CBP
creative benefit plans

2016: Second Quarter

Compliance Digest

Compliance Bulletins Released April-June

2016 Compliance Bulletins

April

May

June

New York Small Group Market Update

Published: April 8, 2016

Prior to the enactment of the Affordable Care Act ("ACA"), New York Insurance Law Section 3231 classified an employer in the small group market if the employer had between 1-50 employees. However, with the enacted ACA, the federal definition of small employer and in effect, small group, changed from 1-50 to 1-100. The new definition of small employer would go into effect January 1, 2016.

Federal Agencies provided a number of transitional policies, which could be adopted by states to delay the application of the new federal definition of small employer, which would affect the definition of small group. New York was one of the few states that refused to adopt any transitional policies. Instead, in April 2015, New York opted to amend the New York Insurance Law, Section 3231, to permanently change the definition of small employer from 1-50 to 1-100. At the time, New York legislators were aligning the New York definition of small group with the federal definition of small employer.

However, in October 2015, Congress signed into law the Protecting Affordable Coverage for Employees Act ("PACE Act"), which would amend the federal definition of small employer from 1-100 back to 1-50, effective January 1, 2016. While many employers exhaled a sigh of relief, employers in the State of New York must still cope with the expanded New York small group definition, which includes employers with 1-100 employees.

Implications – Small vs. Large

Employers in the small group market are limited in plan design, administration, and cost. Under the ACA, an employer in the small group market may see premium rates vary based on only four categories:

1. coverage category;
2. rating area;
3. age; and
4. tobacco use.

A small group may not experience rate variations for any factor other than the four identified. In addition, an employer in the small group market is required to offer an Essential Health Benefits Package, which includes:

1. essential health benefits;

2. limited cost sharing; and

3. bronze, silver, gold, or platinum level coverage of the full actuarial benefits provided under the plan.

New York State Specific Provisions

Under New York State Insurance Law, an employer in the small group market is limited from self-insuring. Specifically, an employer may not purchase stop loss and may not receive administrative service from any carrier licensed in the State of New York. As a result, an employer that falls in the small group market in New York may self-insure without stop loss and by self-administering the plan. Finally, any group medical or group hospital insurance coverage obtained from an out-of-state trust covering between 1-50 employees, covering 1-100 employees (beginning 2016), or covering participating persons who are residents of New York, must be community rated regardless of the situs or delivery of the policy.

New York's Pending Change in Definition

New York is one of four states (the others are California, Colorado and Vermont) that maintain an expanded small group definition (1-100 employees). The imminent change of the law is unknown. However, there have been two recent efforts to effectuate a change to the New York state definition of small group:

- In January 2016, Bill No. A01154 was introduced. The Bill would amend the definition of small group market in the State of New York. However, since January, the Bill remains referred to Insurance.

- In March 2016, Bill No. S07104 was introduced. The Bill would also amend the definition of small group market in the State of New York. The Bill has also been referred to Insurance.

Both Bills are at the infant stages. We will continue to keep you apprised of this situation.

HIPAA Audits to Increase in 2016

Published: April 18, 2016

On March 21, 2016, Health and Human Service's Office for Civil Rights ("OCR") announced the launch of the second round of national HIPAA audits. These audits are focused on covered entities (health plans and health care providers) and business associates (e.g., brokers, TPAs). The audits will target enforcement of HIPAA Privacy, Security and Breach Notification rules. OCR plans to conduct desk and onsite audits for both covered entities and their business associates. The first set of audits will be desk audits of covered entities followed by a second round of desk audits of business associates. OCR intends to complete desk audits by the end of December 2016.

Importantly, OCR has indicated that the audit process will begin via email inquiry to a covered entity or business associate, and that some email systems may classify HHS' inquiry as spam:

> Communications from OCR will be sent via email and may be incorrectly classified as spam. If your entity's spam filtering and virus protection are automatically enabled, we expect you to check your junk or spam email folder for emails from OCR; OSOCRAudit@hhs.gov.
>
> Click here to view a sample email letter: http://www.hhs.gov/sites/default/files/ocr-address-verification-email.pdf
>
> http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/index.html

Why is OCR Conducting Audits?

As part of the HIPAA HITECH legislation passed in 2009, Congress tasked OCR to begin compliance enforcement of HIPAA's regulatory requirements. OCR began the first phase of the audit program (known as the "audit pilot program") in 2012. The limited number of audits conducted in that round were deemed to be a success, and after securing a $4 million increase in funding from Congress for fiscal year 2016, OCR announced phase two will begin effective March 21, 2016.

Who does this Impact?

HIPAA Privacy and Security applies to insured and self-funded group health plans (includes HRAs and health FSAs).

What does HIPAA Privacy and Security Require?

HIPAA regulations impose significant compliance obligations on covered entities. These include:

- Maintaining plan documents – updated for final rules issued in 2013
- Implementing HIPAA Privacy and Security policies and procedures and administrative safeguards – electronic and physical protection of protected health information ("PHI")
- Establishing procedures to (1) facilitate early detections of potential breaches of unsecured PHI and (2) upon the occurrence of an unauthorized use/disclosure of unsecured PHI have procedures in place to conduct appropriate risk analysis.

- Maintaining Business Associate Agreements ("BAAs") -- the covered entity should have a signed BAA between the plan and any service provider that handles PHI, such as brokers/consultants, TPAs, COBRA vendors, certain payroll vendors, accountants, law firms, etc.
- Distributing the Notice of Privacy Notice (self-funded plans only)
- Conducting regular Security risk assessments
- Complying with tracking and communication requirements of participant requests for PHI
- Conducting training for members of a workforce who handle PHI

Importantly, the OCR audits will cover only federal HIPAA Privacy, Security and Breach Notification rules. No state- or city-specific privacy rules will be included.

What are the Penalties?

According to OCR, the audits are meant to help improve HIPAA compliance, although serious compliance issues could prompt further investigation. HIPAA imposes significant non-compliance penalties on covered entities. Penalties can range from $100 per violation up to $50,000 per violation (in the case of willful neglect), with an annual maximum of $1,500,000 per violation.

What to Do?

Upon notification of an audit, OCR will provide covered entities 10 business days to demonstrate they are following HIPAA Privacy and Security rules.

Covered entities should review their HIPAA policies, procedures, notices and documents now to ensure they are updated for HIPAA HITECH and the final HIPAA omnibus rules. In addition, covered entities should ensure up-to-date business associate agreements have been signed with any service providers with access to PHI.

