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CMS RELEASES PROPOSED RULES ON MARKET STABILIZATION FOR HEALTH INSURANCE EXCHANGES

On February 15, 2017, the Centers for Medicare & Medicaid Services (CMS) released proposed rules aimed at stabilizing the individual and small group health insurance marketplace. The final rules are expected to be released by the end of March and would be effective beginning in 2018. Highlights of the proposed rules are discussed below.

Guaranteed Availability of Coverage

Generally, under the guaranteed availability provisions, insurers must offer coverage and accept every individual/employer in the state that applies for coverage, unless an exception applies. This means that, currently, an insurer cannot deny an individual or employer coverage because they owe past-due premiums for a previous year, as long as that individual or employer is not requesting to reenroll in the same exact coverage to which the premiums are owed. This rule, therefore, allows an individual or employer to continue to enroll/offer coverage, even though an individual/employer defaulted on their premium payments in the previous year.

The proposed rules would permit insurers to deny coverage to an individual/employer who failed to pay their premium, until the insurer received full payment of any past due premiums owed by the insured for the previous twelve (12) months. In addition, insurers could attribute premium payments for coverage under the same or different product to any past due premiums for coverage.

Open Enrollment Periods

Currently, the 2018 Exchange open enrollment period is set to run from November 1, 2017 to January 31, 2018, and the 2019 Exchange open enrollment period will be November 1, 2018 to December 15, 2018. Under the proposed rules, the 2018 Exchange open enrollment period would be shortened to 45 days, from November 1, 2017 to December 15, 2017, to match the 2019 open enrollment period.

Special Enrollment Periods

Pre-Enrollment Verification

Similar to employer-sponsored plans, the Exchange allows for special enrollment periods midyear when an individual experiences a certain event that affects health coverage for themselves or their family members (e.g., loss of other coverage or birth of a dependent). The Exchange currently does not require that an individual provide actual proof of a status change to enroll into the Exchange during a special enrollment period.

CMS planned to implement a pilot program in June 2017 that would require 50% of individuals to verify their eligibility to enroll in the Exchange due to a special enrollment event. The proposed rules expand the pre-enrollment verification process to include all individuals applying for midyear Exchange enrollment, either on the Federally-facilitated Exchange or a State-based Exchange.

The proposed process for verification of a status change would begin with an individual submitting an application for coverage in the Exchange and the approval of that application would be considered “pending” until their eligibility for special enrollment was verified. During the pending approval, the applicant would have 30 days to electronically upload or mail documentation verifying his/her eligibility to enroll in the Exchange coverage due to a status change. If approved, coverage would be retroactive to the date he/she submitted their application.

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CMS Releases Proposed Rules on Market Stabilization (Continued)

If the approval takes longer than two (2) months, and the individual would be required to pay two (2) or more months of premiums to have coverage retroactive to the date they elected a plan option, that individual could choose to start their coverage one (1) month later than his/her effective date would have been approved. For example, if an individual's coverage was originally set to begin on March 1, but due to a delay in the verification process that individual would owe retroactive premiums for March, April, and May to have coverage begin March 1, that individual could choose to begin coverage April 1, and only owe retroactive premiums for April and May (saving the individual one month of premium payments).

Limits on Eligibility for Special Enrollment Periods

The proposed rules include additional limits on certain special enrollment periods. First, the proposed rules would allow an insurer to deny an individual's application requesting special enrollment if that individual lost coverage for non-payment of premiums, unless that applicant pays the past-due premiums. The Exchanges would keep a record of individuals who lose coverage due to a failure to pay premiums, which would allow insurers to know when an individual seeking special enrollment could be denied coverage due to non-payment of premiums.

Second, the proposed rules limit the special enrollment period due to marriage. An individual seeking to enroll midyear on account of marriage would need to confirm that at least one spouse had minimum essential coverage (MEC) on one or more days during the previous sixty (60) days, unless at least one of the spouses lived outside of the United States (or in a United States territory) for one or more days during that period.

