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NEW, PROPOSED TEMPLATE FOR SUMMARY OF BENEFITS AND COVERAGE

On February 25, 2016, the Departments of Labor, Treasury, and Health and Human Services (hereinafter the "Departments") released a proposed revised Summary of Benefits and Coverage (SBC) template, individual and group instructions ("Instructions"), and a uniform glossary (collectively, the "revisions"). The Departments are currently soliciting public comments to the proposed revisions, and a finalized SBC template is anticipated to go into effect in time for plan and policy years beginning on or after April 1, 2017. Highlights of the revisions are outlined below.

SBC Revisions Raise "Important Questions"

The proposed template includes several new questions.

Are there services covered before you meet your deductible?

Providers must explain whether plans cover primary care, generic or preferred drugs, and even specialist services before a deductible applies.

What is the Out-of-Pocket Limit for this Plan?

Family coverage plans must disclose whether the plan has "embedded" deductibles or out-of-pocket (OOP) limits. "Embedded" deductibles or OOP limits mean that family members would either meet **individual deductibles** or **individual OOP limits** before the **family deductible** or **family OOP limit** is met. Conversely, "non-embedded" deductibles or OOP limits mean the **full family deductible** or **full family OOP limit** must be met before any family member benefits are available.

Will you pay less if you use a network provider?

Health plans must disclose tiered networks and provide details in the Common Medical Event chart, so consumers can easily evaluate which plan tiers are more expensive. The proposed SBC also cautions consumers that even if they visit an in-network facility, they may receive services from out-of-network providers. Consumers should confirm whether their providers are in-network or out-of-network to avoid surprise balance bills from out-of-network providers.

SBC Revisions - Explanation of Common Medical Events

The proposed Instructions require plans to disclose certain "core" limitations and exceptions in the Common Medical Event chart, including:

- Whether a service category is covered or excluded;
- When cost sharing for covered in-network services does not count toward the OOP limit;
- Limits on the number of visits or on specific dollar amounts payable under the health benefit plan; and
- When prior authorization is required for services.

In addition, premium information must be disclosed separately from the SBC.

Excluded and Other Covered Services - Abortion Services

To address consumer complaints about the difficulty in determining coverage for abortion services, the proposed Instructions require qualified health plans offered through the Marketplace (i.e., Exchange) disclose whether or not they cover abortion services (and if so, whether services include excepted abortions and/or non-excepted abortion services).

Revised Coverage Examples

The proposed SBC contains three coverage examples: coverage for maternity, diabetes, and a simple fracture. These examples offer consumers a clear snapshot of how a particular plan might cover medical care. In addition, the Departments revised the coverage example calculator to make it more accurate.

Non-English Translations

The Departments provided the SBC in English, as well as Spanish, Chinese, Navajo, and Tagalog. Providers are required to provide taglines in the top fifteen languages in their state.

Conclusion

The intent of the Departments in creating the SBC was to require plan providers to present accurate information to consumers in a clear, concise, and comparable format. The Departments anticipate finalizing the template this month, so health plans and insurers will be required to use the new template immediately on the first day of their open enrollment period beginning on or after April 1, 2017 for plan or policy years beginning on or after that date. Plans and insurers that do not use annual enrollment periods will be required to use the new template on the first day of the first plan or policy year that begins after April 1, 2017.

No Action Required

These revisions are not yet in effect. The proposed revised SBC template, individual and group instructions, and uniform glossary are currently open for a thirty-day comment period. Plan providers may want to familiarize themselves with the revisions.

For the complete details, see:

Proposed SBC Template: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/SBC-Template.pdf

Proposed SBC Instructions: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cciio-Individual-Instructions.PDF

Proposed Uniform Glossary: http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html#proposed

CMS EXTENDS TRANSITION RELIEF TO NON-COMPLIANT SMALL GROUP/INDIVIDUAL PLANS FOR ANOTHER YEAR

Current Guidance

On February 29, 2016, Centers for Medicare & Medicaid Services (CMS) issued guidance that extends the compliance deadline for non-compliant Affordable Care Act (ACA) individual policies and/or small group plans. The new guidance extends the ability for small group health plans and individual policies that are not ACA compliant to continue to be renewed until **October 1, 2017,** provided such policies/plans are fully compliant with the ACA by **December 31, 2017**. This is subject to the discretion of each state's authority, and allows a state to choose to apply the transitional policy to the individual market, the small group market, or both markets.

Background

On November 14, 2013, CMS issued a bulletin to State Insurance Commissioners, outlining a proposal for providing transition relief to non-compliant, non-grandfathered coverage in the small group and individual health insurance markets. The letter stated that, pursuant to State authorities, health insurance issuers may choose to continue certain coverage that would otherwise be cancelled due to failing to meet all of the requirements for health coverage under the ACA. Under the transitional policy, non-grandfathered health insurance plans in the individual and small group market that renewed for policy/plan years between January 1, 2014 and October 1, 2014 would not be considered out of compliance with the ACA. On March 5, 2014, the transitional policy was further extended to plan/policy years beginning on or before October 1, 2016 in the small group and individual markets.

No Action Required

Employers in the small group market may have the opportunity to continue offering health insurance coverage that may not be compliant with the ACA for one more plan year, so long as state law allows for such extension.