New York Paid Family Leave and Minimum Wage Increase

Published: April 18, 2016

On April 1, 2016, Governor Cuomo signed legislation as part of the state budget, which among other things, establishes Paid Family Leave and increases the Minimum Wage.

Paid Family Leave

New York has adopted the most expansive paid family leave policy in the nation. When fully phased in, employees will be eligible for 12 weeks of paid family leave when caring for an infant, a family member with a serious health condition or to relieve family pressures when someone is called to active military service.

The Paid Family Leave Act (the "Act") applies to all private sector employers of one or more employees and guarantees 12 weeks of paid leave, which would be funded by employees through payroll contributions. It is important to note that employers would not be required to make any contributions. Beginning in 2018, an employee will be able to receive benefits at 50% of the average statewide weekly wage for 8 weeks. By 2021, an employee will receive 67% of his/her average weekly wages for 12 weeks, capped at 67% of the average statewide weekly wage (for 2015, the New York State Average Weekly Wage was approximately $1,296.48).

While federal law permits unpaid leave, up to 12 weeks, it is often difficult for an employee to take advantage of the leave – many employees are unable to afford extended periods without wages. New York joins three other states that offer similar benefits for a maximum period of 6 weeks – New Jersey, California, and Rhode Island.

Minimum Wage

Under the state budget, the Governor approved a historic increase in the minimum wage to $15 per hour, up from $9 per hour. The minimum wage increase will be gradual and will reach full effect by 2021. The minimum wage increase will be applied as follows:

- For workers in New York City employed by large businesses (those with at least 11 employees), the minimum wage would rise to $11 at the end of 2016, then another $2 each year after, reaching $15 on 12/31/2018.

- For workers in New York City employed by small businesses (those with 10 employees or fewer), the minimum wage would rise to $10.50 by the end of 2016, then another $1.50 each year after, reaching $15 on 12/31/2019.

- For workers in Nassau, Suffolk and Westchester Counties, the minimum wage would increase to $10 at the end of 2016, then $1 each year after, reaching $15 on 12/31/2021.

- For workers in the rest of the state, the minimum wage would increase to $9.70 at the end of 2016, then another .70 each year after until reaching $12.50 on 12/31/2020 – after which will continue to increase to $15 on an indexed schedule to be set by the Director of the Division of Budget in consultation with the Department of Labor.

The Bill also provides that "food service workers" receiving tips shall receive a "cash wage" of at least 2/3 of the minimum wage rounded to the nearest .05 cents or $7.50, whichever is higher. The cash wage and the tips must equal the minimum wage in effect.

Finally, the Bill provides that beginning on January 1, 2019 and each year thereafter, the Division of Budget is required to conduct an analysis of the effect of the wage increase and determine if a temporary suspension is necessary.

Sick Pay Laws to Date

Published: April 21, 2016

States are free to draft sick pay laws that uniquely and diversely affect employers. Current sick pay laws may have common characteristics, but varied application. To date, there are six States and twenty municipalities with sick pay laws. In addition, the President signed Executive Order 13706, which requires entities contracting with the Federal government to provide employees with up to seven days of paid sick leave annually. The result is a hodgepodge of regulation that creates burdensome administration and increased expense for employers.

New Jersey

In 2014, Senate Bill 785 was introduced to mandate sick leave for employees. Bill 785 was amended various times, but never passed. It was re-introduced as Bill 799 on January 12, 2016. Since January the Bill has been amended, but has not yet passed. While Bills 785 and 799 have been contested and criticized for requiring sick leave State-wide, ten (10) municipalities within the State of New Jersey have passed sick pay laws applicable to each municipality.

The ten municipalities are Bloomfield, NJ; East Orange, NJ; Elizabeth, NJ, Irvington, NJ, Jersey City, NJ, Newark, NJ, Passaic, NJ, Paterson, NJ, Trenton, NJ, and Montclair, NJ.

The sick pay laws of these municipalities apply to all private employers and exclude federal and state employers and members of a union that have enrolled or graduated from a registered apprenticeship program covered by a Collective Bargaining Agreement ("CBA"). The municipalities provide up to 40 hours of sick leave annually. An employee is permitted to use sick leave earned after 90 days of employment for medical diagnosis, care, and/or treatment of their own or their family member. Accrual provisions apply as follows:

Specific Requirements of Municipalities – New Jersey		
Employer Size	**Accrual**	**Not to Exceed**
10+ Employees	1 hour of paid sick time for every 30 hours worked	40 hours per year
< 10 Employees	1 hour of paid sick time for every 30 hours worked	24 hours per year
Child Care Worker, Home Health Care Worker, Food Service Worker (Regardless of Hours Worked)	1 hour of paid sick time for every 30 hours worked	40 hours per year

Employers must provide advance notice to employees of the sick leave provisions applicable to each municipality. In addition, employers with a Paid Time Off ("PTO") policy may continue to use the policy so long as the accrual meets the municipal requirements.

New York City

In March 2014, Mayor de Blasio signed the New York City Earned Sick Time Act ("ESTA"), which mandates sick pay for employees of private employers and excludes employees of federal and state governments. In addition, any employee covered by a Collective Bargaining Agreement ("CBA") in effect on April 1, 2014 will be covered by ESTA beginning the date the CBA terminates.

ESTA applies to employees working in the City of New York, even if the employee lives in another State or if the employer is headquartered in another State. Any employer with five or more employees, working 80 or more hours a year, must provide paid sick leave. Employers with less than five employees must provide unpaid sick pay leave. Finally, any employer with one or more domestic workers who have worked for the employer for at least a year and who work more than 80 hours a calendar year must provide paid sick leave.

ESTA provides that an employee can accrue up to 40 hours of sick leave during a calendar year or 1 hour for every 30 hours worked. Once sick leave is earned, the employee may begin to use sick leave after 120 days of employment. ESTA permits a maximum carryover of 40 hours per year, available for immediate use.

Employers must also comply with additional recordkeeping and disclosure requirements, including:

Employer must have a written policy outlining the sick leave policy;

Any advance requirement for sick leave must be outlined in a sick leave policy;

Employer must distribute the sick leave policy to employees either by hand-delivery, mail, e-mail, or by posting the notice in a publicly accessible and visible place;

Additional documents to be distributed with Sick Leave Policy: 1) Employer's Calendar Year; 2) Right to be Free from Retaliation; and 3) Right to File a Complaint.