Third, if an individual applies for special enrollment due to moving residence, the proposed rules require that an individual must prove that they had MEC for one or more days in the previous sixty (60) days, unless they moved from outside of the United States (or from a United States territory). The individual would be required to show documentation of both the previous and new addresses, as well as proof of previous coverage.

Lastly, the proposed rules significantly limit the ability to request special enrollment for an "exceptional circumstance" (e.g., serious medical condition or natural disaster) for the remainder of 2017 and future years. The proposed rules require the circumstance which the employee relies on to specially enroll in Exchange coverage to be "truly exceptional," and the individual must provide supporting documentation to verify the circumstances, if practicable.

Actuarial Value

The proposed rules alter the de minimis ranges used to determine the actuarial value for metal level plans. The changes to the de minimis ranges are intended to provide issuers greater flexibility in determining the actuarial value associated with metal levels of coverage, thereby providing enrollees more coverage options and lowering premiums. The changes to the de minimis ranges for AV metal levels would apply on and off the Exchange, and are adjusted as follows:

- Platinum/Gold metal level: +/-2 to -4/+2 percentage points
- Bronze metal level: +5/-2 to +5/-4 percentage points.

Network Adequacy

Currently, CMS reviews qualified health plans (QHPs) for network adequacy to ensure insurers in the Exchange offer networks with a sufficient number of qualified providers. The proposed rules transfer the responsibility of network adequacy reviews to certain states. States where a Federally-facilitated Exchange is operating would be expected to perform this network adequacy review, if that State has authority and a process in place to perform such a review. For States that have no authority or ability to conduct this review, CMS would accept HHS-recognized accrediting.

No Action Required

Interested employers and individuals may want to be aware of these proposed rules, which reflect the administration's current approach to stabilizing the individual and small group marketplace.

Interested parties can review the proposed regulations, here:
https://www.gpo.gov/fdsys/pkg/FR-2017-02-17/pdf/2017-03027.pdf

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CALIFORNIA SHORT TERM DISABILITY AND PAID FAMILY LEAVE INCREASE JANUARY 1, 2018

Effective January 1, 2018, California's Short Term Disability Insurance (SDI) and Paid Family Leave (PFL) benefits will increase from a 55% wage-replacement benefit to a 60% wage-replacement benefit (those earning under approximately $24,000 per year will receive a 70% benefit). These increases are set to expire after a four (4) year trial run, ending on December 21, 2021, and the California legislature will determine whether to extend or modify changes to the SDI and PFL benefits.

We published an article in our May 2016 Legislative Compliance Newsletter that addressed the expansion of paid family leave in California. This article clarifies that the expansion of benefits not only applies to paid family leave, but also to California SDI. Below is a recap of the changes.

Benefit Levels

Currently, the SDI and PFL programs pay 55% wage replacement, with a minimum benefit of $50 per week and a maximum benefit of $1,173 per week after a seven (7) day waiting period. A claimant's benefit amount is determined based on when the claim began and the claimant's highest wages earned over a quarter in the claimant's twelve (12) month base period.

On January 1, 2018, the SDI/PFL maximum benefit is anticipated to increase from $1,173 per week to $1,216 per week. This increase is an estimate, and may change when the California Employment Development Department (EDD) publishes the exact increase later this year.

Benefit Duration

There are no changes to the benefit duration. The maximum SDI benefit duration remains at fifty-two (52) weeks, and the PFL benefit duration remains at six (6) weeks.

Contribution Rate

Currently, employees that pay into SDI contribute 0.9% of their taxable wages up to $110,902 annually. On January 1, 2018, the contribution rate may increase to 1.0%. This percentage may change, as the EDD will publish the official contribution rate later this year.

Waiting Period

Currently, the PFL waiting period is seven (7) days. The bill would remove this PFL waiting period. However, the SDI waiting period will remain the same, at seven (7) days for accident and sickness disabilities. This waiting period is waived for new mothers transitioning from SDI to PFL.

Action Required

Employers should update their employee handbooks if necessary, and may need to confirm their payroll vendor or department is aware of the increased SDI/PFL contribution rate.

