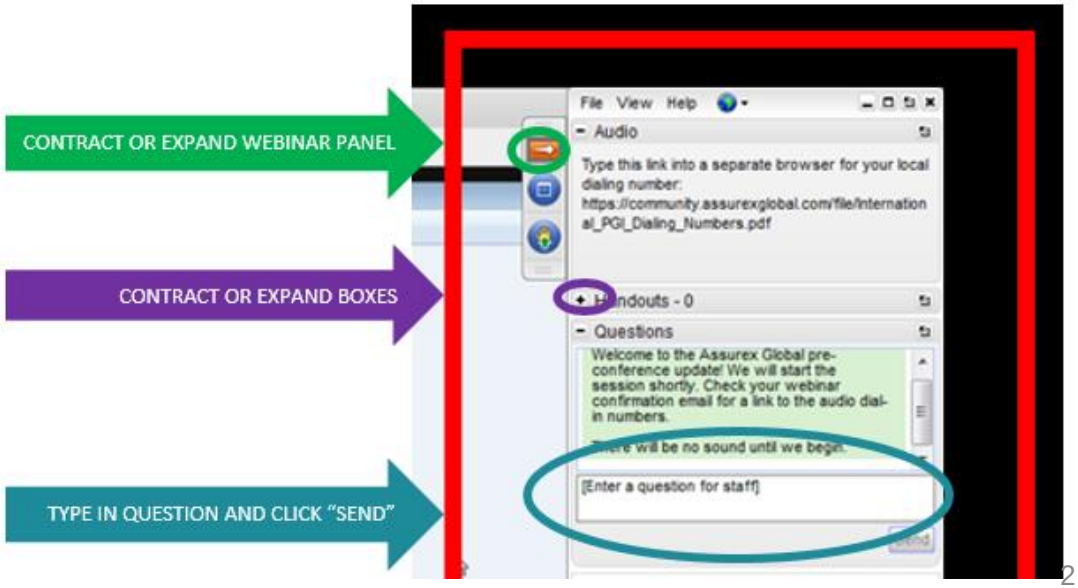
September 22, 2016

ACA and Benefits Compliance Update

Presented by Bob Radecki & Regan Debban
Benefit Comply, LLC

ACA and Benefits Compliance Update

- Welcome! We will begin at 3 p.m. Eastern
- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.
- You will be able to submit questions during the webinar by using the “Questions” box located on your webinar control panel.
- Slides can be printed from the webinar control panel – expand the “Handouts” section and click the file to download.



Assurex Global Partners

- Catto & Catto
- Cragin & Pike, Inc.
- The Crichton Group
- Daniel & Henry
- Frenkel Benefits
- Gillis, Ellis & Baker, Inc.
- Haylor, Freyer & Coon, Inc.
- The Horton Group
- IMA
- INSURICA
- Kapnick Insurance Group
- Kinney Pike Insurance
- Lipscomb & Pitts Insurance
- LMC Insurance & Risk Management
- Lyons Companies
- The Mahoney Group
- MJ Insurance
- Parker, Smith & Feek, Inc.
- PayneWest Insurance
- R&R/The Knowledge Brokers
- RCM&D
- RHSB
- The Rowley Agency
- Seacrest Partners
- Starkweather & Shepley Insurance Brokerage
- Woodruff-Sawyer & Co.
- Wortham Insurance & Risk Management

Agenda

- Reinsurance Fees
- SBC
- HRA Guidance
- §1557 Nondiscrimination
- Form 5500 Changes

ACA and Compliance Update

Reminder - 2016 Reinsurance Fees

- 2016 Reinsurance Contribution
  - One more year (2016) of reinsurance contributions
  - 2016 Reporting
    - Employers who sponsor self-funded plans that provide minimum value must report membership to CMS by 11/15/2016
    - 2016 reinsurance fee = $27 per covered life (it was $44 in 2015) paid in one or two installments in 2017

Summary of Benefits and Coverage (SBC)

- Updated SBC Template and Uniform Glossary
  - Final versions of the new SBC template, uniform glossary, coverage examples calculator released in April 2016
    - Effective for the first open enrollment period, plan year, or policy year beginning on or after April 1, 2017
  - No real changes to delivery timing or method
  - Some form modifications:
    - Shorter template and effort to make SBC more consumer-friendly
    - Revisions/additions to “important questions” and coverage examples
    - Revisions in regard to how minimum essential coverage (MEC) and minimum value coverage is described
    - Additional detail in regard to grievance and appeal rights
    - Details in instructions for describing plan details such as deductibles and cost-sharing, coverage tiers, exclusions/limitations, etc.