An employer may not ask the employee the reason for the leave, but may request 1) a doctor's note; 2) date of clearance to return to work; 3) certification of sick leave use. Finally, employers must keep records that show the leave provided, the leave requested, and any substantiation provided by employees.

Other States with Sick Pay Laws

As previously mentioned, six other States have sick pay laws, which provide for varied accruals sick leave accruals and maximum caps.

The six States are: 1) California; 2) Connecticut; 3) District of Columbia; 4) Massachusetts; 5) Oregon; and 6) Vermont. The requirements can be summarized as follows:

Other States with Sick Pay Laws

State	Eligibility	Accrual	Not to Exceed
California	EE must work 30+ days Covered after 90 days of employment	1 hour of paid sick time for every 30 hours worked	6 days / 48 hours Cannot take more than 3 days / 24 hours annually
Connecticut	Covers service workers for ERs with 50+ employees Required 680 hours of employment		5 days / 40 hours
District of Columbia	After 90 days of employment	1 hour of paid sick time for every 37 hours worked (ERs with 100+ EEs)	7 days / 56 hours (ERs with 100+ EEs)
Massachusetts	Covered after 90 days of employment ERs with 10 or less EEs have to provide unpaid sick leave		5 days / 40 hours
Oregon	Covered after 90 days of employment ERs with less than 10 EEs only have to provide unpaid sick leave	1 hour of paid sick time for every 30 hours worked **-OR-** 1.5 hour of paid sick time for every 40 hours worked	5 days / 40 hours
Vermont	EEs working at least 18 hours per week during the year	1 hour of paid sick time for every 52 hours worked	3 days/24 hours annually until 12/31/2018 5 days/40 hours annually for subsequent years
Municipalities	Emeryville, CA Oakland, CA San Francisco, CA Montgomery County, MD Philadelphia, PA Pittsburgh, PA Seattle, WA Spokane, WA Tacoma, WA	Varied	Varied

2017 Inflation Adjusted Amounts for HSAs

Published: May 5, 2016

The IRS released the inflation adjustments for health savings accounts (HSAs) and their accompanying high deductible health plans (HDHPs) effective for calendar year 2017. Most limits remained the same as 2016 amounts.

Annual Contribution Limitation

For calendar year 2017, the maximum contribution permitted to an HSA for an individual with self-only coverage under a high deductible health plan is $3,400 (up $50 from 2016). For calendar year 2017, the maximum contribution permitted to an HSA for an individual with family coverage under a high deductible health plan is $6,750 (no change from 2016).

High Deductible Health Plan

For calendar year 2017, a "high deductible health plan" is defined as a health plan with an annual deductible that is not less than $1,300 for self-only coverage or $2,600 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $6,550 for self-only coverage or $13,100 for family coverage.

Non-calendar year plans: In cases where the HDHP renewal date is after the beginning of the calendar year (i.e., a fiscal year HDHP), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date.

Catch-Up Contribution

Individuals who are age 55 or older and covered by a qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined by the statute, is $1,000 for 2009 and thereafter.

Final SBC Template and Related Materials Issued

Published: May 6, 2016

On April 6, 2016, the Departments of Labor (“DOL”), the Internal Revenue Service (“IRS”), and Health and Human Services (“HHS”) (collectively, “the Departments”) announced the final version of the new Summary of Benefits and Coverage (“SBC”) template and associated documents.

Health plans are required to use the April 2017 edition of the SBC template and associated documents beginning on 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.

Highlights of Changes

- The April 2017 template is five pages (two and one-half double-sided pages) compared to the current six page version.
- In the coverage examples on the template, the cost-sharing language is more specific when copayments and coinsurance are applied to coverage.
- The description of an embedded deductible has been clarified.
- Each of the terms in the uniform glossary of terms has an independent web link so the key terms in electronic versions of the SBC can be linked directly to their definitions.
- Coverage example calculators and their instructions have been updated.

Employer Action

Employers should continue to comply with the current rules and be ready to apply the new rules beginning April 2017.

- Employers with insured plans should make sure that the carrier is using the appropriate SBC template version.

- Employers with self-funded plans should make sure that they are using the correct SBC template version. If working with a TPA to develop the SBC, ensure the TPA is using the correct SBC.

Further Information

For the SBC regulations and templates on the DOL's EBSA website, see "Templates, Instructions, and Related Materials – Currently Applicable" v. "Templates, Instructions, and Related Materials – for use on or after 04/01/17 (Final)" at:

http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html.

For the SBC materials and supporting documents on the HHS website, see "SBC Materials and Supporting Documents (Authorized for use on and after April 1, 2017)" v. "SBC Materials and Supporting Documents (Authorized for use prior to April 1, 2017)" at:

https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Summary%20of%20Benefits%20and%20Coverage%20and%20Uniform%20Glossary.

Departments Issue 31st Set of FAQs

Published: June 3, 2016

The Departments of Labor, the Treasury, and Health and Human Services (collectively, the "Departments") have issued the 31st set of Affordable Care Act ("ACA") frequently asked questions ("FAQs"). This time, the Departments address a wide range of topics including preventive services, disclosure obligations, coverage in connection with approved clinical trials, reference-based pricing, the Mental Health Parity and Addiction Equity Act, and the Women's Health and Cancer Rights Act. Below is a brief summary of the guidance issued on these topics.

Preventive Care

All non-grandfathered group health plans must cover certain mandated preventive items and services in-network without cost-sharing.

- **Colonoscopy.** Colorectal cancer screening for adults over age 50 is a mandated preventive care service. This includes required preparation as an integral part of the procedure.

  FAQ 31 clarifies that bowel preparation medications are required to be covered without cost-sharing.

- **Contraceptives.** Plans that use reasonable medical management techniques ("MMTs") to control costs and promote efficient delivery of contraceptives (e.g., cover generic drugs without cost sharing and impose a copay for equivalent branded drugs) must have an exception process and the plan must defer to the determination of the attending provider.

  FAQ 31 suggests that the Medicare Part D Coverage Determination Request Form 3 can serve as a model notice for the exceptions process.

Out-of-Network Emergency Services

Non-grandfathered group health plans cannot impose cost-sharing on out-of-network emergency services (expressed as a copayment or coinsurance rate) in a greater amount than what is imposed for in-network emergency services. A plan must pay a "reasonable amount" before a patient is responsible for any balance billing.

FAQ 31 explains that a plan must disclose how it calculated the reasonable amount as a part of its ERISA plan documents and claims and appeals procedures.

