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EMPLOYEE BENEFITS LAW

Health Care Reform ("PPACA") Legal Developments

2016 Year-End Update

1. Under PPACA, non-grandfathered plans must provide in-network **preventive care benefits** without cost-sharing. In 2016, the IRS, DOL and HHS (the "Agencies") published FAQs clarifying preventive care requirements for colonoscopies and contraceptives. Also, the U.S. Preventive Services Task Force issued multiple new and/or updated preventive care recommendations, for example: (1) statin use to prevent heart disease; (2) tuberculosis screening; (3) skin cancer screening; (4) tobacco use counseling and interventions for non-pregnant adults; and (5) women's preventive care.[1]

2. In April 2016, the Agencies issued an updated **summary of benefits and coverage ("SBC")** template, Uniform Glossary, and instructions. In general, plans must start using the updated template on the first day of the first open enrollment period after March 2017.

3. In June 2016 FAQs, the Agencies clarified that plans may include additional information in their **COBRA election notices** about the health insurance Exchanges. Election notices also can be tailored to particular groups, such as children who lost coverage because they turned age 26.

4. PPACA prohibits health programs that receive federal funding from **discriminating on the basis of sex, gender identity, or pregnancy**. ERISA plans could be subject to this rule if, for example, they receive Medicare Part D subsidies. Per a final HHS regulation issued in May 2016, affected plans must now include a nondiscrimination notice in all significant communications to participants and provide free language assistance services. The regulation also requires plans provide nondiscriminatory benefits beginning with the 2017-18 plan year. However, in December 2016 a federal judge entered a preliminary injunction that prevents HHS from penalizing plans that discriminate based on gender identity or termination of pregnancy. The injunction only applies to HHS and does not prevent participants from suing a discriminatory health plan.

5. The IRS issued 2016 forms (and instructions) that health plans and insurers must use to **report** "**minimum essential coverage"** to the IRS and enrollees, and that "applicable large employers" must use to report compliance with the "play or pay" requirements (Forms 1094-B, 1095-B, 1094-C and 1095-C). Forms reporting 2016 coverage are due in early 2017.[2]

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[1] Details about the new/updated preventive care recommendations can be found on the USPSTF's website, at www.uspreventiveservicestaskforce.org.

[2] The IRS extended the deadline to furnish the 2016 forms to employees from January 31 to March 2, 2017. The deadline to file with the IRS is February 28, 2017 (March 31, 2017, if filing electronically).

A penalty may apply if the forms do not include the employee's correct social security number or other taxpayer identification number (TIN). Per prior IRS guidance, the penalty will be waived if the reporting entity followed certain procedures to **solicit the correct TIN** from the employee. In August 2016, the IRS issued a proposed regulation clarifying the TIN solicitation procedure. The proposed regulation can be relied on until a final regulation is issued.

6. In December 2016, President Obama signed the 21st Century Cures Act, which allows **stand-alone Health Reimbursement Arrangements (HRAs)** to be maintained by certain small employers that do not offer other group health plan coverage to employees. These "qualified small employer HRAs" can provide tax-free reimbursement of premiums for individual health insurance policies and other medical expenses, but only if the employee is enrolled in minimum essential coverage. The Act does not otherwise modify the IRS's current position that HRAs and employer payment plans generally must be integrated with group health plan coverage in order to comply with PPACA's benefit mandates.

7. **"Excepted benefits"** are generally exempt from PPACA's benefit mandates and HIPAA's portability requirements. One type of excepted benefit is insurance coverage that supplements group health coverage and is similar to TriCare or Medicare supplemental coverage. In October 2016, the Agencies issued final regulations incorporating prior guidance on when supplemental coverage qualifies as an excepted benefit. The regulations also provide that short-term insurance policies must last for fewer than three months in order to be exempt from the PPACA and HIPAA requirements, and the insurer must give notice that the coverage does not satisfy PPACA's individual mandate.

8. For 2017, the PPACA **out-of-pocket maximums** on in-network benefits cannot exceed $7,150 per person and $14,300 per family.[3]

9. The **Patient Centered Outcomes Research ("PCOR") fee** increased to $2.26 per covered life for the plan year ending after September 2016 and before October 2017. The next PCOR fee must be paid by July 31, 2017.

10. 2016 is the last year for which a **transitional reinsurance ("TR") contribution** is owed. Enrollment counts were due by November 15, 2016. The 2016 TR contribution is $27 per covered life, and the first installment was due by January 17, 2017. As with the 2015 TR contribution, self-funded health plans are exempt from the 2016 contribution if they do not use a third-party administrator for certain administrative functions like enrollment and claims processing.

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[3] HSAs and high-deductible health plans are also subject to out-of-pocket limits under Code § 223. For 2017, these limits are $6,550 for self-only coverage and $13,100 for family coverage.