For the text of AB No. 908, see: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB908.

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NEW YORK CLARIFIES PAID FAMILY LEAVE BENEFITS

The State of New York previously enacted a Paid Family Leave Law (PFL law), which mandates private employers in the State of New York to provide paid family leave benefits to eligible employees under the state's existing Disability Benefits Law. On February 22, 2017, the New York State Workers' Compensation Board (WCB) published proposed regulations clarifying certain provisions of the PFL law. These proposed regulations are currently in a forty-five (45) day public comment period, which ends on April 8, 2017. Subsequently, these proposed regulations will be adopted, with some potential revisions. A summary of the proposed regulations and its clarifications is provided below.

Covered Employers

The PFL law applies to private employers in New York with at least one employee. Public employers may opt in and elect to offer PFL benefits.

Covered Employees

Covered employers must provide leave to covered employees who have worked at least twenty-six (26) consecutive weeks (or 175 consecutive days for part-time employees). Scheduled vacation time and paid personal or sick time count toward determining whether an employee has worked for twenty-six (26) consecutive weeks. However, periods of temporary disability do not count toward the twenty-six (26) week period.

The proposed regulations clarify that part-time employees (employees scheduled to work fewer than five (5) days per week) are eligible to receive pro-rata portions of leave. For example, an employee who works three (3) days per week on January, 2018 would be eligible to receive sixty percent (60%) of the eight (8) weeks of paid leave available to full-time employees, or twenty-four (24) days maximum in a fifty-two (52) week period; .

Short-Term Employees

Employees who work less than twenty-six (26) weeks or 175 days in a fifty-two (52) week period have the option to waive PFL benefits. If the employee files a waiver, the employee will not be subject to payroll deductions for PFL contributions, and the employer will be exempt from offering PFL benefits.

Non-U.S. Citizens and Undocumented Employees

The definition of a covered employee includes non-U.S. citizens and undocumented employees.

Employees Covered Under Collective Bargaining Agreements

Employers with employees covered by collective bargaining agreements with terms at least as favorable as the current PFL laws are exempt from the PFL requirements.

Coverage Required

The PFL law is effective January 1, 2018, and the weekly benefits will increase annually until January 2021.

Effective Date	Maximum Leave (per 52-week period)	Weekly benefits is the lesser of (a) or (b):	
		(a) Required percentage of average wage	(b) State Average Wage
January 1, 2018	8 Weeks	50%	50%
January 1, 2019	10 Weeks	55%	55%
January 1, 2020	10 Weeks	60%	60%
January 1, 2021	12 Weeks	67%	67%

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New York Clarifies Paid Family Leave Benefits (Continued)

The proposed regulations explain that employers may begin collecting weekly employee contributions starting July 1, 2017, to fund PFL benefits, which may be utilized starting January 1, 2018.

If an employer offers employees the option to use accrued paid time off so the employee receives his or her full salary during leave and the employee elects to do so, then the employer may file a claim with the carrier before these benefits are paid, and request reimbursement out of any PFL benefits.

Permitted Uses of Paid Family Leave

Permitted uses of leave include:

1. Bonding with a new infant, adopted child, or foster child during the first year of birth, adoption, or foster placement
2. Care for a family member with a serious health condition; or
3. To relieve family pressures when a family member is called to active military service.

A family member includes the spouse, domestic partner, child, or parent of the employee.

Employee Rights During and After Leave

Employers must maintain an employee's health insurance while the employee is on PFL (if the employee has family coverage, the employer must also maintain family member coverage during leave), if the employee continues to make his/her contributions toward the cost of premiums during PFL. If an employee chooses not to retain health coverage during PFL, then the employee must be reinstated into the health plan upon return from leave, on the same terms as before taking leave.

In addition, an employee must be reinstated to his or her position upon return from PFL.

