2016 BENEFIT AND PAYMENT PARAMETERS AND CADILLAC TAX OVERVIEW

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THE SLIDES WILL BE ARCHIVED ON WWW.NAHU.ORG
COMPLIANCE CORNER

COMPLIANCE CORNER WEBINARS

- **Slides will be archived on nahu.org under the Compliance Corner tab**
- **The session is being recorded and will be archived in Compliance Corner**
- ***Compliance discussions and responses offer NAHU's interpretation and research regarding application of the provisions of the Patient Protection and Affordable Care Act (PPACA). NAHU is providing this guidance as an informational resource for NAHU members. This general information is not a substitute for legal or tax advice.***

ABOUT YOUR PRESENTERS

Jessica Waltman

NAHU Senior Vice President of Government Affairs represents more than 100,000 health insurance agents, brokers and consultants nationwide. Jessica joined the staff of NAHU in 1999, and has led the association's government affairs team since 2008. Jessica coordinates NAHU's legislative and regulatory efforts to advance the interests of professional health insurance producers before Congress and the Executive branch, state legislatures, state insurance departments, other regulatory bodies and intergovernmental organizations. Jessica also directs the administration of the Health Underwriters Political Action Committee (HUPAC) and NAHU's annual Capitol Conference, a four-day meeting in Washington, DC comprised of educational sessions, political speakers and grassroots lobbying for NAHU members.

Pamela Mitroff, MBA

NAHU Senior Director of Health Reform Compliance has more than 30 years in the health care and workers' compensation insurance and cost control field. Mitroff is a licensed Illinois insurance producer and has held positions with a major insurance company and a third-party administrator of benefit plans for self-funded companies. She was a lobbyist for the Illinois State Chamber of Commerce, lobbying on health insurance, employee benefits and workers' compensation issues. Prior to joining NAHU's staff, Mitroff had been an active NAHU member on federal, state and local levels.

2016 SHOP

FF-SHOP APPLICATION AND ENROLLMENT PROCESS REVIEW

- All employers and employees must enroll and renew SHOP coverage online at HealthCare.gov
- To start the enrollment process, employers must create an account online at HealthCare.gov, go through identity proofing, and complete the eligibility application
- Employers may authorize an agent or broker to provide help with completing the application
- After an employer makes an offer of coverage to their employees, employees will need to create an account on HealthCare.gov to complete the eligibility application and accept or waive the offer of coverage

EMPLOYER ELIGIBILITY REQUIREMENTS

In order to participate in the FF-SHOP for plan years beginning on or after January 1, 2016, employers must attest that they meet the following eligibility requirements:

The employer has 100 or fewer full-time equivalent (FTE) employees

The employer has a primary address, or a worksite where eligible employees work, in the state where the employer is applying

All full-time employees of the employer will be offered SHOP coverage

The employer has at least one employee who isn't the owner or business partner, or the spouse of the owner or business partner

EMPLOYER GROUP SIZE IN 2016

For plan years beginning on or after January 1, 2016, a small employer is defined as an employer who employed an average of at least one (1), but not more than 100 full-time-equivalent employees on business days during the preceding calendar year and who employ at least one (1) employee on the first day of the plan year

Qualified Health Plans (QHPs) and Stand-alone Dental Plans (SADPs) will be available to groups with 1-100 full-time-equivalent employees in FF-SHOPs for plan years beginning on or after January 1, 2016

On March 5, 2014, CMS announced transition relief that would apply to employers with between 51 and 100 employees that purchased large employer coverage while still defined as large employers in the State. Under this transition relief, these employers could renew their policies for plan years beginning before October 1, 2016, and be subject to Federal enforcement only of large employer requirements

- Not all states will allow this transition – 14 and DC are not allowing

As of January 1, 2016, employers with 51 to 100 employees purchasing new coverage must comply with small employer requirements

STATES NOT ALLOWING GRANDMOTHER PLANS

Most recent list found that these states are not allowing or limiting grandmothered plans

