THE RJC GROUP, LLC March 2015

Employee Benefits Newsletter

INSIDE THIS ISSUE:

FINAL INSTRUCTIONS FOR IRS REPORTING ON INDIVIDUAL AND EMPLOYER MANDATES

Instructions for Employers to file Form 1094-C to the IRS only and Form 1095-C to both the IRS and named individuals. If its plan is insured, the employer will only complete Parts I and II of Form 1095-C.

Instructions for insurers to send Form 1094-B (a transmittal/cover sheet) to the IRS only, and Form 1095-B to both the IRS and named individuals for insured coverage only.

EMPLOYEE PARTICIPATION IN WELLNESS PROGRAMS AND FLEXIBLE WORK ARRANGEMENTS ON RISE, SHRM SURVEY FINDS

Wellness programs and flexible work arrangements are two of the most popular employee benefits offered by organizations, according to the results of the Strategic Benefits survey released by the Society for Human Resource Management (SHRM). About three-quarters (76 percent) of organizations offered some type of wellness program to employees in 2014, an increase from 70 percent in 2012. Also in 2014, about one-half (52 percent) of organizations provided employees with the option to use flexible work arrangements, such as teleworking.

"More and more employers are leveraging wellness programs and flexible work arrangements as part of the total rewards package that they offer employees," said Evren Esen, director of survey programs at SHRM. "Offering wellness programs and flexible work arrangements can be an effective way to recruit and retain talented employees."

Additionally, employee participation in these programs is increasing. However, employee participation in flexible work arrangements is progressing at a slower rate than wellness programs. More than one-half (53 percent) of organizations indicated employee participation in wellness programs increased last year, whereas just under one-third (31 percent) reported increased employee participation in flexible work arrangements. Although about one-half of organizations provided employees with the option to use flexible work arrangements, only one-third (33 percent) reported that the majority of their employees were actually allowed to use them.

"It is important to understand the obstacles that may be impacting employee participation rates in flexible work arrangements," said Esen. "There needs to be support from management and leadership in order for more employees to participate in flexible work arrangements."

Employee Benefits Management Newsletter,579,Benefits News,(Feb. 10, 2015)

FINAL 2016 AV CALCULATOR AVAILABLE

CMS' Center for Consumer Information & Insurance Oversight (CCIIO) released its Final 2016 Actuarial Value (AV) Calculator and Methodology for non-grandfathered health insurance plans offered in the individual and small group markets, both inside and outside of the Health Insurance Exchanges created under the Patient Protection and Affordable Care Act (ACA). The Final 2016 AV calculator contains updates similar to those proposed in the 2015 AV Calculator methodology that were not implemented as well as updates to the 2016 Draft version. The CCIIO letter details the specific methods used in the 2016 AV calculation.

Background. Under the ACA, there are four metal levels of health insurance coverage: bronze, with an AV of 60 percent; silver, with an AV of 70 percent; gold, with an AV of 80 percent; and platinum, with an AV of 90 percent. Section 1302 of the ACA implemented an essential health benefits (EHB) package that includes coverage requirements, cost-sharing limits, and actuarial value requirements of any health plan.

Final rules. In February 2013, HHS issued a Final rule (78 FR 12834, February 25, 2013) outlining 10 health insurance issuer standards for EHBs that health insurance issuers must cover both inside and outside of the Exchange, which includes the use of an AV calculator for plans offered in the individual and small group markets. The AV calculator must be used to determine levels of coverage and is calculated based on the provision of EHBs to a standard population. The Final rule establishes that a de minimis variation of +/- 2 percentage points of AV is allowed for each level of health coverage. The Final AV calculator updates a Draft AV calculator proposed in November 2014.

The Final AV calculator also updates the 2015 AV Calculator and 2015 AV Calculator User Guide, which was incorporated by reference in a Final rule titled, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015 (2015 Payment Notice) (79 FR 13744, March 11, 2014).