HRA Guidance

- Health Reimbursement Arrangement (HRA) Rules
  - HRAs that cover 2 or more employees must be integrated with a group medical plan to avoid violating health care reform rules (e.g. no annual/lifetime limits)
    - Health care reform requirements do not apply to retiree-only HRAs or HRAs that reimburse only excepted benefits
  - Integrated means the individual with an HRA must also be enrolled in a minimum value group health plan
  - New HRA coverage coordination rule
    - An HRA may only reimburse qualifying medical expenses of individuals that are also enrolled in a group medical plan (e.g. self-only coverage HRA may only reimburse the employee's expenses)
    - Applies for plan years beginning on or after Jan 1, 2017 for HRAs in place prior to 2016

ACA §1557 Non-discrimination

- §1557 Background
  - Prohibits “covered entities” from discriminating in health programs based on race, color, national origin, age, disability, or gender
  - Final rules contain notice requirements and require grievance procedures
- Who is a Covered Entity?
  - The rules apply to “covered entities” - health programs and activities that receive federal financial assistance administered by HHS
    - For an entity that is “principally engaged” in providing or administering health services or health insurance or health coverage (e.g. hospitals, insurance carriers) and receives federal funding, the rules apply to all operations of that entity, including its employer-sponsored benefits for employees.
    - For any other entity, the rules apply only to employees involved in the specific activity for which federal funding is received – e.g. educational institution receiving federal funding for a student health program.
  - Most regular employers (who do not fall into one of these categories) are not covered entities.

ACA 1557 Non-discrimination

- 1557 and Transgender Related Benefits
  - 1557 protections extend to gender identity-based discrimination
  - No specific requirement under the ACA to provide coverage of transgender-related services; however exclusions of such coverage may now be considered discriminatory
  - Most employers are not covered entities directly subject to the rules
    - But may still end up providing coverage for transgender-related medical services (e.g. fully-insured coverage and self-funded employers working with a TPA affiliated with an insurance company)

Affordability

- Opt-Out Credits (i.e. Cash-in-Lieu of Benefits)
  - IRS has provided guidance on affordability and opt-out incentives:
    - Unconditional opt-outs (those available to anyone that declines coverage with no conditions) will be included in determining affordability
    - Conditional opt-outs (e.g. available only to those that show proof of other group coverage) may not need be counted

Affordability

- Opt-Out Credits (Cash-in-Lieu) Examples
  - **Example 1** – Unconditional opt-out
    - Eligible employees have the option to enroll in the employer's group medical plan by contributing $150/month or waive the coverage and receive $75/month in taxable cash
      - For affordability purposes, $225 ($150 + $75) would be used as the monthly employee contribution
  - **Example 2** – Conditional opt-out
    - Eligible employees have the option to enroll in the employer's group medical plan by contributing $150/month or waive the coverage and receive $75/month in taxable cash upon proof of other group health coverage
      - For affordability purposes, $150 would be used as the monthly employee contribution
      - Employers cannot make opt-out conditional on proof of individual coverage

MLR Rebates

- Minimum Loss Ratio (MLR) Background
  - ACA requires carriers to maintain minimum loss ratio of 80% for small group and 85% for large groups
    - First effective in 2011
    - Rebates must be provided to individual and group policy holders by August 1st the following year
  - Rebates could be due to insurer expenses being too high OR claims experience running lower than expected

MLR Rebates

- How Should Employers Handle Rebates?
  - Portion of rebate due to participant contributions is considered a plan asset
    - Asset calculated on an aggregate basis, not by individual participant - Example:
      - Total annual plan premiums for 2011 = $1,000,000
      - Employee and COBRA contributions = $200,000 (20%)
      - Rebate of $15,000 received by employer
      - $3000 (20%) must be treated as plan asset
    - Employer must use plan assets for the general benefit of plan participants in a fair and reasonable manner
      - Employer must weigh all factors
        - How much money involved
        - Cost and complexity of method

MLR Rebates

- How Should Employer Handle the Rebate?
  - Methods to return portion of rebate to participants
    - Return as compensation
    - Premium holiday or credit
    - Benefit improvement
  - Employer is not required to “match” distribution with employees who made contributions
    - DOL technical release (2011-4) states: “*An allocation does not fail to be…in the interest of participants, …merely because it does not exactly reflect the premium activity of policy subscribers*”
  - Tax treatment of returned rebates
    - If employee made contributions on a pre-tax basis then, if rebate money is returned to employees as cash or a premium holiday or contribution credit, it must be treated as taxable income to the employee

