Foster & Foster, Inc.

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BENEFITS BULLETIN

Regulatory Updates

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UPDATE ON PREVENTIVE SERVICES (NON-GRANDFATHERED PLANS ONLY)

When a service or supply gets added to the U.S. Preventive Services Task Force (USPSTF) recommendations with an A or B grade, non-grandfathered plans are required to cover it at 100% in-network. The new coverage becomes effective on the first day of the plan year after one year from the date the new guideline is added.

In addition to the updated USPSTF recommendations, the regulating agencies addressed preventive care in ACA FAQ 29 issued October 23, 2015. This FAQ clarified that:

Lactation Services - The scope of coverage for lactation services must be very broad. Plans need to cover:

- Comprehensive prenatal and postnatal lactation support, counseling, and equipment rental.
- Coverage for any state-licensed provider. Non-licensed counselors must be covered if the state

Newest Preventive Services Approved by the USPSTF
(Non-Grandfathered Plans Must Provide 100% Coverage In-Network)

Date Approved	*Service/Supply*	*Effective First Plan Year On or After*
September 2014	Aspirin to prevent preeclampsia for pregnant women at high risk	September 1, 2015
September 2014	Gonorrhea for women at increased risk	September 1, 2015
September 2014	Chlamydial infection screening (women age 24 or younger or at increased risk)	September 1, 2015
October 2015	High blood pressure screening (18+)	October 1, 2016
Clarifications of previously approved recommendations	Bowel preps, pathology and pre-screening specialist consultations related to screening colonoscopies	January 1, 2016
	Weight management counseling (up to 26 visits) for obese patients	Immediately

does not require licensing. (Very few states have a licensing procedure at this time, but expect that to change.) The guidance does not appear to prevent plans from requiring at least an R.N. degree in states that do not license lactation counselors.

- Services cannot be limited to in-hospital counseling after delivery.
- A list of covered in-network providers must be given to participants. But if the network does not include lactation counselors, the services must be covered in full when rendered by an out-of-network provider.

Weight Management - ACA FAQ 29 added new services to an existing requirement to cover adult obesity screening. The FAQ indicated that obesity "screening" also includes certain weight management services. Specifically, plans must cover group and individual behavioral interventions of high intensity (12-26 sessions per year). "High intensity" sessions include behavior management activities, improving diet, increasing activity, addressing barriers to change, self-monitoring and strategizing how to maintain lifestyle changes.

More than one-third of U.S. adults are obese according to the National Health and Nutrition Examination Survey, 2009–2010.

We recommend limiting coverage to 26 face-to-face behavioral counseling sessions per year with a doctor or covered mental health provider, plus one dietary assessment by a nutritionist, and FDA-approved non-experimental weight loss drugs. Exercise and diet programs that are not supervised by medical practitioners should be specifically excluded. Coverage should be limited to adults with BMI's of 30 or greater.

Non-grandfathered plans should replace blanket exclusions for weight management/obesity with specific coverage provisions.

Colonoscopies - Benefits for screening colonoscopies must include 100% in-network coverage for:

- Pre-colonoscopy consultation with a specialist
- Pathology of polyps
- Bowel preps – This was not addressed in FAQ 30, but the USPSTF list of recommendations now includes bowel preps for covered colonoscopies. We recommend limiting coverage to generics and over-the-counter products.

Effective Dates - The colonoscopy-related clarifications are effective for plan years beginning on or after December 22, 2015 (i.e., plan years on and after January 1, 2016). The FAQ did not include an effective date or transition period for the other clarifications, which generally means the guidance is effective immediately.

ACA FAQ 29 is available at www.dol.gov/ebsa/faqs/faq-aca29.html.

NEW SBC EFFECTIVE DATE OF APRIL 1, 2017

Use of the new SBC template has been postponed yet again. The original effective date was September 1, 2015, but this was later extended to January 1, 2017. The most recent announcement extended the compliance date to April 1, 2017.

The content of the new SBCs was also changed in response to the comments received, including a new question: "Are there services covered before you meet your deductible?" that will identify the types of services and supplies covered at 100%.

For more information see ACA FAQ 30 dated March 11, 2016. The FAQ is available at www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/SBC-FAQ-Final-3-11-16.pdf.

PCORI FEES FOR YEAR 4

- This is Year 4 out of 7 for PCORI fees, although because of plan year start dates, many plans will be making only their third PCORI payment this year.
- The per-person fee for Year 4 PCORI fees, which are for plan years that ended on or after October 1, 2015 and before October 1, 2016 (this includes all plans with a January 1 plan year) will be $2.17 per covered person.

