than Section 1557). For more information, refer to Trion's 6/8/16 HCRAlert! on this topic.

W-2 REPORTING OF HEALTH COVERAGE COST

Since 2012, employers that filed 250 or more W-2s in the prior reporting year are required to report the aggregate cost of employer-sponsored group health plan coverage (including both the employer and employee portions of the cost) for the calendar year on employees' Form W-2. Employers that were not required to file in the past because they were below the 250 form threshold in prior years should review whether they were still below the threshold in 2015 to confirm whether health care cost reporting is required for 2016 W-2s. For more information, refer to the IRS web page on W-2 reporting of health plan cost.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Effective plan years beginning on or after 4/1/17 (i.e., 2018 for calendar year plans), health plan sponsors must update plan SBCs to comply with the revised SBC template, instructions, and coverage example calculator published in April 2016. Regulations issued in June 2015 made permanent the safe harbor originally issued in 2012 FAQ guidance , which allows plan sponsors to provide multiple partial SBCs that, together, satisfy SBC content requirements when benefits are provided through more than one issuer or administrator. For more information, refer to Trion's 4/8/16 HCR*Alert!* on this topic.

MARKETPLACE EMPLOYER NOTICE PROGRAM

The ACA calls for Marketplaces to notify employers when an employee is determined eligible for advanced premium tax credits (APTC) for Marketplace coverage because the employee reported he or she was neither enrolled in employer coverage nor eligible for employer coverage that meets the ACA's affordability and minimum value standards. The Federally-Facilitated Marketplace (FFM) is the first Marketplace to announce implementation of a notice procedure that will provide employers a 90-day window in which they can appeal a determination of APTC eligibility (however, failure to appeal will not impact potential liability for employer shared responsibility penalties, as that is ultimately determined independently by the IRS based on year-end individual tax returns and employer information reporting). The FFM anticipates a phased roll-out starting mid-2016. Applicable large employers should determine a plan regarding if and how they will respond to FFM notices. For more information, refer to Trion's 10/9/15 HCR*Alert!* on this topic.

NOTICE OF COVERAGE OPTIONS

While the DOL has not issued a new template for the notice which informs employees about the health insurance Marketplace and must be provided to new employees within 14 days of hire, information regarding the dates of the next Marketplace open enrollment period should be updated annually. Employers should update their notices to reflect that the next Marketplace open enrollment will take place from 11/1/16 – 1/31/17 for coverage starting as early as 1/1/17.

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Your Trion Strategic Account Managers are here to answer any questions you might have as you prepare to comply with upcoming ACA requirements. If you are not currently a Trion client and would like assistance navigating the changes required by health care reform, please contact us today by emailing trionsales@trion-mma.com.

ACA REGULATIONS & GUIDANCE ISSUED IN THE LAST 2 MONTHS

Jun. 2016:	Agencies Issue Proposed Rule on Expatriate Plans, Excepted Benefits, Lifetime and Annual Limits, and Short-Term Insurance
Jun. 2016:	IRS Issues Information Letters Reiterating Prohibition On Premium Reimbursement for Individual Policies – Letter 2016-0005, Letter 2016-0019, Letter 2016-0021, Letter 2016-0023
May 2016:	CMS Issues FAQ on Benefit-Specific Waiting Periods for Pediatric Orthodontia
May 2016:	EEOC Issues Final ADA and GINA Rules on Wellness Programs and ADA FAQs and GINA FAQs
May 2016:	HHS Issues Final Rule on Section 1557 Nondiscrimination in Health Programs and Activities
May 2016:	ACA FAQs 31 – Patient Bill of Rights Topics

Content provided in collaboration with our compliance partner, Marathas, Barrow and Weatherhead LLP.

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