Employee Notice and Request for Leave

Employees must provide at least thirty (30) days advance notice before taking leave if the reason for the leave is foreseeable (e.g., child's expected birth, placement, or adoption, planned medical treatment, or known military exigency). Otherwise, the employer or carrier may file a partial denial of the PFL claim for a period of up to thirty (30) days from the date notice is provided by the employee (e.g., if an employee's leave was foreseeable, but the employee only provided notice of leave 21 days in advance, then the employer or carrier may deny seven (7) days of PFL). If the reason for leave is not foreseeable, then the employee must provide notice as soon as practicable. Employers have the option to waive advance notice requirements.

To request leave, employees must complete a specific Request for Paid Family Leave form with the employer (if the plan is self-insured) or the carrier (if an insurance carrier administers the PFL plan) and identify reason for the leave when providing notice. The State of New York will release a draft form, or employers may create their own forms based on the State's draft version.

Employees requesting leave may be required to provide complete and sufficient certifications justifying their need for PFL. If an employee fails to provide certain information supporting the need for leave, then the employer or carrier must notify the employee of additional information needed in order to approve their claim, and may deny the claim if the requested information is not provided.

Employer Notice and Posting Requirements

Employees must provide written policies or notifications to employees regarding their PFL rights. Written notice may be provided in the employer's employee handbook. In addition, the employer must display a printed notice in plain view at their place of business.

Penalties

Employers who fail to provide PFL may be liable for a fine of up to 0.5% of their weekly payroll during the time leave is not provided, plus an additional fine up to $500.

Employers who fail to continue to provide health care coverage will be liable for any medical costs incurred by the employee during the period of the leave.

Dispute Resolution

The regulations set forth a process for resolving PFL claims disputes through arbitration. Parties that want to raise a dispute may file requests for arbitration, along with a filing fee, with arbitrators that are appointed by the Chairman of the WCB.

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New York Clarifies Paid Family Leave Benefits (Continued)

Action Required

New York employers should review their payroll and leave policies to ensure they are in compliance with the Paid Family Leave Laws before the January 1, 2018 effective date.

For proposed regulations, see: http://www.wcb.ny.gov/PFL/pfl-regs-text.jsp

For additional information on the Official Website for New York State, see: https://www.ny.gov/programs/new-york-state-paid-family-leave

IRS REAFFIRMS EXTENSION TO FURNISH WRITTEN QSEHRA NOTICE

Background

The 21st Century Cures Act (the Cures Act), enacted December 13, 2016, allows eligible small employers to offer their employees Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs), which are not treated as group health plans and would not subject eligible small employers to excise taxes. An eligible small employer is one that:

- Employed fewer than fifty (50) full-time and full-time equivalent employees during the previous year; and
- Does not offer a group health plan in the current year.

Employers offering QSEHRAs must furnish a written notice to employees at least ninety (90) days before the beginning of the year for which QSEHRAs are provided. An employer that fails to provide timely notice could be subject to penalties of $50 per employee per incident, up to $2,500 per year. However, the Internal Revenue Service (IRS) confirmed that eligible small employers offering QSEHRAs for a year beginning in January 2017 had until March 13, 2017 to furnish the written QSEHRA notice (which is ninety (90) days from the enactment of the Cures Act).

As a reminder, the written notice must explain:

1) The employee's benefit amount for the year

2) That the employee should provide information about the QSEHRA if applying for premium tax credits on the Exchange, and

3) For any month the employee does not have minimum essential coverage, he or she may be subject to Individual Mandate penalties, and QSEHRA reimbursements may be included in gross income.

Please see our December 2016 Legislative Compliance Newsletter (Issue 12) for more information on QSEHRAs.

No Action Required

The IRS Notice confirms that eligible small employers offering QSEHRAs had until March 13, 2017 to furnish the written QSEHRA notice. Eligible employers that want to offer QSEHRAs for future years must furnish the written QSEHRA notice at least ninety (90) days before the beginning of the year they intend to offer QSEHRAs to avoid penalties.

For more information, see IRS Notice 2017-20, here: https://www.irs.gov/pub/irs-drop/n-17-20.pdf.

For additional information on QSEHRAs, see FAQs about Affordable Care Act Implementation Part 35 here: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-35.pdf.