Clinical Trials

Non-grandfathered group health plans may not deny a qualified individual from participating in an approved clinical trial with respect to the prevention, detection or treatment of cancer and certain life-threatening illnesses, including routine patient costs in connection with such participation.

The Departments believe this provision is self-implementing. Unless and until further guidance is issued, plans are expected to implement these requirements using a good faith, reasonable interpretation of the law.

FAQ 31 provides additional guidance with the following clarifications:

- A plan cannot deny (or limit or impose additional conditions on) the coverage of such item or service on the basis that it is furnished in connection with participation in an approved clinical trial such as a clinical trial for an anti-nausea medication.

- Routine patient costs include items and services to diagnose or treat complications or adverse events (e.g., side effects) arising from participation in an approved clinical trial and must be covered.

Referenced-based Pricing

Non-grandfathered health plans are required to ensure that any annual cost-sharing imposed with respect to essential health benefits is limited to the annual maximum out-of-pocket ("MOOP") limit (for 2016, $6,850 for self-only coverage and $13,700 for other than self-only coverage).

As previously announced, the Departments are concerned with a reference-based pricing structure (or similar network design) because such a pricing structure could be a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and an adequate network of providers. The Department outlined specific factors that will be considered whether evaluating whether a reference-based pricing program (or other similar design) is using a reasonable method to ensure adequate access to quality providers. These factors are restated in the appendix for reference.

Per FAQ 31, a plan that merely establishes a reference price without using a reasonable method to ensure adequate access to quality providers at the reference price will not be considered to have established a network. If there is not adequate access to quality providers willing to accept the price as payment in full, the plan is required to count an individual's out-of-pocket expenses for the provider who did not accept the reference price toward the MOOP limit.

Mental Health Parity and Addiction Equity Act ("MHPAEA")

MHPAEA applies to:

- Employers with at least 51 employees offering group health plan coverage that includes any mental health and/or substance use disorder ("MH/SUD" benefits)

- Non-grandfathered insured small group and individual health plans, as MH/SUD is considered an essential health benefit.

With respect to MHPAEA, the FAQs provide the following clarifications.

1. **Plan-specific data must be used when running the substantially all and predominant tests.** The financial requirements and treatment limitations imposed on MH/SUD benefits cannot be more restrictive than the predominant financial

requirements and treatment limitations that apply to substantially all medical and surgical benefits. The regulations outline specific requirements to demonstrate compliance with these requirements and permit "any reasonable method" to be used to determine the dollar amount of all plan payments under these tests.

In performing the substantially all and predominant tests, it is not reasonable to base the analysis on a carrier's (or TPA's) entire book of business. Rather, to the extent group health plan-specific data is available, each self-funded group health plan must use such data. For fully-insured group health plans, the issuer should use group health plan-specific data to make projections, or if none, then data from other similarly-structured group health plans with similar demographics.

2. **Disclosure requirements.** A plan administrator or issuer must disclose the criteria for medical necessity determinations with respect to MH/SUD benefits upon request and the reason for denial of reimbursement or payment for services. Such disclosure must be made to any current or potential participant, beneficiary, or contracting provider and must include the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits.

   FAQ 31 clarifies that, upon request, a group health plan must make available to any current or potential enrollee or contracting provider the criteria for medical necessity determinations.

   Additionally, a provider acting as a plan participant's authorized representative can request the following documents with respect to the plan's compliance with MHPAEA:

   - The summary plan description ("SPD") or other summary information;
   - The specific plan language regarding the imposition of the nonquantitative treatment limitation ("NQTL") (i.e., preauthorization requirement);
   - The specific underlying processes, strategies, evidentiary standards, and other factors considered by the plan in determining that the NQTL would apply to this particular MH/SUD benefit;
   - Information regarding the application of the NQTL to any medical/surgical benefits;
   - The specific underlying processes, strategies, evidentiary standards, and other factors considered by the plan in determining the extent to which the NQTL would apply to any medical/surgical benefits within the classification; and
   - Any analysis performed by the plan as to how the NQTL complies with MHPAEA.

3. **MHPAEA applies to opioid use disorder benefits.** Group health plans that offer any medication assisted treatment ("MAT") benefits for opioid use disorder must comply with MHPAEA, including the special rule for multi-tiered prescription drug benefits. The behavioral health services component of MAT should be treated as outpatient and/or inpatient benefits as appropriate.

Women's Health and Cancer Rights Act (WHCRA)

WHCRA provides protection for individuals who elect breast reconstruction in connection with a mastectomy. If a group health plan covers mastectomies, it must provide coverage for certain services in a manner determined in consultation with the attending physician.

FAQ 31 clarifies that such coverage must be provided for all stages of breast reconstruction, including coverage for nipple and areola reconstruction and repigmentation. Plans may impose deductibles and coinsurance for these benefits if consistent with those established for other benefits.

Appendix

The 31st set of ACA FAQs specifies the following factors will be considered as to whether the reference-based price structure (or similar network design) is a reasonable method:

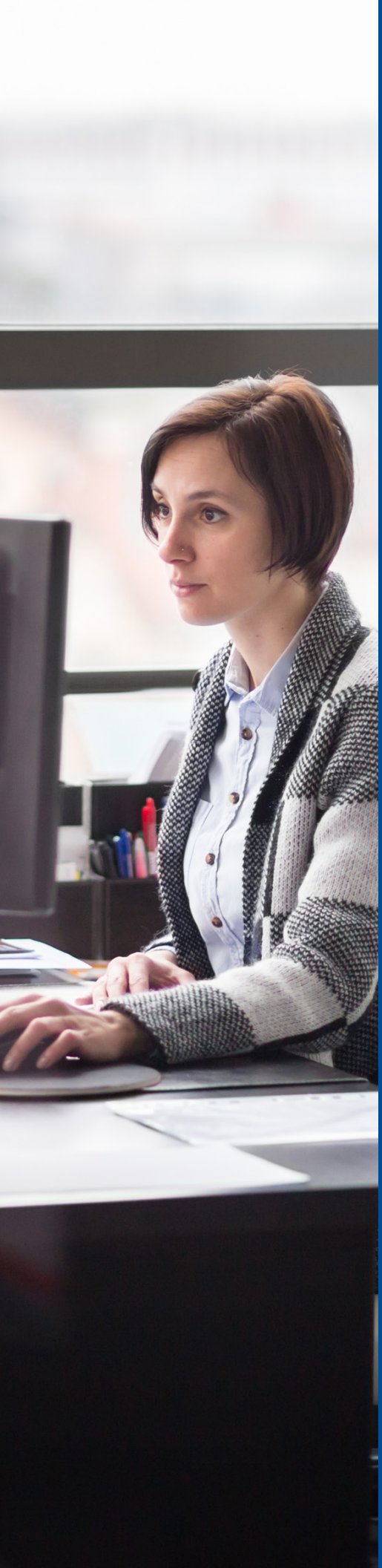
1. **Type of service.** Plans should have standards to ensure that the network is designed to enable the plan to offer benefits for services from high-quality providers at reduced costs. For this purpose:
   a. In general, reference-based pricing should apply only to those services for which the period between identification of the need for care and provision of the care is long enough for consumers to make an informed choice of provider.
   b. Limiting or excluding cost-sharing from counting toward the Maximum Out-of-Pocket ("MOOP") is not reasonable with respect to emergency services.