2016 updates. Under the regulatory guidance of 45 C.F.R. Section 156.135 (g), some of the 2016 calculator updates include:

- an annual limit on cost sharing based on a projected estimate (maximum out-of-pocket costs (MOOP) limit and related functions have been set at approximately $6,800);
- a plan to reflect more current enrollment data when data becomes available (current available data sources did not include complete individual and small group market enrollment for 2014);
- The use of effective coinsurance to determine when the MOOP limit is reached in the AV calculator instead of the general coinsurance rate, allowing the AV calculator to apply 100 percent coinsurance for both copayment-based and non-copayment-based plans (previously, users were allowed to apply 100-percent coinsurance for only copayment-based plans);
- improved functionality in several areas (e.g., for plans with separate medical/drug deductibles and separate medical/drug MOOPs, the 2016 AV Calculator supports MOOPs between the individual separate deductible and the MOOP limit; also when entering amounts in the copayment field, a default amount of $0 will be entered when the field is left blank).

The AV calculator is updated annually, with input from the American Academy of Actuaries and the National Association of Insurance Commissioners, as well as from other stakeholders.

Daily Document Update: Employee Benefits Management,¶2083V (Jan 27, 2015) Healthcarereformnews Healthinsurancenews CMSnews

Deminimis Variation

The allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is +- 2 percentage points.

FAQs ADDRESS WHEN SUPPLEMENTAL HEALTH COVERAGE CONSTITUTES EXCEPTED BENEFITS

The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (the Departments) have jointly issued frequently asked questions (FAQs) that address the circumstances under which coverage that supplements group health coverage qualifies as excepted benefits, which are generally exempt from the Patient Protection and Affordable Care Act's (ACA) market reform requirements.

Background. Benefits are excepted supplemental benefits only if they are provided under a separate policy, certificate, or contract of insurance. Additionally, these benefits must be characterized as Medicare supplemental health insurance (Medigap), TRICARE supplemental programs, or "similar" supplemental coverage provided to coverage under a group health plan. Regulations provide that similar supplemental coverage "must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles."

The Departments issued guidance in 2007 and 2008 on the circumstances under which supplemental health insurance would be considered excepted benefits under which supplemental health insurance would be considered excepted benefits under PHSA Sec. 2791(c). In addition to the requirement that the coverage be issued as a separate policy, certificate, or contract of insurance, the guidance lists the following four criteria that the Departments will apply to determine if supplemental coverage is similar to Medigap or TriCare and therefore qualifies as an excepted benefit:

1. the policy, certificate, or contract of insurance must be issued by an entity that did not provide the primary coverage under the plan;

2.the supplemental policy, certificate, or contract must be designed to fill gaps in the primary coverage;

3. the cost of the supplemental policy must not be more than 15 percent of the cost of the primary coverage; and

4. the coverage cannot differentiate among individuals in eligibility, benefits, or premiums due to a health factor exhibited by an individual.

Meaning of coverage designed to "fill in the gaps." The FAQs provide that in determining whether insurance coverage sold as a supplement to group health coverage can be considered "similar supplemental coverage" and an excepted benefit, the Departments will continue to apply the applicable regulations and the four criteria indicated in the previous guidance.

In addition, the Departments intend to propose regulations clarifying the circumstances under which supplemental insurance products that do not fill in cost-sharing under the primary plan are considered to be specifically designed to fill gaps in primary coverage.

Specifically, the Departments intend to propose that coverage of additional categories of coverage would be considered to be designed to "fill in the gaps" of the primary coverage only if the benefits covered by the supplemental insurance product are not an essential health benefit (EHB) in the state where it is being marketed. If any benefit in the coverage is an EHB in the state where it is marketed, the insurance coverage would not be an excepted benefit under the intended proposed regulations.

Failure to comply. The FAQs also indicate that the Departments will not initiate an enforcement action if an issuer of group or individual health insurance coverage fails to comply with the provisions of the PHSA, ERISA, and the Code, as amended by the ACA, with respect to health insurance coverage that:

1. provides categories of benefits that are not essential health benefits (instead of coverage that is meant to fill in cost-sharing gaps) in the applicable state;

2.complies with regulations and meets requirements for "similar supplemental coverage;" and

3.has been filed and approved with the state.

