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BENEFITS BRIEF

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Year-end Legislation and Agency Guidance Affects Health and Welfare Plans

November and December of 2015 saw plenty of health and welfare news coming from Capitol Hill and the Departments of Labor, Treasury, and Health and Human Services (the "Departments"). In case you missed any important developments while participating in holiday festivities, below are some highlights of what you need to know for the coming months.

Delay in ACA Reporting

The ACA imposes reporting requirements on applicable large employers ("ALE"s) and providers of minimum essential coverage ("MEC"). Under these requirements, insurers, self-insured employers, and ALEs must provide statements to individuals and file returns with the Internal Revenue Service ("IRS") containing information necessary for the enforcement of the individual and employer shared responsibility provisions of the ACA.

On December 28, 2015, the IRS issued Notice 2016-04, delaying the deadline for furnishing statements to individuals by two months (from February 1 to March 31) and the deadline for filing forms with the IRS by three months (from February 29 to May 31, or from March 31 to June 30 for electronic filings).

Final Insurance Market Reforms

On November 18, 2015, the "Departments published final regulations regarding what are informally known as the Affordable Care Act's ("ACA") "market reforms" (the "Final Rule"). 80 Fed. Reg. 72192. These "market reform" requirements relate to grandfathered health plans, preexisting condition exclusions, lifetime and annual dollar limits on benefits, rescissions, coverage of dependent children to age 26, internal claims and appeal and external review processes, and patient protections under the ACA. The Final Rule finalizes changes to the interim final rules, and incorporates subregulatory guidance (such as FAQs), without substantial change.

The Final Rule applies to group health plans and health insurance issuers beginning on the first day of the first plan year (or, in the individual market, the first day of the first policy year) beginning on or after January 1, 2017.

The Final Rule includes some important clarifications regarding the market reform rules. As a result, group health plans and health insurance issuers should carefully review the modifications to the market reform rules to determine how those modifications will change the plan or issuer's compliance efforts. Important clarifications regarding the market reform rules include:

- Adding an Employer to a Grandfathered Multiemployer Plan Will Not Affect Grandfathered Status. The addition of a new contributing employer or new group of employees of an existing contributing employer to a grandfathered multiemployer plan will not affect the plan's grandfathered status, provided that the multiemployer plan has not made any other changes that would cause the plan to relinquish grandfathered status.

- Prohibiting HMOs from Excluding Dependents Under Age 26 Because They Live Outside the Service Area. Eligibility restrictions requiring participants to live, work, or reside in the service area violate the ACA, to the extent such restrictions are applicable to dependent children up to age 26.

- Right to Receive New or Additional Evidence or Rationale *Automatically* in Connection with Appeal. Plans and issuers must provide the claimant, free of charge, with new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim, as well as any new or additional rationale as soon as possible and in advance of the notice of final adverse benefit determination. The Final Rule clarifies that this information must be provided *automatically*. Notice of new information is insufficient.

- Health Reimbursement Account ("HRA") Integration Rules. The Final Rule allows HRA integration with Medicare for employers with fewer than 20 employees that are not required to offer their group health plan coverage to employees who are eligible for Medicare coverage, and clarifies that for purposes of the HRA integration rules generally, forfeiture or waiver occurs even if the forfeited amounts or waived reimbursements may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event).

Delay in Cadillac Tax and HIF Moratorium

On December 18, 2015, the President signed H.R. 2029, a massive year-end spending and tax bill containing a number of provisions affecting health and welfare plans. H.R. 2029 includes both an omnibus appropriations bill that funds the government through September 30, 2016 – the Consolidated Appropriations Act, 2016 ("CAA") – and an extension (in some cases, a permanent one) of a large number of expiring or expired tax incentives – the Protecting Americans from Tax Hikes Act of 2015 ("PATH Act"). Issues of particular note to health and welfare plans include:

- High Cost Employer-sponsored Health Coverage Excise Tax ("Cadillac Tax"). The CAA includes a two-year delay of the high cost employer-sponsored health coverage excise tax (commonly dubbed the "Cadillac tax"). The tax will now not be effective until 2020. The CAA also makes the excise tax deductible for employers, and commissions a study by the General Accounting Office on the appropriate benchmark for adjustments in the excise tax threshold based on the employer's workforce age and gender characteristics as compared to the national workforce.