For the complete details, see:

CMS Bulletin: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf

SANTA MONICA PAID SICK LEAVE LAW

Santa Monica, California Enacts Paid Sick Leave Ordinance

On February 25, 2016, the City Council of Santa Monica, California passed Ordinance Number 2509 (the "Ordinance"). Aside from requiring employers pay employees a minimum wage, and pay hotel workers a living wage, the Ordinance requires that employers provide paid sick leave to employees working in Santa Monica beginning July 1, 2016. Covered employees (i.e., workers who perform at least two hours of work per week within the geographic boundaries of Santa Monica) are eligible to accumulate paid sick leave at the rate of 1 hour of sick leave for every 30 hours worked in Santa Monica. Some highlights of the law are listed below:

- Large employers (employers with 26 or more employees) shall provide at least 72 hours of accrued paid sick leave. Large employers may limit employees from accruing more than 72 hours of paid sick time. Employers must allow employees to carry over up to an accumulated maximum of 72 hours of paid sick leave, unless an employer establishes a more generous policy.*
- Small employers (employers with 25 or fewer employees) shall provide at least 40 hours of accrued paid sick leave. Small employers may limit employees from accruing more than 40 hours of paid sick time. Employers must allow employees to carry over up to an accumulated maximum of 40 hours of paid sick leave, unless an employer establishes a more generous policy.*
- Accrual will be in one-hour increments only; there will be no accrual of fractions of an hour for time off.
- For current employees (current as of the operative date of the Ordinance), paid sick leave begins to accrue as of the operative date of the Ordinance.
- For new employees (hired after the operative date of the Ordinance), paid sick leave begins to accrue 90 days after the commencement of employment.
- Employers are not required to pay out accrued, unused sick leave upon the employee's termination, resignation, or retirement.
- Employers may adopt leave policies more generous than those set forth in the Ordinance.
- Government agencies (federal, state, county, city), school districts, and other public entities are exempt from the Ordinance.

*The Ordinance is unclear whether covered employees only include those working in Santa Monica, or the company's total number of employees.

Action Required

Employers in Santa Monica, California should pay close attention to the new paid sick leave ordinance and update their policies if they are not currently in compliance.

For the complete details, see:

http://santamonicacityca.iqm2.com/Citizens/Detail_LegiFile.aspx?ID=1712 (click on the "Ordinance" link)

HHS RELEASES MAXIMUM ANNUAL LIMITS ON COST-SHARING FOR 2017

The Department of Health and Human Services (HHS) released its finalized out-of-pocket (OOP) maximums for 2017. The Affordable Care Act (ACA) imposes annual OOP maximums on the amount an enrollee in a non-grandfathered health plan must pay for essential health benefits (EHBs) through cost-sharing. Highlights from the HHS Notice of Benefit and Payment Parameters detailing these limits are as follows:

Out-of-Pocket Limits for Self-Only and Family Coverage, 2016-2017

	2016	2017	Change
Self-Only Coverage OOP Limits	$6,850	$7,150	2016 to 2017: $300
Family Coverage OOP Limits	$13,700	$14,300	2016 to 2017: $600

These ACA OOP maximums are calculated using what is known as the Premium Adjustment Percentage (PAP). The PAP used to calculate the 2017 limits was approximately 13.3%.

It is important to remember that these ACA OOP maximums are different than the IRS OOP maximums for High Deductible Health Plans (HDHPs). This difference is because HHS and the Internal Revenue Service (IRS) are subject to different requirements when calculating the annual OOP limits. To determine ACA OOP maximums, HHS uses the PAP to determine the yearly limit increases. On the other hand, the IRS uses the Consumer Price Index to adjust its OOP limits. The IRS has not yet released the 2017 OOP limits for HDHPs.

No Action Required

Employers should be aware that these out-of-pocket maximums are increasing in 2017, and ensure health plans offered are in compliance with these limits.

For a summary of the Final HHS Notice of Benefit and Payment Parameters, see:

https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-29.html

For the complete details, read the HHS Final Regulations:

https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf

QUESTION OF THE MONTH

Q: Our company (as plan administrator of our health plan) recently mailed a COBRA election notice by first-class mail, but it was returned as undeliverable. What should we do?

A: This can be a difficult decision. COBRA requires only that the plan administrator mail the notice to the qualified beneficiary's last-known address. But courts have applied "inquiry notice" and "fiduciary responsibility" theories to impute to plan administrators knowledge that a qualifying event has occurred, and those theories could be extended to a returned election notice when a plan administrator knows that a notice has not been received. It seems to us that plan administrators should, at a minimum, consider the possibility that the notice was sent to the wrong address and confirm that the last-known address on file was used. You may also want to do one or more of the following:

- Ask the insurer or third-party administrator (TPA) if a different address is on file. Recent claims may have triggered correspondence between the insurer or TPA and the qualified beneficiary showing that the qualified beneficiary has a new address.
- Check with other departments (e.g., payroll or human resources) or pension benefits administrators to see if they have a more recent address for the qualified beneficiary.
- Call the home or cellular telephone number last given by the qualified beneficiary.
- Check with coworkers of the former employee if the qualifying event was a termination of employment.
- And, of course, if the qualified beneficiary contacts you about not receiving the notice, get current contact information and send the notice again.

To protect against a related COBRA lawsuit, be sure to create a written record of whatever steps you take (e.g., a descriptive memo to the file or copies of written inquiries and responses). In addition, your plan's summary plan description (SPD), COBRA initial notice, and other benefits and HR communications—including termination letters—should conspicuously remind qualified beneficiaries to keep you informed of any address changes and include specific directions for doing so.

Source: Thomson Reuters/EBIA