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Group Health Plan Compliance Update

Legislative & Regulatory Recap

October 11, 2017

This summary highlights recent legislative and regulatory changes impacting Group Health plans. The following topics are included:

1. Status of the Affordable Care Act (ACA) -- Senate Fails to Pass ACA Replacement Legislation
2. President Trump Narrows ACA Contraception Coverage Requirement -- Employer Impact
3. 2017 ACA Reporting Requirements -- Final Forms Released
4. Patient Centered Outcomes Research Institute (PCORI) Fee -- Update
5. Reminder -- Annual Medicare Part D Reporting of Creditable or Non-Creditable RX Coverage
6. State-Specific Update -- New York Family Paid Leave Act

Senate Fails to Pass ACA Replacement Legislation

On September 26th, the Republican leadership failed to bring a vote to the Senate floor on their most recent proposed legislation to repeal portions of the ACA. The Graham-Cassidy bill failed to gain support from Republican Senators John McCain (R., AZ.), Susan Collins (R., ME.), Lisa Murkowski (R., AK.) and Rand Paul (R., KY). Following the defeat of the Health Care Freedom Act (HCFA), i.e., the "skinny repeal" bill in July, with a vote on the Senate floor (49-51), a formal GOP repeal and replace effort will not occur in 2017.

The Graham-Cassidy bill was an 11th hour push to dismantle significant portions of the ACA through the budget reconciliation process. Senators Bill Cassidy (R., La.) and Lindsey Graham (R., S.C.) sponsored the bill. The budget reconciliation option expired on September 30th.

GOP leadership hoped to overcome objections that derailed earlier proposals by granting states significant flexibility. Ultimately, the bill faced the same challenges as the Republicans' earlier repeal efforts in winning support from centrist Republicans. The Graham Cassidy bill:

- Funneled money currently used for the ACA's Medicaid expansion and premium subsidies into block grants to states for shaping their health care system
- Allowed states to waive rules prohibiting higher premiums for pre-existing conditions
- Capped federal Medicaid funding for the first time

Following the decision not to proceed to a vote on the Graham-Cassidy bill, tax reform is anticipated as the next legislative measure. Oswald will monitor any potential changes to the tax exclusion for employer-provided health insurance if the tax reform legislation advances.

In 2017, future legislative efforts will be deemed beyond the limited scope of a budget-specific reconciliation bill; therefore, Republicans will need at least eight Democrats to move forward. Both Republicans and Democrats have expressed an idealistic goal to work together. As one recent sign of progress, Senator

Lamar Alexander (R., TN.), announced potential bipartisan legislation aimed at stabilizing markets. Senator Alexander is partnering with Senator Patty Murray (D., WA).

On October 10th, President Trump's administration announced executive orders to expand health care options are planned within the next week. Using the power of the pen, it is anticipated that President Trump will instruct the department of HHS to implement changes allowing consumers to purchase coverage through association health plans. Specifics are unknown, but such arrangements may not be subject to all ACA provisions. Further, via an executive order, it is expected that consumers may have additional options to purchase coverage across state lines.

Lastly, the resignation of the Secretary of Health and Human Services, Dr. Tom Price., on September 30th added another hurdle to the timeline for regulatory change. Within the ACA, the language *"HHS Shall…"* instructs the Department of HHS to execute the law's intent with broad regulatory options; however, the instructions may vary significantly under a new HHS Secretary. Until any replacement legislation is signed by the President, the ACA remains the law today and all current compliance requirements remain in place.

President Trump Narrows Contraceptive Coverage Requirement

On Friday, October 6th, President Trump announced a broad exception to the Affordable Care Act (ACA) contraceptive coverage requirement. These interim rules were issued in coordination with guidance from the Attorney General, Jeff Sessions, to interpret and clarify existing law in regards to religious liberty. The change widens the range of employers and insurers that are able to invoke religious or moral beliefs to limit or exclude contraceptive coverage within the definition of preventive care.