2. **Reasonable access.** Plans should have procedures to ensure that an adequate number of providers that accept the reference price are available to participants and beneficiaries.

3. **Quality standards.** Plans should have procedures to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.

4. **Exceptions process.** Plans should have an easily accessible exceptions process, allowing services rendered by providers that do not accept the reference price to be treated as if the services were provided by a provider that accepts the reference price if:
   a. Access to a provider that accepts the reference price is unavailable (for example, the service cannot be obtained within a reasonable wait time or travel distance).
   b. The quality of services with respect to a particular individual could be compromised with the reference price provider (for example, if co-morbidities present complications or patient safety issues).

5. **Disclosure.** Plans should provide the following disclosures regarding reference-based pricing (or similar network design) to plan participants free of charge.
   a. Automatically. Plans should provide information regarding the pricing structure, including a list of services to which the pricing structure applies and the exceptions process. (This should be provided automatically, without the need for the participant to request such information, for example through the plan's Summary Plan Description or similar document.)
   b. Upon Request. Plans should provide:
      i. A list of providers that will accept the reference price for each service;
      ii. A list of providers that will accept a negotiated price above the reference price for each service; and
      iii. Information on the process and underlying data used to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.



Checking Your Employee Handbook for Benefit Provisions

Published: June 6, 2016

Handbooks are important for many reasons such as informing employees of their rights and duties, communicating available resources, and outlining paid time off policies. With respect to health and welfare benefits, here are a few things to consider:

Q1: Does your handbook go too far?

Handbooks cannot change the terms of governing benefit documents such as summary plan descriptions ("SPDs"). Handbook provisions should mirror plan terms and/or refer to plan documents. Any provisions purporting to amend plan documents are ineffective.

However, handbooks may fill in the blanks where the plan documents are silent or refer to outside policies. For example, an SPD may indicate that certain eligibility criteria is determined by the employer. In this case, that criteria may be explained elsewhere such as a handbook or benefit booklet.

Q2: Are all handbook provisions current?

A handbook should reflect current, compliant provisions such as those addressing benefits, eligibility, and termination.

Does your handbook exclude certain employee groups from benefits (e.g., temporary employees or interns)? If so, be aware of potential exposure under the Employer Penalty which defines a "full-time employee" as any employee who works at least 30 hours per week. There are no exclusions of categories of employees. However, if using the look back measurement method, part-time employees, seasonal employees, and variable hour employees can be asked to wait up to 13+ months to determine full-time employee status without penalty.

- Does the handbook contain an outdated waiting period (e.g., indicating that plan entry is the first day of the month following 90 days of continuous service)?

- A handbook should reflect current, compliant provisions such as those addressing benefits, eligibility, and termination.

- Does your handbook exclude certain employee groups from benefits (e.g., temporary employees or interns)? If so, be aware of potential exposure under the Employer Penalty which defines a "full-time employee" as any employee who works at least 30 hours per week. There are no exclusions of categories of employees. However, if using the look back measurement method, part-time employees, seasonal employees, and variable hour employees can be asked to wait up to 13+ months to determine full-time employee status without penalty.

- Does the handbook contain an outdated waiting period (e.g., indicating that plan entry is the first day of the month following 90 days of continuous service)?

- Does the handbook contain conflicting eligibility terms? For example, does the handbook indicate that an employee must work at least 40 hours per week to be eligible for benefits when an employee must only work at least 30 hours per week?

- If the look back measurement method rules are being used, are those referenced or outlined?

- Does the handbook indicate that same-sex spouses are excluded from benefit eligibility? Excluding same-sex spouses is not advisable due to recent court cases and EEOC discrimination inquiries and likely conflicts with plan terms. It may also conflict with the company anti-discrimination workplace policy.

Q3: Does the handbook demonstrate that an offer of coverage was made?

Under the Employer Penalty rules, an employee must be offered an effective opportunity to accept coverage at least once with respect to the plan year. Final regulations do not apply any specific rules for demonstrating that an offer of coverage was made.

Many employers require an affirmative waiver of medical benefits. This is the best method to prove an offer was made, provided that a waiver can be collected from every single employee waiving. Otherwise, any waiver not returned by the employee arguably proves that he was never made the offer.

When an affirmative waiver is not required, otherwise documenting information regarding the election process is key. An employer will want to show that employees received sufficient information about the offer so that they must have known medical coverage was available. A widely-distributed handbook with clear information about the offer and its terms can be a valuable part of an employer's distribution of information as well as benefit booklets, email correspondence, posters, mandatory meetings, etc., as applicable.

If you need assistance with creating or modifying your handbook, please contact us and we can help you with a solution.

PCOR Fee Filing Reminder for Self-Insured Plans

Published: June 14, 2016

The PCOR filing deadline is August 1, 2016 for all self-funded medical plans and HRAs for plan years ending in 2015.

The plan years and associated amounts are as follows:

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2014 – January 31, 2015	$2.08/covered life/year	July 31, 2016
March 1, 2014 – February 28, 2015	$2.08/covered life/year	July 31, 2016
April 1, 2014 – March 31, 2015	$2.08/covered life/year	July 31, 2016
May 1, 2014 – April 30, 2015	$2.08/covered life/year	July 31, 2016
June 1, 2014 – May 31, 2015	$2.08/covered life/year	July 31, 2016
July 1, 2014 – June 30, 2015	$2.08/covered life/year	July 31, 2016
August 1, 2014 – July 31, 2015	$2.08/covered life/year	July 31, 2016
September 1, 2014 – August 31, 2015	$2.08/covered life/year	July 31, 2016
October 1, 2014 - September 30, 2015	$2.08/covered life/year	July 31, 2016
November 1, 2014 – October 31, 2015	$2.17/covered life/year	July 31, 2016
December 1, 2014 - November 30, 2015	$2.17/covered life/year	July 31, 2016
January 1, 2015 - December 31, 2015	$2.17/covered life/year	July 31, 2016

For the Form 720 and Instructions, visit: http://www.irs.gov/uac/Form-720,-Quarterly-Federal-Excise-Tax-Return.