2016 PCORI Fees

PY start	PY end	7/31/16 Payment Rate
Year 3 Rate:		
2/1/14	1/31/15	$2.08
3/1/14	2/28/15	$2.08
4/1/14	3/31/15	$2.08
5/1/14	4/30/15	$2.08
6/1/14	5/31/15	$2.08
7/1/14	6/30/15	$2.08
8/1/14	7/31/15	$2.08
9/1/14	8/31/15	$2.08
10/1/14	9/30/15	$2.08
Year 4 Rate:		
11/1/14	10/31/15	$2.17
12/1/14	11/30/15	$2.17
1/1/15	12/31/15	$2.17

2017 OUT-OF-POCKET LIMITS (NON-GRANDFATHERED PLANS)

On March 1, 2016, the Department of Health and Human Services (HHS) announced the finalized 2017 health plan out-of-pocket limits (OOPLs). These represent the maximums that non-grandfathered plans can require participants to pay for deductibles, coinsurance and co-pays during a year.

Maximum Cost-Sharing (Out-of-Pocket Limits)
(Non-Grandfathered Plans)

	Per Person	*Per Family*
2016	$6,850	$13,700
2017	$7,150	$14,300

IRS CLARIFIES AFFORDABILITY SAFE HARBOR PERCENTAGES

IRS Notice 2015-87 issued December 16, 2015 clarified that the safe harbors for determining whether health coverage is "affordable" are subject to the same inflation factor used for determining whether an employer's coverage is affordable. The percentage is 9.66% for 2016.

MORE ON HRA'S

IRS Notice 2015-87 also addressed health reimbursement arrangements (HRA's) and the ACA. In brief, the Notice confirmed the following:

- ACA permits HRAs if they are either:
  - Integrated with a regular medical plan that meets the ACA's requirements (e.g., no dollar limits and 100% coverage for preventive care); or
  - For retirees only.
- An HRA for current employees must be integrated with an ACA-compliant group health plan.
- Only current employees and their dependents who are covered by the ACA-compliant health plan can use the HRA. There is a transition period for this requirement: HRAs must be fully integrated for plan years beginning before January 1, 2017.
- Current-employee HRAs may cover individual premiums for ACA-excepted benefits, such as stand-alone dental or vision plans.
- An employer cannot offer an arrangement through a cafeteria plan that reimburses the cost for individual health insurance policies, regardless of whether the arrangement is funded by employee salary reduction or by employer contributions.
- A retiree-only HRA can be used to purchase individual (including exchange) policies once the retiree is no longer covered by a health plan that is integrated with the HRA.
- If a retiree does purchase an exchange policy, he will not be entitled to an ACA premium tax credit.

WILL ERISA PLANS BE EXEMPT FROM MICHIGAN HICA TAX?

The State of Michigan's Health Insurance Claims Assessment Act (HICA) imposes a 1% tax on all claims paid on or after January 1, 2012 for health care services provided in Michigan to Michigan residents. The law stated that it applied to all health plans, including ERISA plans.

Due to recent developments, ERISA plans may soon be freed from the HICA tax and similar requirements by individual states. Below is a summary of the events leading up to this potential relief:

- In 2014 the Self-Insurance Institute of America, Inc. (SIIA) challenged the HICA tax, arguing that ERISA plans should be exempt.
- This challenge lost in the U.S. Sixth Circuit Court of Appeals (which covers Michigan). The Court based its August 2014 ruling on a narrow interpretation of ERISA-preemption statutes.
- The SIIA then petitioned the U.S. Supreme Court to overturn the Sixth Circuit's decision, arguing that the ERISA-preemption language enacted by Congress is in fact broader than the Sixth Circuit determined it to be. The SIIA further argued that Michigan's HICA "imposes a tax obligation and related onerous recordkeeping and reporting duties on self-insured employers and Taft-Hartley plans, and that if the decision is not reversed it could encourage the proliferation of state laws that burden ERISA plans contrary to ERISA's central goals of preserving national uniformity and efficiency in plan administration."

If Michigan's HICA is deemed applicable to ERISA plans, other states will seek to enact similar

- Then, on March 1, 2016, the Supreme Court ruled in favor of a broader ERISA-preemption in another case, *Gobielle v. Liberty Mutual*, thus exempting ERISA plans from a Vermont data-collection requirement.

- A few days later, on March 7, 2016, the Supreme Court ordered the Sixth Circuit to reconsider its HICA decision in light of the *Liberty Mutual* decision.

Until the Sixth Circuit issues a new decision, ERISA plans should continue to comply with Michigan's HICA requirements.

BIZARRE SCOTUS SUBROGATION RULING

On January 20, 2016, the U.S. Supreme Court issued an 8-1 opinion in *Montanile v. Board of Trustees of the National Elevator Industry Health Benefit Plan* finding that a health plan may not collect on a subrogation claim against a participant whose third-party settlement is dispersed into non-traceable items like food or travel. Specifically, the Court concluded that when a plan participant spends all of the money recovered for his injuries on non-traceable items, the plan fiduciary may not sue under Section 502(a)(3) to enforce its equitable lien against the participant's general assets. The plan in question had obtained a reimbursement agreement signed by the participant affirming his obligation to repay the Plan from any recovery he obtained. As the lone dissenting judge (Ruth Bader Ginsburg) noted: "This decision basically lets him escape that reimbursement obligation….What brings the Court to that bizarre conclusion?"

This is bad news for health plans. This decision will make it more difficult for subrogation liens to be recouped.