On the Horizon

More Employer Reporting

- §2715A of the Public Health Services Act requires non-grandfathered group health plans and health insurers to report information on health plan enrollment and claims, including:
  - Claims payment policies and practices;
  - Periodic financial disclosures;
  - Data on enrollment and disenrollment;
  - Data on the number of denied claims;
  - Data on rating practices;
  - Information on cost-sharing & payments with respect to out-of-network coverage;
  - Information on enrollee and participation rights; and
  - Other information as determined by the Secretary
- §2717 of the PHSA requires non-grandfathered group health plans to report various quality and outcome information
  - The information reported by plans will also assist the Secretary of Labor in making an annual report to Congress on self-insured health plans required by the ACA.

5500 Reporting

- DOL has proposed significant changes to 5500s which would begin to implement these requirements for group health plans
  - Would apply for plan years beginning January 1, 2019
  - Eliminate this small plan exception and would require all employer-sponsored group health plans that are subject to ERISA to file a Form 5500
  - New Schedule J:
    - Number of participants and beneficiaries covered under the plan
    - Number of individuals offered and receiving COBRA
    - Whether plan offers coverage for employees, spouses, children, and/or retirees and the type of group health plan benefits offered
    - Information about the plan's funding and contribution structure
    - Whether the plan is grandfathered, includes a high deductible health plan, a health FSA, or an HRA
    - Information regarding rebates, refunds or reimbursements from service providers
    - Identifying information for service providers to the plan