The information is reported in Part II.

Please note that Form 720 is a tax form (not an informational return form such as Form 5500). As such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third party administrators and USI, cannot report or pay the fee.

Short Plan Years

The IRS issued FAQs that address how the PCOR fee works with a self-insured health plan on a short plan year.

Does the PCOR fee apply to an applicable self-insured health plan that has a short plan year?

Yes, the PCOR fee applies to a short plan year of an applicable self-insured health plan. A short plan year is a plan year that spans fewer than 12 months and may occur for a number of reasons. For example, a newly established applicable self-insured health plan that operates using a calendar year has a short plan year as its first year if it was established and began operating beginning on a day other than Jan. 1. Similarly, a plan that operates with a fiscal plan year experiences a short plan year when its plan year is changed to a calendar year plan year.

What is the PCOR fee for the short plan year?

The PCOR fee for the short plan year of an applicable self-insured health plan is equal to the average number of lives covered during that plan year multiplied by the applicable dollar amount for that plan year.

Thus, for example, the PCOR fee for an applicable self-insured health plan that has a short plan year that starts on April 1, 2015, and ends on Dec. 31, 2015, is equal to the average number of lives covered for April through Dec. 31, 2015, multiplied by $2.17 (the applicable dollar amount for plan years ending on or after Oct. 1, 2015, but before Oct. 1, 2016).

See FAQ 12 & 13, http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers.

Form 5500 Filing Reminder

Published: June 15, 2016

For calendar year plans, the 2015 plan year Form 5500 is due to be filed electronically no later than **August 1, 2016.**

ERISA requires that Form 5500 be filed with the Department of Labor for most health and welfare plans (for example, medical, dental, and life insurance plans) by the last day of the seventh month following the end of plan year unless an extension (Form 5558) is completed and mailed to the IRS.

A plan with fewer than 100 covered employees as of the first day of the plan year that is unfunded (no trust) or fully insured is exempt from this requirement. Certain other exceptions apply such as for church plans and governmental plans. Multiple employer welfare arrangement (MEWA) plans must file regardless of size.

Form 5500 also applies to retirement plans, regardless of employee count.

Final Regulations Shed Light on Wellness Programs

Published: June 15, 2016

Background

The Americans with Disabilities Act (ADA) generally prohibits employers with at least 15 employees from making disability-related inquiries or requiring medical examinations unless job-related and consistent with business necessity. There is an exception where participation is voluntary, a term which was not defined.

The Genetic Information Nondiscrimination Act (GINA) Title II prohibits all employers with at least 15 employees from using genetic information (which includes the current and past health status of a spouse and children) in making decisions about employment. It restricts employers from requesting, requiring, or purchasing genetic information, unless one or more of six narrow exceptions applies. It also limits the disclosure of genetic information.

On April 20, 2015, the Equal Employment Opportunity Commission (EEOC) issued proposed regulations providing the first guidance on how employers may use incentives in wellness programs and comply with the ADA. Similar guidance was subsequently released with respect to GINA.

On May 17, 2016, the EEOC announced final regulations under the ADA and GINA Title II regarding wellness programs. These regulations are similar to the proposed rules issued last year and more restrictive than the existing HIPAA rules. All three rules need to be carefully looked at when implementing incentive-based programs.

Bottom Line on Rewards

- Incentivized wellness programs with the reward at or below 30% of the total cost of self-only coverage generally are permissible under HIPAA, ADA, and GINA. Assuming compliance with the other requirements of these various laws, namely notice requirements, such rewards will not pose a risk.

- Employers intending to be more aggressive with their wellness program and offer incentives larger than the 30% self-only threshold require close review. While larger rewards are permissible in some cases, the specific features

of the wellness program will determine whether the reward meets the applicable requirements under HIPAA, ADA, and GINA.

- One caveat with rewards is if the employer is rewarding a spouse for completion of a risk assessment or tying the spouse's risk assessment to enrollment. GINA Title I prohibits a group health plan from collecting genetic information prior to or in connection with enrollment in health insurance coverage and for underwriting purposes. It is not clear whether a wellness program that provides rewards for a spouse's completion of a risk assessment (or ties the assessment to enrollment) violates GINA Title I as a spouse's medical history (which is collected in the spouse's risk assessment) is considered genetic information of the plan participant. More guidance on this issue is needed.

Highlights

Here are the highlights of the final regulations:

Applicability

The ADA rules on voluntary wellness programs apply to any employer wellness program that asks disability-related questions or requires medical examinations of employees. For example:

- Programs where employees must complete a health risk questionnaire, undergo an annual physical, or have other medical testing (e.g., biometric screenings) are subject to the ADA rules on voluntary wellness programs.

- Programs that require attendance in a nutrition class or a certain amount of exercise a week are not subject to the ADA voluntary rule. However, separate from these rules, the ADA requires employers to make reasonable accommodations to allow employees with disabilities to participate in any type of wellness program.

The final rules clarify that the safe harbor for insurance, that allows insurers and plan sponsors to use information, including actuarial data about risks posed by certain health conditions, to make decisions about insurability and the cost of health insurance coverage does not apply to wellness programs.

If the wellness program uses incentives to encourage a spouse to answer questions related to his/her current or past health status or complete a medical examination, GINA Title II applies. Such incentives are prohibited for children. The final rules clarify a "child" for this purpose includes an adult, minor, and adopted child. GINA also prohibits incentives tied to a spouse providing his or her own genetic information (e.g., results of a spouse's genetic tests).

Both the ADA and GINA apply to all wellness programs, regardless of whether the program is part of, or outside of, a group health plan.

Voluntary Wellness Programs

To qualify as a voluntary wellness program under the ADA, the employer:

- cannot require any employee to participate in the program;

- cannot deny any employee access to coverage under any group health plan for non-participation in the program or prohibit any non-participating employee from choosing a particular plan;

- cannot take any adverse action, retaliate against, or coerce employees who choose not to participate in the program; and

- must provide employees with a notice that clearly explains what medical information is obtained, who will receive it, how it will be used and the restrictions on disclosure (including whether the restrictions on disclosure comply with HIPAA Privacy Rule). The EEOC is expected to issue a model notice employers can use to meet this requirement.