The change expands options for both nonprofit organizations and for-profit companies based on religious and moral objections. Publicly traded companies and higher educational institutions are also included. The rules are effective immediately.

This political controversy arose when President Obama's administration included birth control within the ACA preventive care requirements. Of note, HHS officials stated the change will still result in 99.9 percent of women with access to free birth control through their insurance.

2017 ACA Reporting Requirements – Final Forms Released

The IRS released the 2017 final forms for the ACA employer reporting requirements. The 2017 forms are very similar to the 2016 forms. The most significant change is the deletion of transition relief. Significant changes to employer reporting requirements are not anticipated this year.

Oswald recommends that employers begin reporting preparations to meet the 2018 deadlines. Forms are to be submitted by the end of February (or by the end of March for those filing electronically).

Background Information - Applicable large employers (ALEs), which are those averaging 50 or more full-time equivalent employees (FTEs) in the previous calendar year, must report information about health care coverage offered to full-time employees using IRS Forms 1094-C and 1095-C. Reporting is required regardless of whether coverage is offered; and if offered, regardless of whether the coverage is fully insured or self-funded. The IRS uses this information to administer the ACA employer coverage mandate and penalty requirements, known as the employer "shared responsibility" requirements and to administer the subsidies available on the public Exchange. All employers offering a self-funded Group Health Plan with Minimum Essential Coverage (MEC) must report information about individuals actually covered under the plan.

If an ALE offers a self-funded Group Health Plan, all information will be reported using Forms 1094-C and 1095-C. If a small employer (fewer than 50 FTEs) offers a self-funded group health plan, coverage information will be reported using Forms 1094-B and 1095-B.

For fully insured Group Health Plans, this information will be reported by the insurance carrier using Forms 1094-B and 1095-B, as the IRS uses this information to enforce the individual mandate requirements.

Moderate Form Modifications:

Waiver of Coverage - The instructions clarify that there is no specific code to indicate a waiver of coverage on Line 16 of Form 1095-C. If a full-time employee is offered and waives coverage, the employer should enter the applicable affordability safe harbor (i.e., Code 2F, 2G, or 2H) or leave it blank.

Affordability Percentage - The applicable affordability percentage for 2017 is 9.69%.

Line 22 - Transition relief was applicable only for 2015 (as well as for a portion of 2016 for non-calendar year plans). In 2017, no further transition relief is available, and therefore Box C is marked as "reserved." In addition, Part III, column (e) is marked as "reserved." This change may simplify reporting slightly.

Line 15 Safe Harbor - Inadvertent errors in reporting the employee contribution on Line 15 of Form 1095-C will not require correction as long as the amount is de minimis (i.e., within $100 of the correct amount). Individuals receiving the Form 1095-C must be allowed the opportunity to request a corrected statement. If a corrected form is not provided upon request, the standard penalties may apply.

Reporting Penalties - The penalty amount is $260 per form and capped at $3,218,500 annually (up from $3,193,000 in 2016).

The forms and instructions are on the IRS website:

https://apps.irs.gov/app/picklist/list/draftTaxForms.html.
Enter the form number in the search box.

- Form 1095-C – https://www.irs.gov/forms-pubs/about-form-1095-c
- Form 1094-C – https://www.irs.gov/pub/irs-pdf/f1094c.pdf
- Instructions for the "C" forms – https://benefitslink.com/src/irs/i109495c-2017.pdf
- Form 1095-B – https://www.irs.gov/forms-pubs/about-form-1095-b
- Form 1094-B – https://www.irs.gov/pub/irs-pdf/f1094b.pdf
- Instructions for the "B" forms – https://www.irs.gov/pub/irs-pdf/i109495b.pdf

Patient Centered Outcomes Research Institute (PCORI) Fee -- Update

The PCORI fee is part of the Affordable Care Act (ACA) and funds the Patient-Centered Outcomes Research Institute, a private, non-profit corporation intended to advance informed health decision-making and to support clinical effectiveness research, and effective plan years ending after September 30, 2012 and before October 1, 2019.

