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HHS finalizes 2017 Benefit and Payment Parameters regulations

In brief:

• HHS finalized the 2017 Benefits and Payment Parameters regulations with few changes from what was proposed this past December, including establishing the dates for open enrollment for the Marketplace exchanges for 2017 and 2018, formally recognizing a new state-federal hybrid marketplace arrangement, setting new standardized plan options, and allowing certain small employers to offer to a “vertical choice” option for certain coverage available on Marketplace exchanges.

• However, certain network adequacy requirements and rules concerning out-of-network bills at in-network facilities were modified and delayed.

On February 29, 2016, the Department of Health and Human Services (HHS) issued its final 2017 Benefit and Payment Parameters regulations and other related guidance. As discussed in our December 2015 Employee Benefits Compliance Update, HHS issues a similar set of rules each year to set forth the parameters of various premium stabilization programs under the Affordable Care Act (ACA) and make a wide variety of technical amendments and updates to its rules governing the ACA Marketplace exchanges and health insurance markets in general.

For employers, the most significant update included in these final regulations are the 2017 maximum annual limitation on out-of-pocket cost-sharing of $7,150 for self-only coverage and $14,300 for other than self-only coverage (as reported in our March 2016 Employee Benefits Compliance Update). Another important change was the extension of the rules with respect to transitional plans, delaying the need to comply with certain ACA market reform rules until the end of 2017, as opposed to September 30, 2017 (see the separate article later in this Employee Benefits Compliance Update).

Otherwise, the 2017 Benefit and Parameters final regulations generally adopt the rules proposed last December with relatively few changes. A few of the highlights include:

Annual open enrollment
For the 2017 and 2018 benefit years, open enrollment for Marketplace exchanges will run from November 1st until January 31st, which is the same as this past year. However, open enrollment will run from November 1st to December 15th in future years to better align with the calendar year.

State-based Marketplaces using the federal platform (SBM-FP)
The rules finalize recognition of a new hybrid marketplace arrangement in which a state-based Marketplace exchange uses Healthcare.gov for enrollment and eligibility functions, but the state retains all the responsibilities traditionally handled by state insurance commissions (such as plan management, consumer assistance, and ongoing oversight and program integrity). SBM-FPs currently are being used in Hawaii, Oregon, Nevada, and New Mexico. The Federally Facilitated Marketplace (FFM) user fee for these states will be 1.5 percent for 2017 and 3 percent thereafter. In contrast, the standard fee for other FFM states will be 3.5 percent in 2017.

Standardized plan options
The final rules essentially adopt the rules regarding standardized plan options that may be offered on the FFM exchanges as originally proposed. Thus, beginning in 2017, qualified health plan issuers will have the option of offering six standardized plans (a bronze plan, a gold plan, a standard silver plan, as well as three silver plan options with different actuarial value values). Design elements in these standardized options will include:

• Standard deductibles (ranging from $250 for the 94 percent silver cost-sharing option to $3,500 for the standard silver plan to $6,650 for the bronze plan)

• Deductible-free services (for the silver level plan, including urgent care, primary care visits, specialist visits, and drugs)

• Only one in-network provider tier

• Four-tier drug formularies

• A preference for copayments over coinsurance
Network adequacy standards
The final rules adopt some, but not all, of the proposed network adequacy requirements. While FFM itself will generally apply quantitative time and distance standards to access health care providers, the final regulations decline to require states to adopt such standards for 2017 or impose federal default rules in states that fail to do so.

Out-of-network bills at in-network facilities
The final regulations delayed the proposed requirement that insurers must apply the in-network cost sharing limit to the cost of services provided by out-of-network providers at an in-network facility until 2018. In addition, this requirement only applies to ancillary providers (such as anesthesiologists or radiologists), can be avoided by giving advance notice at the time of prior authorization that treatment might be received from out-of-network providers, and does not apply to balance bills.

“Vertical choice” option allowed in FF-SHOPs
In addition to allowing employers under the Federally Facilitated—Small Employer Health Options Program (FF-SHOP) to either offer its employees a single qualified health plan option or a choice of plans within a given metal tier (bronze, silver, gold, or platinum), the final rule allows FF-SHOPs to offer a “vertical choice” option, where employees can choose a plan at any actuarial level offered by a single carrier. However, states have the flexibility to recommend against the FF-SHOP offering the vertical choice in their state and states with SBM-FPs can completely opt out from making vertical choice available.

U.S. Supreme Court upholds ERISA preemption of state health data collection law

In brief:

- U.S. Supreme Court decides in the Gobeille case that federal ERISA law preempts a state law requiring insurance carriers and self-insured plans to report detailed health care claims information to a state agency.
- Therefore, the state health care data collection law does not apply to employer-sponsored plans governed by ERISA.