The EEOC makes clear that certain tiered health benefit and cost-sharing structures that base eligibility for a particular health plan on completing the risk assessment or undergoing a medical exam will not meet this voluntary requirement. Two examples in the preamble help clarify this point:

- A program that allows employees who participate in the risk assessment to enroll in a comprehensive health plan, while non-participating employees are only eligible for a less comprehensive plan violates the ADA.

- However, such an arrangement would not violate the ADA if the non-participating employee could choose the more comprehensive program and pay more for the same comprehensive coverage than what a participating employee pays for the coverage (so long as the difference in cost does not exceed the permitted incentive limits).

Incentives

Unlike the proposed regulations, the final regulations adopt the same framework for establishing permissive incentive thresholds for purposes of the ADA and GINA Title II. Notably, these rules are more restrictive than what is permitted under the HIPAA rules.

The 30% Limit.

If a wellness program is available to the employee and includes medical examinations and/or health risk assessments, the maximum reward available is no more than 30% of the total cost of self-only coverage.

If the wellness program is available to the employee and spouse and includes medical examinations and/or health risk assessments, the maximum reward available is 30% of the total cost of self-only coverage for the employee PLUS 30% of the cost of self-only coverage for the spouse.

No incentive may be offered for a child to provide information about his or her current or past health status.

The ADA and GINA rules do not permit the employer to use family coverage when calculating the 30%.

The 30% threshold takes into account all incentives. This includes financial incentives (e.g., premium reductions or surcharge, cash, or gift cards) and in-kind incentives (e.g., t-shirts, water bottles, or fitness trackers).

How is the cost of coverage determined?

The cost of coverage is determined based on the total cost of self-only coverage (this includes employer and employee costs).

When participation in the wellness program is limited to employees (and spouses) who are enrolled in the health plan, the cost of coverage is based on the plan in which the employee is enrolled.

The final regulations provide a framework to determine the cost of coverage when the wellness program is available to all employees (and their spouses) regardless of enrollment in a health plan option:

- When the employer offers one health plan option and allows both enrolled and non-enrolled employees to participate in the wellness program, then the permissible incentive is determined using 30% of the cost of self-only in the sole health plan option.

- When the employer offers multiple health plans and allows both enrolled and non-enrolled employees to participate in the wellness program, then the permissible incentive is determined using 30% of the cost of self-only coverage in the lowest cost health plan option.

Tobacco use.

When an employer uses medical tests to detect nicotine (e.g., through a blood draw or mouth swab), then the ADA's 30% limit is triggered.

A wellness program that merely asks employees about their tobacco use is not a program that asks disability-related inquiries. It is not subject to the 30% threshold.

However, to the extent the program is tied to a group health plan, the maximum reward is capped at 50% of the total cost of coverage and a reasonable alternative standard must be provided under HIPAA.

GINA does not apply to tobacco use.

Reasonable Design

Under both the ADA and GINA Title II, the wellness program must be reasonably designed to promote health and prevent disease.

This means the program cannot require an overly burdensome amount of time for participation, involve unreasonably intrusive procedures, be subterfuge for violating the ADA, GINA, or other employment discrimination laws, or require employees to incur significant costs for medical examination.

- A program that asks employees (and their spouses) to answer questions about health conditions or have a biometric screening or other medical examination for the purposes of alerting them to health risks (like elevated cholesterol) is reasonably designed.

- Asking employees (or their spouses) to complete a risk assessment without providing additional feedback or follow-up or advice about risk factors or using the aggregate information to design programs to treat specific conditions is NOT reasonably designed.

- A program that merely shifts costs to the employees based on their health or is used only to predict future costs is NOT reasonably designed.

Confidentiality

The two rules also make clear that the ADA and GINA provide important protections for safeguarding health information. The ADA and GINA rules state that information from wellness programs may be disclosed to employers only in aggregate terms except as necessary to administer a health plan.

The ADA rule requires that employers give participating employees a notice that describes what information will be collected as part of the wellness program, with whom it will be shared and for what purpose, the limits on disclosure, and the way information will be kept confidential. GINA includes statutory notice and consent provisions for health and genetic services provided to employees and their family members.

Both rules prohibit employers from requiring employees or their family members to agree to the sale, exchange, transfer, or other disclosure of their health information to participate in a wellness program or to receive an incentive.

The guidance published along with the final ADA rule and the preamble to the GINA final rule identify some best practices for ensuring confidentiality, such as adopting and communicating clear policies, training employees who handle confidential information, encrypting health

information, and providing prompt notification of employees and their family members if breaches occur. A wellness program that is part of a group health plan may satisfy its obligation by adhering to the HIPAA Privacy Rule.

Effective date

The ADA and GINA provisions are effective for plan years beginning on or after January 1, 2017 (except that ADA provisions related to denying a plan option or failing to make a reasonable accommodation are simply clarifying language and should be followed now).