California – individual market

Connecticut

Delaware

District of Columbia

Maryland

Massachusetts

Minnesota

Montana

Nevada

New York

Rhode Island

Texas

Washington

Vermont

Virginia

SHOP MINIMUM PARTICIPATION RATE (MPR)

SHOP (State-based SHOP (SB-SHOP) or FF-SHOP) may establish a uniform group participation rate

Single, uniform rate applies to all groups and issuers in the SHOP

- Based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer

Participation Holiday

- November 15 and December 15 of each year Outside of this one month period, the minimum participation rate in the FF-SHOP is calculated at the time of initial enrollment and renewal

For plan years beginning on or after January 1, 2016, the FF-SHOP MPR will be based on the rate of full-time employee participation in the SHOP and in other minimum essential coverage (MEC)

- Includes employees offered SHOP coverage who are enrolled in another group health plan, governmental coverage, and coverage sold through the individual market
- Excludes former employees in calculation

STATES WITH STATE ESTABLISHED MINIMUM PARTICIPATION RATES

All FF-SHOP States require a Minimum Participation Rate (MPR) of 70%, except the following: Arkansas (AR) – 75%

Iowa (IA) – 75%

Nevada (NV) – 75%

New Hampshire (NH) – 75%

New Jersey (NJ) – 75%

South Dakota (SD) – 75%

Tennessee (TN) – 50%

Texas (TX) – 75%

COBRA COVERAGE

Employer can enter into an agreement with SHOP to aid with continuation coverage

SHOP bills continuees directly

SHOP will not composite rate in 2016 as initially promised

TERMINATION OF SHOP COVERAGE

Non-payment of premium

- Last day of month for which full payment was received
- May only be reinstated once a calendar year
- SHOP must provide notice to enrollees if terminated or a loss of eligibility

Timelines for notices – "promptly and without undue delay"

- 3 days electronic
- 5 business days paper

THE SLIDES WILL BE ARCHIVED ON WWW.NAHU.ORG
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MARKET RULES

Rate Increases of 10% or more in individual and group market

- Public disclosure of increases and justification
- Revision for 2017 will trigger review when any plan within a product has an increase that meets or exceeds threshold

Establishes uniform timeline for rate filings

ELIGIBILITY, ENROLLMENT AND BENEFITS

OEP for individual exchange

- November 1, 2015 - January 31, 2016
- Uniform for all exchanges including state-based

Standard policy for deadline for 1st month's premium

- No earlier than the coverage effective date
- No later than 30 calendar days from the coverage effective date
- 1st month payment required for coverage to be effectuated (claims can be pended)

MORE ELIGIBILITY, ENROLLMENT AND BENEFITS

Pediatric services

- End of the plan year in which enrollee turned 19 years of age was proposed
- Final requires at least through the end of the month in which enrollee turns 19

Prescription drugs

- Must have Pharmacy & Therapeutics committee (P&T)
- Goal is to have discussion/addition of new drugs
- If a plan elects to cover more drugs than the benchmark plan – they are considered EHB and count toward cost-sharing limit
- Once drug okayed through exception process, then all refills covered for duration of prescription
- Formulary changes must be posted to website before applicable to plan as of 1/1/17 plan years
- Can't have exclusive mail order must allow retail

SPECIAL ENROLLMENT PERIODS

Moving

- Must affect coverage
- Includes release from incarceration
- Coverage effective date – 1st day of the month following move if plan selection made before or on the day of the loss of coverage effective 1/1/17
- Effective 1/1/16 – 60 days advanced access to special enrollment; 1/1/17 for incarceration "move"

Child support orders/ death of enrollee with dependent

- 1st day court order is effective
- Coverage 1st day of the month following death of enrollee/dependent

Death

- 1st of the month following date of death
- Only affected members get a SEP

Coverage expiring in non-calendar year group or individual plan

- Also applies outside the exchange

State exchanges can add own special enrollments

Administration decided not to make pregnancy an SEP-qualifying event, but when the child is born there is an SEP.