SOURCE: Daily document Update: Employee Benefits Management 2084LFAQs About Affordable Care Act Implementation (Part XXIII),February 13, 2015.Healthcarereformnews Healthinsurancenews HHSnews DOLnews

SPOTLIGHT ON FEDERAL GOVERNMENT ACTIVITIES

GOP LAWMAKERS UNVEIL ALTERNATIVE TO ACA

Senate Finance Chairman Orrin G. Hatch, R-Utah, along with Sen. Richard Burr, R-N.C., and House Energy and Commerce Chairman Fred Upton, R-Mich., on February 5 unveiled the Patient Choice, Affordability, Responsibility, and Empowerment (CARE) Bill, which would cap the exclusion for employer-provided health coverage, and provide a targeted tax credit to help buy health care.

Under the CARE Bill, there would be no mandate for individuals to buy health care coverage and employers would not be required to provide any. "Under our plan, every American will be able to access a health plan, but no American is forced to have health insurance they do not want," stated the lawmakers in the outline of their plan.

The introduction of the bill comes just days after the House voted to repeal the Patient Protection and Affordable Care Act (ACA). The House measure also instructs three House committees, including Ways and Means, to develop legislation to replace the health care law with new policies.

"Today, we offer a bold bicameral plan that fully repeals and replaces the healthcare law with reforms that empower patients—not Washington," said Hatch. "We agree we can't return to the status quo of the pre-Obama care world, so we equip patients with tools that will drive down costs while also ensuring those with pre-existing conditions and the young are protected."

The plan is expected to lower health care costs by providing lower- and middle-income families with a refundable tax credit to purchase private health care coverage of their choice. They

would no longer be subject to an individual mandate or be limited to federally approved plans. Workers for small businesses would also be eligible.

In addition, the plan would not allow a patient to be denied coverage based on a pre-existing condition. "We create a new "continuous coverage protection," and if you change your job and buy a plan on your own, we would provide protections so you could not be denied coverage or be forced to pay a higher premium because of a pre-existing condition," said the lawmakers in an Op-Ed in USA Today.

The plan would also ban insurance companies from imposing lifetime limits on a consumer, and adopts age-rating changes, which lower costs for younger individuals and allows them to stay on their parents' health plan up to age 26, unless a state chose otherwise.

The proposal would reportedly cut more than $1 trillion in taxes and reduce federal spending by hundreds of billions of dollars, according to the lawmakers. All of the ACA's taxes would be scrapped, including the medical device tax, health insurance tax, pharmaceutical tax and other fees.

Daily Document Update: Employee Benefits Management,¶2083F,GOP lawmakers unveil alternative to ACA,(Feb. 10, 2015)

HATCH, ALEXANDER ANNOUNCE LEGISLATION TO REPEAL EMPLOYER MANDATE

Senate Finance Committee Chairman Orrin G. Hatch, R-Utah, and Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Lamar Alexander, R-Tenn., on January 29 introduced the American Job Protection Bill, which would repeal the employer mandate under the Patient Protection and Affordable Care Act (ACA). Under the health law, businesses with 50 or more full-time equivalent employees are required to offer health insurance of minimum value or pay a penalty between $2,000 and $3,000 for each employee working 30 hours or more a week. The chairmen were joined by 26 senators in cosponsoring the bill.

"Obamacare's burdensome employer mandate continues to hinder job-creation and growth, and the best action Washington can take is to repeal it entirely," said Hatch. "By doing away with the mandate, job-creators will be able to grow their businesses without the added concern of reaching an arbitrary and punitive threshold."

The U.S. Chamber of Commerce's Small Business Outlook Survey released in April 2013 found that the requirements of the health care law were the biggest concern for small businesses. Of small business respondents, 77 percent say the health care law will make coverage for their employees more expensive, and 71 percent say the law makes it harder for them to hire more employees. As a result of the employer mandate, one-third of small businesses plan to reduce hiring and will cut back hours to reduce the number of full-time employees, according to the survey.