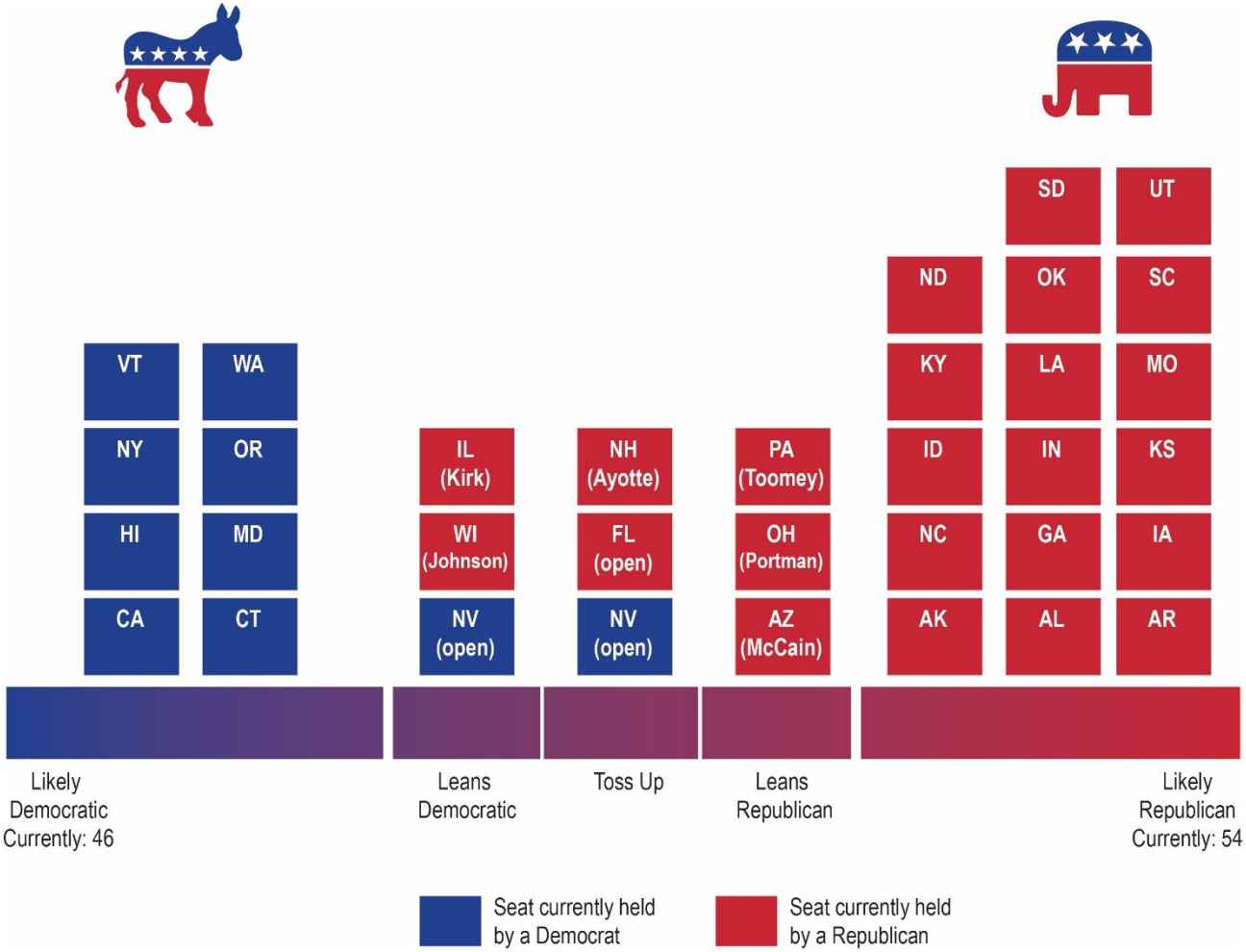
5500 Reporting

- DOL has proposed significant changes to 5500s
  - New Schedule J **(cont.)**
    - Stop-loss coverage premiums, information on the attachment points of coverage, individual and/or aggregate claims limits
    - For self-funded plans, information regarding contributions received or receivable as well as any failure to timely transmit participant contributions to the plan;
    - Information about inability to pay and/or any unpaid claims, including the total dollar amount of claims paid during the plan year, and if the plan was fully-insured, any delinquent payments to the insurance carrier and resulting lapse
    - Whether plan assets were held in trust or held by an insurance company qualified to do business in a State or under insurance contracts or policies issued by insurers consistent with federal regulations
    - Whether the plan's SPD, SMM, and SBC comply with requirements
    - Information regarding the plan's compliance with applicable Federal laws, including, for example, HIPAA, GINA, MHPAEA, and the ACA
    - Detailed claims payment data, including information regarding how many benefit claims were submitted, appealed, approved and denied during the plan year, as well as the total dollar amount of claims paid during the plan year
    - DOL is also considering collecting more information on denied claims

Election Result Scenarios

- **Scenario 1** – Clinton President
  - Little change to current legislation or regulatory efforts
- **Scenario 2** – Trump President, Democrats Control Senate, Republicans Control House
  - Changes in regulatory approach with Republican appointed agency heads
  - Few legislative changes with divided Congress
- **Scenario 3** – Trump President and Republican controlled Senate and House
  - Some legislative changes likely but Republicans will not have 60 seats in Senate so Democrats could slow or stop some major changes through use of the filibuster in Senate

Election Result Scenarios



Audio Trouble? Dial 1-719-867-1571 Access Code 265313

Other Legislative Things to Watch

- HR 4469 /S 2499 –Heath Savings Act of 2016
  - Carve out from Cadillac Tax for employee contributions to FSAs and HSAs
- Proposals to Limit Tax advantages of Employee Benefits
  - HR 5284 (Named - The World's Greatest Healthcare Plan Act of 2016!) - Texas Rep. Pete Sessions (R) & Louisiana Sen. Bill Cassidy (R) - would limit the tax exclusion for employer-sponsored health plans to $2,500 annually per individual plus $1,500 annually for dependents.
  - Paul Ryan’s recent proposal to replace Obamacare includes a cap (not defined) on the amount of health insurance that can be provided tax free.

Assurex Global Partners

- Catto & Catto
- Cragin & Pike, Inc.
- The Crichton Group
- Daniel & Henry
- Frenkel Benefits
- Gillis, Ellis & Baker, Inc.
- Haylor, Freyer & Coon, Inc.
- The Horton Group
- IMA
- INSURICA
- Kapnick Insurance Group
- Kinney Pike Insurance
- Lipscomb & Pitts Insurance
- LMC Insurance & Risk Management
- Lyons Companies
- The Mahoney Group
- MJ Insurance
- Parker, Smith & Feek, Inc.
- PayneWest Insurance
- R&R/The Knowledge Brokers
- RCM&D
- RHSB
- The Rowley Agency
- Seacrest Partners
- Starkweather & Shepley Insurance Brokerage
- Woodruff-Sawyer & Co.
- Wortham Insurance & Risk Management

Thank you.

September 22, 2016

ACA and Benefits Compliance Update

Presented by Bob Radecki & Regan Debban
Benefit Comply, LLC