- Health Insurer Fee Moratorium. The CAA imposes a one-year moratorium, for 2017, on the annual fee on health insurance providers (ACA sec. 9010).

IRS "Potluck" Guidance on Employer Group Health Plans

On December 16, 2015, the IRS released Notice 2015-87, the so-called "Potluck Notice", addressing various unresolved issues under the ACA relating to employer-provided coverage. Specifically, Notice 2015-87 addresses:

- The employer shared responsibility, or "employer mandate" rules, particularly with regard to how an employer determines if the coverage offered is "affordable" for employees.

- How hours of service must be credited for employees receiving employer-sponsored disability benefits, under the employer mandate rules.

- The application of the COBRA continuation rules to unused amounts in health flexible spending arrangements ("health FSAs").

- Defined contribution health arrangements, and how they can be integrated with medical plans under the ACA.

Highlights of the Notice include the following regarding the employer mandate provisions of the ACA:

- Opt Out Credits. Future regulations will provide that cash incentives offered to an employee for opting-out of group health coverage, often referred to as "opt out credits", will count against the affordability of the health coverage (effectively making the coverage less affordable for the employee).

- Contributions for Service Contract Act Employees. Employer payments under the McNamara-O'Hara Service Contract Act ("SCA"), Davis-Bacon Act, or the Davis-Bacon Related Act ("DBRA") generally can be counted toward the employee's required contribution, and therefore are considered to make the coverage more affordable for the employee.

- Treatment of Disability Income Payments. An employer must credit "hours of service" for employees receiving short-term or long-term disability, unless the payments are made from an arrangement to which the employer did not contribute directly or indirectly.

- Updated Affordability Safe Harbors. Updates to the indexing of "affordability" standards for purposes of the employer shared responsibility final regulations.

Taxation of Identity Protection Services

On December 30, 2015 the IRS released Announcement 2016-02 extending tax relief for identity protection services provided prior to the detection of a data breach. Notice 2016-02 is an extension of the relief provided in Announcement 2015-22 for identity protection services provided after the discovery of a data breach. The Announcement provides that the IRS will not assert that:

- An individual must include in gross income the value of identity protection services provided by the individual's employer or by another organization to which the individual provided personal information (for example, name, social security number, or banking or credit account numbers).

- An employer providing identity protection services to its employees must include the value of such services in the employees' gross income and wages.

- The value of such service needs to be reported on information returns such as Forms W-2 or 1099.

Proposed Regulations on Disability Claims

On November 18, 2015, the Department of Labor (the "DOL") published proposed amendments to the claims procedure regulations for ERISA plans providing disability benefits ("Proposed Rule"). 80 Fed. Reg. 72014. The DOL states that its intent is to extend the procedural rules that apply to health care claims under the ACA (which were also finalized on November 18, 2015) to disability claims. The disability changes would take effect 60 days after publication of the final rule. Written comments are due by January 19, 2016.

The Proposed Rule would almost certainly increase the administrative costs and burdens of administering disability plans, and would encourage claimants to pursue their claims in court. Disability plans should consider what changes may be required if the final rule goes into effect as quickly as proposed, and how to minimize costs and litigation risk. Changes of concern include:

- Disclosure of the Basis for Disagreeing with a Third Party. Adverse benefit determinations would have to contain a discussion of the decision, including the basis for disagreeing with any disability determination by the Social Security Administration, a treating physician, or other third party disability payor presented by the claimant, to the extent the plan did not follow those determinations. It is unclear how a plan can protect itself when its doctors disagree with the treating physician, for example.