Healthcarereformnews Healthinsurancenews Legnews Daily Document Update: Employee Benefits Management,¶2084A,,(Feb. 3, 2015)

Continued from Page 4

SUPREME COURT DECLINES TO REVIEW STATE'S CHALLENGE TO PREMIUM TAX CREDIT REGULATIONS

The U.S. Supreme Court has announced it will not take up Oklahoma's challenge to the Code Sec. 36B premium assistance tax credit regulations. Oklahoma petitioned the Supreme Court to review State of Oklahoma v. Burwell. The Court has already granted certiorari in a similar case, King v. Burwell.

Legal challenges. After the IRS issued regulations allowing enrollees in both state-run and federally-facilitated Marketplaces to claim the Code Sec. 36B premium assistance tax credit, several legal challenges arose. Opponents argued that the Patient Protection and Affordable Care Act (ACA) limited the credit to enrollees in state-run Marketplaces.

The U.S. Court of Appeals for the Fourth Circuit upheld the IRS's regulations in King in July. The Supreme Court granted certiorari in King in December and oral argument is scheduled for March 4, 2015.

In September, a federal district court struck down the same regulations in State of Oklahoma.

An appeal was filed by the federal government in the Tenth Circuit, which is now on hold pending a decision by the Supreme Court in King.

Appeal to Supreme Court. Oklahoma asked the Court to bypass the Tenth Circuit and take up and hear the district court decision. Oklahoma argued that it had two different bases for standing to challenge the IRS regulations than the taxpayers in King: Oklahoma had a stake in the controversy as a sovereign state making the decision whether to establish its own Marketplace and as a large employer subject to ongoing compliance costs and penalty risks. A number of other states also urged the Court to take up State of Oklahoma.

"It is absolutely paramount the Court takes up Oklahoma's lawsuit to ensure state's rights are at the table when a decision is made," Oklahoma Attorney General Scott Pruitt said in a statement at that time. "Neither of the parties in King is a state nor is subject to the large employer mandate," he added.

The federal government opposed Oklahoma's petition. The government told The government told the Supreme Court that the proper procedure for an interested nonparty to make its views known is to file an amicus brief.

Certiorari denied. On January 26, the Supreme Court announced that Oklahoma's petition was denied. The Court did not elaborate.

Healthcarereformnews Healthinsurancenews CourtnewsDaily Document Update: Employee Benefits Management,¶2084B Feb. 4, 2015)

QUESTION OF THE MONTH

Q Among your 500 or so employees, you have several with some severe health problems. Unfortunately, they are likely to incur high health cost claims in the coming year. You were thinking of offering each of them $10,000 in lieu of signing up for your company's health care plan. Normally, employees pay $3,000 toward the cost of employee-only coverage under your plan and your company pays $6,000 per employee for coverage. You were also thinking of perhaps having the high-cost employees use the $10,000 for premium reimbursements so they could purchase individual policies on the ACA Marketplace. Are there any potential problems here?

A Yes. First of all, the Labor Department's Employee Benefits Security Administration (EBSA) has clarified that arrangements for providing cash reimbursements to employees for the purchase of individual market policies are considered group health plan coverage subject to the ACA's market reform provisions, and they cannot be integrated with individual policies out on the ACA Marketplace for the purpose of satisfying the ACA's provisions. You would run the risk of triggering excise taxes and penalties.
Second, it is the EBSA's view that an opt-out offer, even if it amounts to more than an employer and employee would normally pay for employer-sponsored coverage, effectively does not reduce the amount charged to the employee with high health-cost risks, and is discriminatory. It is the EBSA's opinion that the effective required contribution for one of your high-claims-risk employees for plan coverage under the scenario described above would be $13,000, or the $3,000 in normally required employee contributions plus the $10,000 in additional compensation that the employees would forgo if they enrolled in your plan, even if that amount is only offered to only high-risk employees. The EBSA believes that providing cash as an alternative to health coverage for individuals with adverse health factors is an eligibility rule that discourages participation in the group health plan
SOURCE: FAQs about Affordable Care Act Implementation (Part XXII).

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