For the text of the bill, see: https://www.congress.gov/114/bills/hr34/BILLS-114hr34eah.pdf.

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ACA TRANSITION RELIEF POLICY EXTENDED THROUGH 2018 TO CONTINUE NON-COMPLIANT POLICIES AND HARDSHIP EXEMPTIONS

On February 23, 2017, the Centers for Medicare and Medicaid Services (CMS) announced that the transitional policy, first issued on November 13, 2013, has been **further extended** to health insurance policies beginning **on or before October 1, 2018**. Under this transitional policy, individual policies and small group plans that would otherwise be considered non-compliant under ACA will be considered in compliance with ACA insurance market reforms. At the election of States, issuers that have renewed policies under the transitional policy continuously since 2014, may once again renew coverage for a policy year that begins **on or before October 1, 2018**, and does not extend past December 31, 2018. States may authorize partial-year policies as this extension is intended to facilitate the smooth transition from transitional coverage to Affordable Care Act compliant coverage.

Health insurance issuers that renew coverage under this transition relief policy must notify affected individuals and small businesses of their right to continued non-ACA compliant coverage.

The transitional policy will allow the following provisions to be non-compliant within individual and small group health plans:

- Guaranteed availability and renewability
- Prohibitions on health status underwriting
- The requirement to provide Essential Health Benefits or limit out-of-pocket pending
- Fair Insurance premiums rules
- Prohibitions on pre-existing conditions and discrimination based upon a health factor (only applies to individual policies
- Hardship exemptions from the Individual Mandate continue to be available, so long as an individual's policy was cancelled because of non-compliance and other options are more expensive for that individual.

Action Required

Small employers offering ACA non-compliant plans must inform enrollees of their right to continued coverage, the unavailability of certain ACA protections, and the opportunity to enroll in ACA-compliant coverage. Sample notices to employees can be found in the CMS notice.

For more information and model notices to employees, please see CMS Notice here:

https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Extension-Transitional-Policy-CY2018.pdf

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COMPLIANCE REMINDER: SAN FRANCISCO HEALTH CARE ANNUAL REPORTS DUE APRIL 30, 2017

San Francisco's Health Care Security Ordinance (HCSO) or Healthy San Francisco require "covered employers" (i.e., for-profit employers with 20 or more total employees and nonprofit employers with 50 or more total employees) to spend a **minimum** amount on health care benefits for covered employees.

Plan: Covered Employers must file an Annual Report with the City on the health care expenditures made for employees working in San Francisco. Covered Employers must file the 2016 Annual Reporting Form (ARF) no later than April 30, 2017. The 2016 ARF is expected to be available on or around April 1, 2017. Below is a link to the 2016 Annual Reporting instructions:

- Instructions: Annual Reporting Instructions

Tips for completing the Annual Reporting Form

1. Do not submit (2) separate 2016 Annual Reporting Forms using the same Business Account Number unless you are submitting a correction. If multiple businesses or locations share the same Business Account Number, combine the relevant data into a single Annual Reporting Form. If multiple forms are submitted, only the most recent submission will be recorded.
2. Fill out the form completely. Do not enter commas in numeric fields. Enter zeros where appropriate. Enter all dollar amounts in whole dollars; do not include cents.
3. You may report multiple types of health care expenditures for each employee. For example, if you paid health insurance premiums and also paid into a HRA for a particular employee, the employee would be reported on both the Health Insurance page and the Revocable Expenditure page.
4. Employees who worked for you throughout the year should be counted in each quarter.
5. If you cannot access the online forms, call the HCSO Office at (415) 554-7892 to request a paper copy of the Annual Reporting Form.

Employers who fail to submit the form are subject to a $500.00 penalty for each quarter that the violation occurs.

Irrevocable Expenditures

For 2016, **only 20% of the 2016 expenditure** per person **may** qualify as **revocable**. **Note:** Percentages are for each individual and not an average for the group.

