UBA ComplianceCenter

Acadia BENEFITS INC.

Compliance Recap

September 2015

After a slow summer, federal agencies picked up the pace in September, with a large assortment of guidance, proposed rules, and updated forms and instructions. Nondiscrimination regulations were proposed, a temporary safe harbor was announced for summary and benefits of coverage, and the 2015 6055/6056 reporting forms and instructions were finalized, among other things.

In addition the larger updates, the American Bar Association's Committee on Employee Benefits released the minutes of a presentation from the IRS, with questions 21 through 24 pertaining to the employer shared responsibility provisions and related IRS reporting. The IRS also released the special per diem rates used to substantiate business expenses incurred during travel on or after October 1, 2015.

The Center for Consumer Information and Insurance Oversight (CCIIO) released technical guidance on the limited circumstances under which a health insurance issuer will not be out of compliance with regulatory deadlines for 2014 reporting year medical loss ratio (MLR) rebate distributions.

UBA Guides and Compliance Documents

UBA released an updated version of the "Effects of the Patient Protection and Affordable Care Act."

UBA released an ACA Advisor on information returns relating to IRS reporting: "Affordable Care Act Information Returns."

UBA released a guide on handling leaves of absence in relation to the employer shared responsibility rules, titled "Perfect Attendance! How to Handle Leaves of Absence Under the ACA."

UBA released updated versions of "PCORI, TRF, and HIP Fee Highlights," "PCORI vs TRF Comparison Chart," "Instructions for Completing TRF Filing," and "FAQ on the TRF."

Exchange and Marketplace Notifications

The Centers for Medicare & Medicaid Services (CMS), through the CCIIOO, released an FAQ providing that all Exchanges on Healthcare.gov will notify certain employers if one or more employees received a subsidy on the Exchange. The notification process will be phased in, with the Exchanges first sending notices to employers with employees who received a subsidy for at least one month in 2016 and who

provided a complete employer mailing address. CMS will be working to determine the next stage of the phase-in. For now, notifications will come via mail, but CMS is considering using email notifications in the future. An employer has 90 days from the notice to appeal, and the appeal request form will be available on Healthcare.gov.

Non-Discrimination Regulations Proposed

The Department of Health and Human Services (HHS) has issued the first of the anticipated nondiscrimination rules, which sets forth proposed regulations to implement Section 1557 of the Patient Protection and Affordable Care Act (ACA). Section 1557 provides that individuals shall not be excluded from participation, denied the benefits of, or subjected to discrimination under any health program or activity that receives federal financial assistance, on the basis of race, color, national origin, sex, age, or disability. The proposed regulations also apply to any program administered by an agency of the federal government or an entity established under Title I of the ACA. These applicable entities are "covered entities" and include a broad array of providers, employers, and facilities. State-based Marketplaces are covered as Title I entities, as are Federally-Facilitated Marketplaces.

Although the proposed regulations are aimed primarily at preventing discrimination by health care providers and insurers, it would also apply to the employee benefits programs of an employer that is principally or primarily engaged in providing or administering health services or health insurance coverage, or employers who receive federal financial assistance to fund their employee health benefit program or health services. Employee benefits programs include fully insured and self-funded plans, employer-provided or sponsored wellness programs, employer-provided health clinics, and longer-term care coverage provided or administered by an employer, group health plan, third party administer, or health insurer.

Read about the proposed nondiscrimination regulations.

Minimum Value Rule Change

Beginning in 2015, under the ACA, large employers must offer affordable, minimum value coverage to their full-time employees or potentially pay a penalty. Some companies have or had been marketing a plan that they state satisfies the minimum value requirement (an actuarial value of 60 percent), based upon a calculator provided by the Department of Health and Human Services (HHS), even though the plan does not cover inpatient hospital charges. New information provided by the IRS and HHS in 2014 and recently in 2015 should be considered as employers review their benefit offerings.

On September 1, 2015, the Department of the Treasury issued a supplemental notice of proposed rule making that would modify its current rule regarding the ACA minimum value standards to ensure that to meet minimum value requirements, a group health plan must meet or exceed an actuarial standard value of at least 60 percent and provide substantial coverage of inpatient hospital services and physician services. The purpose of the proposal is to incorporate the substance of the earlier HHS rules into IRS regulation.

Read about the minimum value rule change.

Summary of Benefits and Coverage Safe Harbor

A Summary of Benefits and Coverage (SBC) is four-page (double-sided) communication required by the federal government under the ACA. It must contain specific information, in a specific order and with a

minimum size type, about a group health benefit's coverage and limitations. An SBC is required whenever application or open enrollment materials are provided to new hires or current employees. If no application or open enrollment materials are given, an SBC must be provided when the person can first enroll in the plan.

The Department of Health and Human Services (HHS) has announced that, due to difficulties for some issuers that have hundreds of documents that must be posted to comply with the requirement for both individual and group coverage, it will not take enforcement action against issuers that make available individual coverage policy or group certificate of coverage documents no later than November 1, 2015. HHS expects all group and individual health insurance issuers to provide an Internet address for the group certificate of coverage or individual policy documents by the date on which the SBC is otherwise required.

Read about the summary of benefits and coverage safe harbor.

2015 IRS Reporting Forms and Instructions Finalized

Under the ACA, individuals are required to have health insurance while applicable large employers (ALEs) are required to offer health benefits to their full-time employees. In order for the Internal Revenue Service (IRS) to verify that (1) individuals have the required minimum essential coverage, (2) individuals who request premium tax credits are entitled to them, and (3) ALEs are meeting their shared responsibility (play or pay) obligations, employers with 50 or more full-time or full-time equivalent employees and insurers will be required to report on the health coverage they offer. Final instructions for both the 1094-B and 1095-B and the 1094-C and 1095-C forms were released in September 2015, as were the final Forms 1094-B, 1095-B, 1094-C, and 1095-C.

Guidance was provided on reporting offers of COBRA coverage, when to report health reimbursement arrangement (HRA) coverage, and when extensions or waivers might be available.

The IRS also updated its corresponding FAQ on 1094-C and 1095-C reporting.

Read about the 2015 IRS reporting forms and instructions.

Minimum Essential Coverage Reporting

Minimum essential coverage (MEC) is the type of coverage that an individual must have under the Patient Protection and Affordable Care Act (ACA). Employers that are subject to the ACA's shared responsibility provisions (often called play or pay) must offer MEC coverage that is affordable and provides minimum value.

The IRS has issued Notice 2015-68 stating that it intends to propose regulations relating to reporting on MEC that would:

- Provide that health insurance issuers must report coverage in catastrophic health insurance plans, as described in section 1302(e) of the Affordable Care Act, provided through an Affordable Insurance Exchange (Exchange, also known as a Health Insurance Marketplace),
- Allow electronic delivery of statements reporting coverage under expatriate health plans unless the recipient explicitly refuses consent or requests a paper statement,
- Allow filers reporting on insured group health plans to use a truncated taxpayer identification number (TTIN) to identify the employer on the statement furnished to a taxpayer, and

- Specify when a provider of minimum essential coverage is not required to report coverage of an individual who has other minimum essential coverage.

Read about minimum essential coverage reporting.

Question of the Month

Q. If an employee chooses not to elect coverage for his or her spouse or dependents during open enrollment, would the spouse's or dependent's loss of coverage be a COBRA qualifying event?

A. No. An employee's decision to drop coverage is not a COBRA triggering event.

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