SPECIAL ENROLLMENT PERIODS (MORE)

Loss of Dependent status

Newly eligible for APTC due to change in household income in non-Medicaid expansion states

- Income had been less than 100% of FPL

Can elect 1st of month effective date following birth, adoption

EHBS

Don’t apply to US Territories

Habilitative services

- Defined as including devices , provided for a person to attain, maintain or prevent deterioration of a skill or function never learned or acquired due to a disabling condition
- Separate limits to apply to habilitative and rehabilitative services for 2017 plan year
- Devices included in both habilitative and rehabilitative definitions

COST SHARING

Cost sharing for Essential Health Benefits may never exceed the self-only annual out-of-pocket limit

- 2016 limit is $6,850 self-only and $13,700 for other than self-only coverage

Limits application of a true "family deductible"

FEES

Transitional reinsurance fee for 2016 - $27 per enrollee

- 2015 - $44
- 2014 - $63

User fee in marketplace remains 3.5% of monthly premium

Self-insured expat plans do not make reinsurance contributions for 2015 and 2016 benefit years

FFM BROKER TRAINING

In the years ahead, FFM broker training will be done through approved vendors

Agents will pay a fee for training, which will be four hours long and must be CE-eligible

The regulation sets out the approved vendor criteria and application process.

Great news—NAHU was just conditionally approved as a vendor for 2016!

MISCELLANEOUS

To meet MV, a plan must have hospital and physician services

High risk pool deadline is eliminated since some states may still have members in high risk pools or have legislative barriers to terminating pool

- If eligible for a pool, doesn't prohibit exchange enrollment and APTC eligibility

Web brokers only need to provide interpretation services

CADILLAC TAX - UPDATE

Notice 2015-16 was published 2/24/15. Not a lot of guidance, a lot of questions.

Recap - 40% excise tax on the total cost of employer-sponsored coverage over a threshold amount that will take effect for tax years beginning after 12/31/2017

The thresholds will be $10,200 for self-only and $27,500 for other than self-only coverage.

Most recent CBO estimate projects excise tax revenue at $87 billion

25% of revenue from tax, 75% from increased income and payroll taxes

WHO WILL PAY THE TAX?

Health insurance issuer for insured plans

Employer if employer makes contributions to an HSA

Plan administrator for other applicable coverage

Employer calculates the tax and notifies the liable entity of the amount

WHAT THE GUIDANCE TELLS US APPLICABLE COST OF COVERAGE

Aggregate cost of applicable coverage

Based on coverage in which employee is enrolled

Employee includes surviving spouse, retiree or other primary insured individual

May allow aggregation by benefit package or some other measure of similarly situated individuals

… MORE

They are considering making employee pre-tax HSA contributions subject to tax – but not after-tax

Employer contributions to HSAs have to be included as per the statute

HRAs an open question. May have to include claims and administrative expenses of HRA.

FSA will include salary reduction amounts as applicable coverage

Specified disease or fixed indemnity insurance if pre-tax or tax deductible

Fully insured dental and vision plans are specifically excluded. Self-funded and comprehensive plans TBD.

EAPs – TBD

On-site medical clinics excluded if de minimis care provided, otherwise, TBD

CADILLAC TAX

Additional concerns not raised by the guidance:

- How will the adjustments work? There will need to be a composite rate for various ages on the plans.
- How will they provide for adjustments for geography, high risk occupations, etc.

The many differences between fully-insured and self-funded plans could create an inbalance/unlevel playing field in the market.

Tax could really be as high as 60% for fully-insured plans since it will be collected by the carriers. Since it will be in the premium, it will considered income for insurers. To treat the premiums as income to the insurer for tax purposes is an IRS construct but one they have been unwilling to change (this is what they do for the HIT tax) so a fully-insured plan that exceeds the threshold will definitely pay more.

CADILLAC TAX

Strategies to consider:

- Higher deductibles
- Higher out-of-pocket expenses
- Lower subsidies to spouse/family
- Limit contributions to HSAs, FSAs, HRAs
  - Consider employee contributions
- Similarly situated employees - especially retirees

For self-funded plans, revisit COBRA applicable premium calculation

Offset of premium reductions on increases in payroll taxes

THANK YOU FOR ATTENDING!

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http://www.nahu.org/education/programs/compliance.cfm