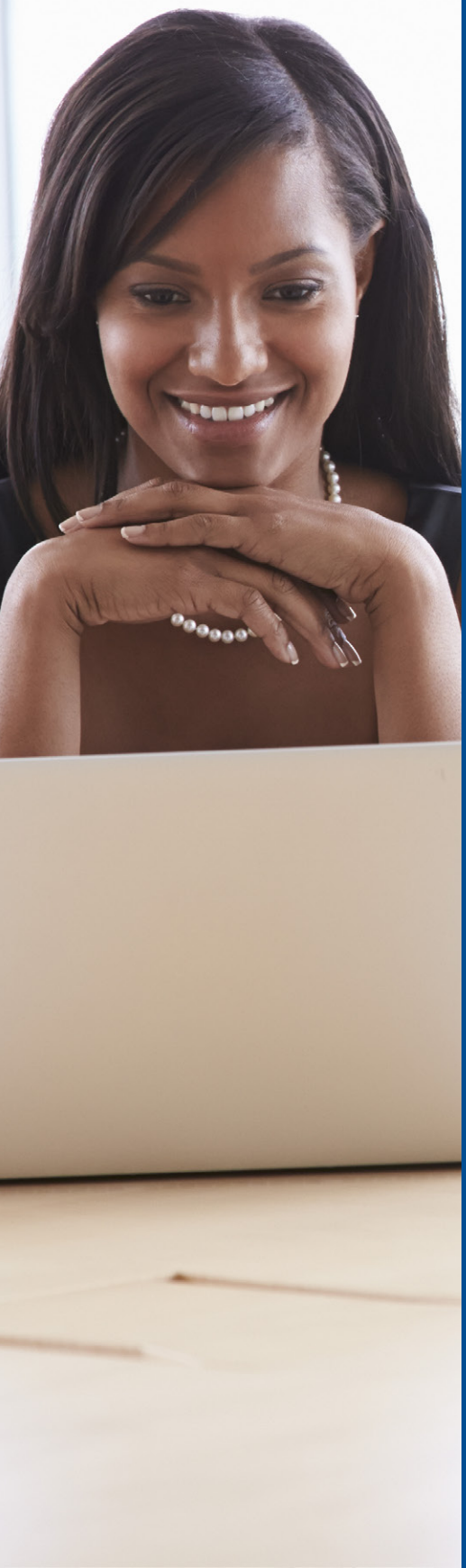
Employer Action

- Employers with rewards at or under 30% of the total cost of self-only coverage generally will not need to alter their approach to incentives.

- Employers that extend wellness program incentives to employees who do not participate in the group health plan and/or have participatory wellness programs should review whether the incentives are set at the appropriate level in light of the new guidance.

- Employers looking to be more aggressive with incentives will need to carefully review the coordination of HIPAA, ADA, and GINA provisions to ensure compliance with the various applicable limits for plan years that begin on or after January 1, 2017.

- For plan years beginning on or after January 1, 2017, a new notice will be required if the employer's wellness program includes medical exams and disability-related inquiries.



Notice of Subsidies in the Federal Marketplace

Published: June 16, 2016

The Affordable Care Act ("ACA") requires each Health Insurance Marketplace ("Marketplace") to notify any employer whose employee was determined to be eligible for Advance Premium Tax Credits ("APTC") and Cost Sharing Reductions ("CSR") because the employee attested that he or she was not:

- enrolled in employer sponsored coverage, or
- eligible for employer coverage that is affordable and meets minimum value requirements.

In 2016, the Federally-Facilitated Marketplace ("FFM") will begin issuing these notices to employers. State-based Marketplaces began this notification process in 2015.

Briefly, these notices serve as an initial "heads-up" to the employer if any employee receives a subsidy and buys coverage in the Marketplace during the current calendar year.

Following are some frequently asked questions.

Q1: What states have an FFM?

Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, Wyoming.

Q2: Which employers will be notified through FFM's employer notice program?

The FFM will send notices to employers whose employees received an APTC in 2016 and whose employees provided FFM with information identifying the employer (e.g., the employer's address).

Any employer (regardless of size) may receive a notice from FFM. The notice will identify the specific employee and include a statement that the employee is enrolled in FFM coverage with APTC. The notices will not contain the employee's personal health information or federal tax information.

After 2016, the Department of Health and Human Services ("HHS") will evaluate and determine whether to further expand and improve the notification program.

Q3: When can employers expect to receive notices?

The FFM will send notices in batches. The first batch will likely be released in the spring of 2016. HHS anticipates this will be the largest batch of notices as it will include employers whose employees enrolled in Marketplace coverage with APTC during Open Enrollment which ended on January 31, 2016. Additional batches of notices are expected throughout 2016.

Q4: Is there an appeal process?

Yes. An employer may appeal a notice and assert that it provides its employee access to affordable, minimum value employer sponsored coverage or that its employee is enrolled in employer coverage, and therefore ineligible for APTC. If the employer is successful, FFM will notify the employee to encourage him or her to update their information to reflect access to, or enrollment in, other coverage. Employees will be notified that their failure to update this information with the Marketplace may result in a tax liability.

Q5: How does the employer submit an appeal?

In the FFM, the employer has 90 days from the date of receipt of the notice to request an appeal. The appeal request form is available here: https://www.healthcare.gov/downloads/marketplace-employer-appeal-form.pdf. Note, employers will need to use the correct appeals form identified by state.

An employer must either mail or fax an appeal request to FFM. The address and fax number are available on the form.

Q6: Is this a penalty assessment notice?

For applicable large employers, subject to the employer mandate, this is not a notice of a penalty assessment. Penalty assessment determinations are made by the Internal Revenue Service ("IRS") in the year that follows the calendar year to which any assessment relates.

However any applicable large employer that receives a notice from the FMM or a state Marketplace should carefully review current year records to determine whether the employee identified in the notice is an ACA full-time employee.

Q7: What about the appeals process for state-based Marketplaces?

Some states, including California, Colorado, the District of Colombia, Maryland, Massachusetts, New York and Vermont, use the Federal appeals process.

Other states, including Washington and Connecticut, have adopted their own appeals process.

Q8: Where can I get more information?

For more information, visit:

- FAQs on FFM notice process. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Employer-Notice-FAQ-9-18-15.pdf

- How to appeal a Marketplace decision. https://www.healthcare.gov/marketplace-appeals/

Mental Health Parity Non-Compliance Triggers

Published: June 17, 2016

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") requires a group health plan that offers mental health and substance use disorder benefits to be at parity with medical and surgical benefits. As such, financial requirements and treatment limitations for mental health and/or substance use disorder benefits cannot be more restrictive than the medical and/or surgical benefits offered.

Non-Quantitative Treatment Limitations

While employers can easily discern differences between financial ($30 copay vs. $50 copay) and quantitative treatment limitations (3 visits vs. 5 visits), ensuring parity of non-quantitative treatment limitations ("NQTLs") is more difficult to detect. As such, NQTLs require an in-depth review of plan documents and plan administration.

Examples of NQTLs include:

- Network tier designs;
- Formulary design for prescription drugs;
- Fail first policies or step therapy protocols;
- Network participation standards, including reimbursement rates;
- Exclusions based on failure to complete a course of treatment;
- Plan methods to determine usual, customary, and reasonable charges;
- Limits or exclusion of benefits based on experimental or investigative treatments; and
- Limits or exclusion of benefits based on medical necessity or medical appropriateness.

Recently, the DOL issued a list of "trigger" phrases that require additional review of plan documents and administration to ensure parity of benefits. In January, the Department of Labor issued a report to Congress describing the importance of mental health and substance use disorder benefits, compliance concerns, and future enforcement activity. Employers should expect to see a rise in investigations focusing on mental health and substance abuse disorder benefit provisions.

To read the warning signs, visit:

https://www.dol.gov/ebsa/pdf/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf

www.cbplans.com

28 West Railroad Avenue

Jamesburg, NJ 08831

heatherb@cbplans.com