On March 1, 2016, the U.S. Supreme Court upheld the Second Circuit’s decision in Gobeille v. Liberty Mutual Insurance Company, ruling 6-2 that a Vermont healthcare data collection law is preempted by the federal Employee Retirement Income Security Act of 1974 (ERISA).

Vermont is among several states that have sought to establish an “all-payer claims database” as a healthcare cost containment strategy, consisting of information about health care utilization, costs and resources within the state. To that end, Vermont enacted a state law requiring health insurers, self-insured plans, and third-party administrators to periodically submit data on members, subscribers, and policyholders relating to health care costs, prices, quality, and utilization, in accordance with specific formatting requirements.

Liberty Mutual Insurance Company filed a lawsuit, claiming the Vermont law is preempted by ERISA and therefore unenforceable against its self-insured health plan, which covers over 80,000 individuals in all 50 states. The District Court for the District of Vermont sided with the state of Vermont, but on appeal, the Court of Appeals for the Second Circuit reversed and sided with Liberty Mutual.

The U.S. Supreme Court agreed with the Second Circuit, finding that “the state statute imposes duties that are inconsistent with the central design of ERISA, which is to provide a single uniform national scheme for the administration of ERISA plans without interference from
laws of the several States even when those laws, to a large extent, impose parallel requirements.”

The Supreme Court noted that reporting, disclosure, and recordkeeping are an integral part of this uniform system of plan administration contemplated by ERISA. It concluded that ERISA preemption protects employer-sponsored plans from having to comply with each individual state’s unique, inconsistent and potentially burdensome reporting requirements. The court also noted that the U.S. Secretary of Labor, not the states, has the authority to dictate the reporting requirements of ERISA plans – possibly even to require the reporting of data similar to that being requested by Vermont.

Medicare sent our company a letter about a “Data Match Questionnaire” relating to company employees and its health plan – what is this about and what should we do?

In brief:

- The purpose of the CMS Data Match program is to identify situations where another payer may be primary to Medicare.
- Employers may be required to complete a questionnaire that requests group health plan information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary.
- Employers that fail to comply with CMS’s request for information can be subject to adverse consequences, including penalties, legal action, and excise taxes.

In 1989, Congress enacted legislation to provide the Center for Medicare & Medicaid Services (CMS) with better information about the group health plan coverage of Medicare beneficiaries. Section 6202 of the Omnibus Budget Reconciliation Act of 1989 requires the Internal Revenue Service (IRS), the Social Security Administration (SSA), and CMS to share information that each agency has about whether Medicare beneficiaries or their spouses are working. The process for sharing this information is called the IRS-SSA-CMS Data Match and the purpose is to identify situations where another payer may be primary to Medicare.

Employers may be required to complete an online questionnaire that requests group health plan information on identified workers who are either entitled to Medicare or married to a Medicare beneficiary. In most situations, for individuals covered under both an employer plan and Medicare, the employer plan should pay primary, with Medicare paying secondary. The questionnaire information is used to identify the primary and secondary payers for medical services provided to a Medicare beneficiary. This process helps Medicare identify claims on an ongoing basis for which Medicare should not be the primary payer.

The questionnaire asks, among other things, whether each identified individual worked during a specified time period and, if so, whether he or she had employer-sponsored group health coverage. It also asks for a list of the groups health plans under which such individuals have or had coverage during the specified time period. A detailed instruction booklet with sample filled-in responses is available to assist employers in completing the Data Match Questionnaire.

Employers must complete the Data Match Questionnaire within 30 days, unless an extension has been requested and approved. Employers that fail to comply with CMS’s request for information can be subject to adverse consequences, including:

- civil monetary penalties of $1,000 for each person for whom the employer has neither responded to nor has provided incomplete information;
- subpoenas of business records and members of the organization; and
- an investigation of the employer’s group health plan for a determination of nonconformance, which may result in a referral to the IRS for imposition of an excise tax on the employer.

Employers interested in pursuing an extension should contact the Benefits Coordination & Recovery Center (BCRC) of CMS to request a 30-day extension. Requests for extensions beyond 60 days (the original 30 days and
one 30-day extension) generally are not granted to any employer that is reporting on fewer than 150 workers. Extensions will be reviewed on a case-by-case basis for those employers reporting on more than 150 workers. Requests for extensions beyond the 60-day period must be submitted by letter detailing the reasons and sent to:

IRS/SSA/CMS Data Match Project  
P.O. Box 660  
New York, NY 10274-0660

The Data Match process is not new. CMS has been sending out questionnaires in batches from time to time for many years. According to CMS, the Data Match Project has saved Medicare more than $3.5 billion to date.

An employer that receives a Data Match questionnaire may designate an authorized representative to complete the questionnaire on its behalf. A self-insured employer may want to contact its third-party administrator to see if it is willing to provide this service, although there may be an additional fee for doing so.

Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) added mandatory reporting requirements for group health plans and for non-group health plan arrangements (liability insurance including self-insurance, no-fault insurance, and workers’ compensation). These requirements took effect in 2009 and require insurers for group health plans, or in the case of self-insured plans, TPAs, to provide specified information to CMS for individuals who may be eligible for Medicare. If a group health plan is self-insured and self-administered, the reporting requirement falls on the plan administrator or plan fiduciary. CMS has indicated that if the mandatory reporting program is successful, it will consider requesting Congress to eliminate current employer responsibilities under the IRS/SSA/Data Match program.

CMS extends transition relief for small group and individual health insurance

In brief:

• Some ACA market reform standards do not apply to small group and individual health insurance policies, under transition relief that has been in effect since 2014.

• CMS announced an extension of this transition relief to policy years beginning on or before October 1, 2017; however, all insurance policies subject to transition relief must end by December 31, 2017.

• States may elect to limit the transition relief to a shorter period, and may also exclude the small group and/or individual market from the extended transition relief.

The Centers for Medicare and Medicaid Services (CMS) recently announced an extension of the transition relief currently in effect for certain non-grandfathered small group and individual health insurance policies. The transition relief operates as an exemption from some of the market reform standards of the Affordable Care Act that were otherwise required to be adopted back in 2014, such as guaranteed renewability of coverage and participation in approved clinical trials.

According to the CMS announcement issued February 29, 2016, this transition relief is being extended to policy years beginning on or before October 1, 2017. However, all insurance policies that are subject to transition relief must end by December 31, 2017. States may elect to limit the transition relief to a shorter period (but not a longer one). States may also apply the extended transition relief to both the small group and individual markets, to the small group market only, or to the individual market only.

The transition relief does not apply to insurance policies in the large group market (i.e., employers with more than 50 or 100 employees, depending on the state), to self-insured plans, or to grandfathered plans. Transition
relief also does not apply to all of the ACA market reform standards. For example, policies subject to transition relief are still not permitted to have a lifetime and/or annual dollar limit on essential health benefits.

For more details about transition relief from the ACA market reform standards, refer to the April 2014 and December 2013 Employee Benefits Compliance Updates.

**DOL releases final SBC template and related materials**

In our March 2016 Benefits Compliance Update, we discussed the Department of Labor's proposed revisions to the Summary of Benefits and Coverage (“SBC”) and related materials, pursuant to final guidance issued in June 2015. Since that Update was released, the agencies issued the final revised SBC template and related materials. Use of the new materials will be required starting with the first day of the first open enrollment period that begins on or after April 1, 2017, with respect to coverage for plan years beginning on or after that date.

**In brief:**

- Beginning January 1, 2016, during an employee's leave under the Oregon Family Leave Act (OFLA), the employer must maintain the employee's coverage under the group health plan on the same conditions as if the employee was continuously employed.
- This change aligns the OFLA with the federal Family and Medical Leave Act (FMLA) with respect to continuation of coverage requirements.

**Background**

The Oregon Family Leave Act (OFLA), effective since 1995, applies to employers with 25 or more employees in Oregon during each working day of 20 or more calendar workweeks in the year in which the leave will be taken or in the preceding year. Such employers must provide their workers with job protected leave to care for themselves or family members in cases of illness, injury, childbirth, bereavement, and adoption.

An employee must be returned to his or her former position after OFLA leave, even if the position has been filled during the leave. If the position held by the employee at the time the OFLA leave began has been eliminated, the employer must restore the employee to any available, equivalent position.

**OFLA Amendment**

Effective January 1, 2016, Oregon Administrative Rule 839-009-0270 amended the OFLA by prohibiting an employer from cancelling an employee’s insurance while the employee is on OFLA protected leave. Under the new rule, employees continue to be responsible for paying their portion of health insurance premium payments while on OFLA protected leave.
If an employee on leave cannot or will not pay the cost:

- The employer may elect to discontinue benefits, unless to do so would prevent the employer from later restoring the employee to full benefit coverage. If an employer pays any part of the employee’s share of health insurance premiums while the employee is on OFLA leave, it may deduct up to 10 percent of the employee’s gross pay each pay period after the employee returns to work until the amount is repaid.

- If the employee fails to return to work, unless due to a serious health condition or other circumstances beyond the employee’s control, the employer may recover the employee’s share of benefits paid by the employer by any legal means, including a deduction from the employee’s final paycheck.

- If coverage lapses because an employee has not made required premium payments, upon the employee’s return from OFLA leave the employer still must restore the employee to coverage/benefits equivalent to those the employee would have had if leave had not been taken and the premium payment(s) had not been missed, including family or dependent coverage.

How can we help?

To learn more about current benefits compliance issues, please visit us online or contact your local Wells Fargo Insurance Services representative.