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FYI® Roundup
For Your Information®

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Health and Welfare Benefits 2014 – Fall Edition

Our latest *FYI Roundup* highlights some recent developments affecting health and welfare benefits.

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Federal Appeals Courts Disagree on Marketplace Premium Subsidies

In July, the DC Circuit and the Fourth Circuit Courts of Appeals issued conflicting opinions addressing whether low income subsidies for coverage purchased in the marketplace could be provided by federally facilitated marketplaces. The DC Circuit held that subsidies are available only to individuals purchasing health coverage in marketplaces established by the states. In contrast, the Fourth Circuit determined that the subsidies are available in all marketplaces — federally facilitated as well as state-operated. If there continues to be a split between the Circuit Courts on this critical aspect of the ACA, this issue may well be one that the Supreme Court chooses to take up. (See our July 23, 2014 *For Your Information*.)

Contraceptive Coverage Mandate Guidance

Non-grandfathered group health plans must provide in-network, FDA-approved contraceptive services without cost-sharing. Churches and conventions or associations of churches are exempt from this mandate. Nonprofit religious entities and closely held for-profit entities with religious objections to providing contraceptive coverage have been provided an accommodation for satisfying the mandate.

Nonprofit Religious Entities

The accommodation for nonprofit religious entities involves signing EBSA Form 700, a self-certification form that indicates that the organization meets certain requirements and, because of religious objections, opposes providing the required contraceptive coverage. In August, in response to litigation, the Departments issued interim final rules setting forth an alternate method by which these entities could obtain relief from the mandate. Rather than signing

Form 700, the nonprofit entity may notify HHS in writing of its religious objection to coverage of all, or a subset of, contraceptive services. (See our September 9, 2014 *For Your Information*.)

Closely Held For-Profit Entities with Religious Objection to Providing Contraceptive Coverage

This past June, the Supreme Court ruled that closely held, for-profit employers have the right to refuse to provide coverage of specific contraceptive methods that conflict with the company owners' sincerely held religious beliefs. Following this decision, in July, the Departments issued an FAQ explaining that for such employers a plan amendment reducing or eliminating contraceptive coverage mid-year is a material reduction in benefits that requires notice of the change within 60 days after the amendment's adoption. (See our July 24, 2014 *For Your Information*.)

Additionally, in August, the Departments issued proposed regulations addressing how closely held, for-profit entities with religious objections to providing contraceptive coverage may obtain compliance relief. Under the proposed regulations, these entities would follow the regulatory processes established for nonprofit entities (see above). Further, the proposed rules set forth two possible ways of defining "closely held" entity for this purpose. (See our September 9, 2014 *For Your Information*.)

IRS Releases Draft Forms and Instructions for ACA Reporting

This summer the IRS released draft instructions and forms to accommodate the ACA's information reporting requirements for insurers and employers on the health care coverage offered to individuals and employees. The IRS will use the reported information to enforce the individual and employer shared responsibility requirements and to administer the low-income subsidies provided to eligible individuals who purchase coverage in the marketplace. The reporting requirements will go into effect for the 2015 calendar year. (See our July 25, 2014 and August 29, 2014 editions of *For Your Information*.)

CMS Updates Regulations on Marketplace Special Enrollment

As part of final regulations on marketplace and insurance market standards for 2015 and beyond, CMS recently updated the rules governing marketplace special enrollment opportunities. These special enrollment periods allow individuals to enroll in marketplace coverage outside of the annual open enrollment period. The updated rules provide guidance on providing marketplace-related information to qualified COBRA beneficiaries, early retirees, employees on unpaid leave, and others who have lost or are about to lose coverage. (See our August 4, 2014 *For Your Information*.)

ACA and US Territorial Employees

Employees of US employers working in the country's territories have a special status for purposes of the ACA's shared responsibility requirements. Generally, US territorial workers will not be full-time employees and will not affect an employer's potential liability for an assessment if not offered affordable, minimum value health coverage. Employers should also be aware that their plans covering employees in US territories must comply with most ACA market reforms. (See our September 17, 2014 *For Your Information*.)

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Massachusetts Completes Repeal of Employer Coverage Requirements; Individual Mandate Remains in Place

The board of directors of the Massachusetts Health Connector has voted to repeal the regulations that enforced certain employer provisions of the Massachusetts health reform law, which had been repealed earlier. However, the requirement that Massachusetts residents either have health coverage that satisfies Massachusetts' minimum creditable coverage requirements or pay a penalty remains in effect. (See our July 10, 2014 *For Your Information*.)

California Repeals 60-Day Waiting Period Limit

For plan years beginning on or after January 1, 2014, group health plans subject to the ACA may not impose a waiting period of more than 90 days on individuals who are otherwise eligible for coverage. Since 2012, California has prohibited insured group health plans from imposing a waiting period of more than 60 days on individuals otherwise eligible for coverage. In August, Governor Jerry Brown repealed the California law to align it with the ACA waiting period rules. (See our August 29, 2014 *For Your Information*.)

Approaching HPID Deadline Poses Conundrum for Self-Funded Plans

Under final regulations issued by HHS, a "controlling health plan" is required to obtain and use a health plan identifier (HPID) for all standard transactions conducted by the plan and its business associates. Large health plans must obtain their HPIDs by November 5. All health plans must use the HPID in standard transactions by November 7, 2016. The HPID application system presents some usage issues for certain self-funded plan sponsors, and many questions remain unsolved. HHS is aware of the issues and they will be addressed. In the meantime, HHS recommends that plan sponsors apply for an HPID before the deadline. (See our August 26, 2014 *For Your Information*.)

HHS Releases Guidance on Electronic Process for HIPAA Opt-Out for Self-Funded, Non-Federal Government Plans

HHS issued final regulations on the new process for self-funded, non-federal government group health plans to opt out of certain applicable HIPAA-related mandates. Hard copy elections for the opt-out will be accepted until December 31, 2014. Starting January 1, 2015, opt-out elections should be submitted electronically following the new process. In July, the CMS issued guidance on this electronic election process. (See our August 18, 2014 *For Your Information*.)

New Hepatitis C Medication Sparks Debate on Innovation and Cost

In late 2013, the pharmacy marketplace was alerted to the likelihood of significantly increased costs to treat hepatitis C resulting from the FDA's approval of two new drug therapies, Olysio and Sovaldi. As a result, in 2014, plan sponsors and insurers have absorbed significantly higher costs thus far for hepatitis C drug therapy, creating a controversy on the trade-offs between innovation and cost that has caught the attention of some in Congress. For the moment, plan sponsors are left to deal with the costs and decisions about plan coverage. (See our August 21, 2014 *For Your Information*.)

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Business Associate Agreement Revisions Due September 22, 2014

HIPAA omnibus regulations made changes to the administrative simplification rules requiring updates to contracts between covered entities and their business associates. Generally, compliance was required by September 23, 2013. However, a special transition rule allowed certain covered entities (that were renewing, modifying, or executing BAAs) until September 22, 2014 to revise business associate agreements. (See our August 4, 2014 *For Your Information*.)

Medicare Part D Creditable/Non-Creditable Coverage Due October 14, 2014

Plan sponsors that offer prescription drug coverage must provide annual notice to Medicare-eligible individuals about whether the plan's prescription drug coverage is creditable or non-creditable. A plan's prescription drug coverage is creditable if it provides, on average, as much coverage as Medicare's standard Part D coverage. The notice may be provided in annual enrollment materials, separate mailings, or electronically and is required no later than October 14, 2014. (See our September 12, 2014 *For Your Information*.)

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