The PCORI Fee:

- Applies to Fully Insured and Self-Funded Plans, including retiree-only & mini-med plans. Fee applies for active employees and former employees (qualified beneficiaries under COBRA continuation coverage).

- Reported / paid once a year & due no later than July 31 of the year following the last day of the plan year on IRS Form 720 (Quarterly Federal Excise Tax Return).

- Does NOT apply to HIPAA excepted benefit plans (e.g., stand-alone dental & vision plans), long-term care, home care (if offered separately from medical plans), disease/illness coverage, accident coverage, disability coverage, and workers' compensation. Stop-Loss & reinsurance polices are NOT subject to the PCORI fee.

- Fully Insured Plans: Insurer must file and pay the fee directly to the IRS.

- Self-Funded Plans: Plan sponsors must pay the fee directly to the IRS. Third Party Administrators (TPAs) cannot pay the fee on behalf of the plan. Self-Funded Plans cannot pay the fee from plan assets; cannot be part of employee contributions.

Payment & Reporting:

Calendar Year Plans: Fee Applies for Calendar Plan Year 2012 – 2018

Non-Calendar Year Plan Example: Fee for Plan Year of July 1 - June 30: Applies from [July 1, 2012 - June 30, 2013] until [July 1, 2018 - June 31, 2019].

Fee Per Covered Life Plan Years Ending after September 30, 2016 and Before October 1, 2017:
$2.26 Paid by July 31, 2017

Fee Per Covered Life Plan Years Ending after September 30, 2017 and Before October 1, 2018:
$2.39 Paid by July 31, 2018

Group Health Plan Compliance Reminder

Annual Medicare Part D Reporting of Creditable or Non-Creditable RX Coverage to CMS

- If employers offer prescription drug benefits within Group Health Plans, Medicare Part D regulations require employers to distribute a notice of Creditable or Non-Creditable prescription drug coverage to Medicare-eligible employees and retirees by October 14 each year.

- In addition to the notice of Creditable or Non-Creditable coverage to Medicare-eligible employees by October 14 annually, employers must also report to the Centers for Medicare and Medicaid Services (CMS) Online as to the plan(s)' Creditable or Non-Creditable prescription drug status.

- These notification and CMS reporting requirements apply to all employers offering medical benefit plans that include prescription drugs. Reporting is due to CMS within 60 days of the beginning of the plan year; within 30 days after termination of a prescription drug plan; or within 30 days after any change in Creditable or Non-Creditable coverage status.

- Creditable means the coverage is "as good as" and comparable to Medicare Part D coverage.

Reporting Reference Chart & Timeline:

If the Plan Year Begins:	Report Online to CMS By:	If the Plan Year Begins:	Report Online to CMS By:
Jan. 1	*Mar. 1*	*July 1*	*Sept. 1*
Feb. 1	*April 1*	*Aug. 1*	*Oct. 1*
Mar. 1	*May 1*	*Sept. 1*	*Nov. 1*
Apr. 1	*June 1*	*Oct. 1*	*Dec. 1*
May 1	*July 1*	*Nov. 1*	*Jan. 1*
June 1	*Aug. 1*	*Dec. 1*	*Feb. 1*

STEP-BY-STEP Instructions – Guideline to Report to CMS.GO:

1: Enter Disclosure Information.

Box A: All Employers Must Complete:

1. Employer's Name
2. Federal Tax Identification Number
3. Address
4. Phone Number
5. Type of Coverage
6. Creditable Coverage Status (fill in if coverage is creditable or non-creditable)
7. Click "Continue" & Select Box B, C or D, as appropriate

Box B: If All Plan Options are Creditable
Box C: If All Plan Options are Non-Creditable
Box D: If Creditable and Non-Creditable Plans are available

8. "Plan Year" Period

9. # of Part D eligible individuals expected to be covered at start of Plan Year (if employers are unsure, carriers may provide guidance)
10. # of individuals expected to be covered in Retiree Plan (zero if employer does not have a retiree plan)
11. Date notice of creditable coverage sent to Part D eligible individuals or all employees (by October 14th of the prior plan year)
12. Check if there was a change in creditable coverage status during the prior plan year (unlikely to occur)
13. Name, title and email of authorized individual completing submission
14. Verify and Submit Disclosure Information

2: Verify Disclosure Information.