- Strict Compliance and Possible De Novo Review. If the plan fails to strictly adhere to all the claims requirements, the reviewing court would not give special deference to the plan's decision, but would review the dispute de novo. The proposal allows for a minor errors exception, which would apply only when a violation was (1) de minimis, (2) non-prejudicial, (3) attributable to good cause or matters beyond the plan's control, (4) in the context of an on-going good faith exchange of information, and (5) not reflective of a pattern or practice of noncompliance. The strict compliance standard will encourage claimants to litigate, in the hope that a judge will ignore the plan's decision and review de novo. The DOL's stated rationale, in part, for the Proposed Rule is "the volume and constancy of litigation in this area;" it would appear that the DOL seeks to give claimants an edge in court that they do not currently enjoy.

- Right to Review and Respond to New Information Before Final Decision. Prior to a decision on appeal, the plan would be required to provide to the claimant, free of charge, any new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan in connection with the claim, as well as any new or additional rationale for a denial. The claimant must then be given a reasonable opportunity to respond to such new or additional evidence or rationale. The Proposed Rule does not state how a plan can meet existing deadlines for a decision while adding this extra step to the appeals process.

For more information, please see our December 1, 2015 bulletin: http://www.groom.com/resources-1019.html

Other Miscellaneous Guidance

- On December 2, 2015, the Department of Health and Human Services ("HHS") published its annual proposed regulation, informally known as the "Payment Notice." 80 Fed. Reg. 75488. This rule generally proposes standards for HHS ACA insurance market programs for 2017. More specifically, the Payment Notice includes proposals regarding HHS' premium stabilization programs, Program Integrity, the Exchanges, market rules, rate review, and medical loss ratio. Written comments were due by December 21, 2015.

- On December 16, HHS and the Treasury published guidance on ACA section 1332 regarding State Innovation Waivers. 80 Fed. Reg. 78131. This guidance provides additional information about the requirements that must be met for a State Innovation Waiver to be approved, including operational considerations. In order for a State Innovation Waiver to be approved, a State must show that the waiver will provide coverage to a comparable number of state residents as would be provided absent the waiver, will provide coverage that is at least as comprehensive and affordable as would be provided absent the waiver, and would not increase the Federal deficit.

- On December 23, 2015, HHS released its 2017 Letter to Issuers in draft form. See https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Draft-2017-Letter-to-Issuers-12-23-2015_508.pdf. This guidance provides issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-facilitated Marketplaces (FFMs) or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs) with the general requirements, including operational and technical guidance, for participation in the Marketplaces in 2017. Written comments are due by January 17, 2016.

ADA Wellness

On December 31, 2015, in *EEOC v. Flambeau, Inc*., the US District Court for the Western District of Wisconsin held that the "bona fide benefit plan" safe harbor under the Americans with Disabilities Act (ADA) allowed an employer to design its wellness program to require a health risk assessment and a biometric screening as a condition of plan enrollment (2015 WL 9593632 (Dec. 31, 2015)). The EEOC argued that this was a prohibited medical examination under the ADA. The employer's argument was that it used the wellness program to identify health risks and for underwriting purposes and thus, the program was permitted under the bona fide benefit plan safe harbor exception, and the program fit within the ADA exception for voluntary wellness programs.

The court held that the wellness program was permissible under the bona fide benefit plan safe harbor, and therefore, did not address whether the program was voluntary. Notably, the court rejected the EEOC's argument that the bona fide benefit plan safe harbor would invalidate the exception for voluntary wellness programs. This is important because in the proposed ADA wellness program rules the EEOC issued last year, it noted in a footnote that it "does not believe that the ADA's 'safe harbor' provision . . . . is the proper basis for finding wellness program incentives permissible." It will be interesting to see if the EEOC addresses this issue when it issues the final ADA wellness regulations.

2016 Legislative and Regulatory Outlook

Almost immediately after passing H.R. 2029, Congress adjourned for the holidays. Members returned on January 6, 2016, to start the Second Session of the 114th Congress. However, the passage of H.R. 2029 was intended largely to clear the deck for Congress as they head into an election year. With spending levels set and no threat of expiring tax provisions, Congress will have very little pressure to pass major legislation in 2016.

It remains uncertain whether the Department of the Treasury and IRS will issue guidance on the Cadillac Tax in light of the two year delay in its effective date. With the upcoming presidential election, the Departments will likely not issue much major guidance in 2016.