An Irrevocable Health Care Expenditure is an expenditure that the employer cannot recover. Employers who set up benefit plans, such as a limited scope HRA (e.g. dental-only plan), will no longer be able to recover the unused amounts, even if the employee leaves the job or if the business ceases to exist. An irrevocable expenditure includes premium payments to insurers for medical, dental, vision coverage, contributions to employees' HSA, MSA, etc. Any payment to the City Option is considered irrevocable.

Conditions for Revocable Expenditures.

- The expenditure is "reasonably calculated to benefit the employee," and the employer must provide an expenditure summary notice within 15 days of each employer expenditure.
- Employer must provide the summary notice within 3 days of termination of employment.
- No portion of the expenditure can revert to the employer prior to the earliest of: 24 months from the date of the expenditure or, 90 days after termination of employment.

Note: Beginning January 1, 2017 *only* Irrevocable Expenditures will be counted toward the Employer Spending Requirement under HCSO.

The 2016 and 2017 HCSO-required health care expenditure rates are as follows:

Employer Size	Number of Employees	2016 Expenditure Rate	2017 Expenditure Rate
Large	All employers w/100+ employees	$2.53 per hour payable	$2.64 per hour payable
Medium	Businesses w/20-99 employees Nonprofits w/50-99 employees	$1.68 per hour payable	$1.76 per hour payable
Small	Businesses w/0-19 employees Nonprofits w/0-49 employees	Exempt	Exempt

Notice Update: Covered Employers must replace last year's posted Official Notice with the updated HCSO 2017 Official Notice at every workplace or job site where there is an HCSO-eligible individual.

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QUESTION OF THE MONTH

Is Our Self-Insured Health Plan Subject to the Section 1557 Nondiscrimination Rules?

QUESTION: The claims administrator for our company's self-insured health plan is also an insurer that sells policies through the Exchanges. Does this make our company or our group health plan subject to the "Section 1557" nondiscrimination in programs and activities rules?

ANSWER: As explained below, an employer sponsoring a self-insured health plan is not subject to the Section 1557 nondiscrimination rules simply because its third-party administrator (TPA) may be covered by those rules. Health care reform's Section 1557, which prohibits discrimination in certain "health programs and activities" on the basis of race, color, national origin, sex, age, or disability, applies broadly to a wide variety of federally assisted entities. Notably, the rules apply to federal and state Exchanges (including Small Business Health Option Programs (SHOPs)) and the insurers that participate in them. Furthermore, HHS regulations (see article) confirm that the rules generally apply to Exchange insurers even with respect to the plans and services they offer outside the Exchanges or, in some instances, as third-party administrators (TPAs) for employer group health plans. Exchange insurers are prohibited from denying, canceling, limiting, or refusing to issue or renew policies; using discriminatory benefit designs; denying or limiting coverage of a claim; or imposing additional cost-sharing or other coverage limitations on any of the prohibited bases. The regulations interpret discrimination on the "basis of sex" as including gender identity and termination of pregnancy. However, a court has imposed a nationwide injunction blocking the enforcement of the regulations' prohibitions against discrimination on the basis of gender identity and termination of pregnancy (see article). HHS will not enforce these two provisions while the injunction is in place but will continue to enforce the regulations as to other forms of prohibited discrimination.

The regulations make clear that an employer does not become covered by the rules just because its self-insured health plan's TPA is covered. However, recognizing that TPAs generally do not control the design of the self-insured health plans they administer, HHS will only process a complaint against a TPA where the alleged discrimination is related to the TPA's own administration of the plan. If the alleged discrimination relates to the benefit design of the plan, HHS will instead proceed against the employer/decisionmaker if it has jurisdiction over the employer (e.g., a hospital that is a federally assisted entity and directly subject to Section 1557). Where HHS lacks jurisdiction, it may refer the matter to the EEOC, which enforces other nondiscrimination rules that may apply to your plan (e.g., Title VII of the Civil Rights Act, which prohibits discrimination based on race, color, religion, sex, or national origin under separate rules and regulations). Keep in mind that your self-insured health plan may also be subject to the more familiar nondiscrimination requirements under Code § 105(h), which prohibits discrimination in favor of highly compensated individuals (see Question of the Week).

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