3: Receive Confirmation.
Employers are finished until the next plan year, unless there is a change in the plan(s)' coverage status, then: Complete online notification within 30 days, starting with # 1

Action Items

- Send the Creditable or Non-Creditable coverage notice to all Medicare-eligible employees by October 14, annually.
    - The notice need not be sent as a separate mailing and may be included with other plan participant materials as long as it is prominent & conspicuous. If it is known that any Medicare eligible spouse or dependent resides separately from the participant, a separate notice is required. Plan sponsors may use e-mail to provide the notice only with consent and a valid e-mail address for the beneficiary. The individual must also be advised of his or her right to receive a paper version. In addition to e-mail delivery, the notice must be posted on the entity's website (except for personalized notices).
- Complete the online disclosure, as to the Creditable or Non-Creditable status of the RX plan, within 60 days of the beginning of the plan year.

Group Health Plan Compliance Update
State-Specific Update – New York State Paid Family Leave Act

Final regulations addressing the New York State Paid Family Leave Act (PFL) have been released. PFL provides job security for employees on paid leave. Under federal law, employers with 50 or more employees must provide unpaid leave under the Family and Medical Leave Act (FMLA); however, the PFL applies regardless of the size of the employer. Several states have passed similar laws expanding the federal requirements, including California, Connecticut, Hawaii, Maine, Minnesota, New Jersey, Oregon, Rhode Island, Vermont, Washington and Wisconsin. Below are highlights from the New York law, effective January 1, 2018.

All full-time and part-time employees working for private companies qualify. Employees qualify after 26 consecutive weeks if working 20 or more hours per week (or those scheduled less than 20 hours and working 175 days within 52 weeks). Union members may be covered if the PFL is collectively bargained.

Impact to Employers:

- Employers must provide wage replacement with employment protection to employees in need of time away from employment. If an employer declines to reinstate an employee returning from PFL, the employee may report that employer to New York State. If a report is filed, an employer has 30 days to either take corrective action or file a formal response to the employee.

- PFL will be a part of an employer's disability benefits policy. All employees who are currently covered under disability insurance will be covered under PFL.

- Employers are responsible to inform employees of PFL options. Employers must display a poster concerning employees' PFL rights with the other employer-to-employee notices, update employee handbook language (if available) or provide employees with a written notice.

- Health insurance must be maintained during an employee's time off.

- PFL benefits will phase-in with the benefit amount gradually increasing over four years. New York State sets the rate. Therefore, it's important for employers to remain current with annual changes to the maximum benefits.

- Employees will need to provide notice 30 days in advance of the paid leave; therefore, employers could begin receiving notices by December 1, 2017.

- Employers may not require employees to exhaust accumulated PTO to become eligible for PFL.

Impact on Employees:

- PFL provides up to eight weeks of paid leave in 2018 and is intended to allow employees to bond with a new born, adopted, or foster child; care for a family member with a health condition; assist when a family member is deployed on military duty.

- PFL will be funded via employee payroll contributions at 0.126% of the employee's weekly wage up to the state's average weekly wage maximum. The collection of premiums was allowed as of July 1, 2017; therefore, in NY, paycheck deductions will fund the premium for PFL.

Takeaways

As additional information is released, Oswald will provide ongoing guidance and strategic direction for employers. We will remain vigilant in monitoring all regulatory actions, and through our relationships with industry experts in Washington, DC, we will continue our proactive communication efforts to anticipate change.

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