

Recent Health and Welfare Developments 2016 – Spring Edition

Our latest *FYI Roundup* looks at some recent developments affecting health and welfare benefits. We include ACA guidance on, among other things, employer shared responsibility, the Summary of Benefits and Coverage, out-of-pocket maximums and student health plans. We also highlight the latest on transit benefits, health FSA carryovers, wellness programs and San Francisco's healthcare expenditure requirements.

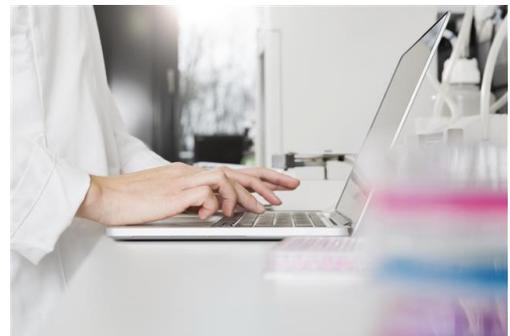
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Affordable Care Act

Recent Affordable Care Act (ACA) guidance includes proposed ACA nondiscrimination regulations, a new Summary of Benefits and Coverage (SBC) template, transition relief for certain student health plans and final market mandate regulations.

Proposed Regulations Address ACA Nondiscrimination in Health Programs and Activities

The Department of Health & Human Services (HHS) issued proposed regulations prohibiting discrimination in certain health programs and activities on the basis of race, color, national origin, sex, age or disability. Entities subject to the rules include many hospitals and insurers, and could include employers with self-insured medical plans. The proposed rules would require covered entities to provide assurances and notices of nondiscrimination, designate a responsible employee for coordinating compliance with the rules, and adopt grievance procedures. The rules include specific protections regarding sex discrimination in general, and transgender individuals in particular. (See our *For Your Information* from [January 7, 2016](#).)



IRS Notice Provides Additional ACA Employer Shared Responsibility Guidance

IRS Notice 2015-98 provided a variety of ACA-related guidance including the crediting of hours of service for periods when no duties are performed for purposes of determining full-time status and the application of the “rehire” rules to individuals performing services for educational organizations through a third party. The IRS also addressed the treatment of government entities and their reporting obligations under the shared responsibility rules and the status of AmeriCorps participants and employer-provided TRICARE coverage under the ACA. (See our *For Your Information* from [March 3, 2016](#).)

New Final SBC Template, Instructions and Materials

After receiving comments, the Departments of Labor (DOL), Treasury, and HHS (departments) finalized and released a new SBC template, instructions and related materials. The ACA requires group health plans and health insurers to provide an SBC to participants and beneficiaries to help them understand their coverage options and make informed decisions about their health benefits. The new SBC template and other materials should be used for open enrollment periods beginning on or after April 1, 2017. (See our [April 21, 2016](#) *For Your Information*.)

Employer Cannot Escape Claims That It Cut Employee Hours to Avoid ACA Requirements

A trial court allowed an ERISA lawsuit — alleging that the employer intentionally interfered with employees’ benefit rights by keeping their weekly work hours under 30 hours to avoid the ACA employer mandate — to go forward. The ACA’s employer mandate requires large employers to offer minimum essential coverage to their full-time employees (and their dependents) or make an assessable payment if at least one full-time employee receives subsidized marketplace coverage. For this purpose, a full-time employee is one who averages at least 30 hours per week. ERISA prohibits employers from interfering with and/or taking action against a participant who is exercising a right or attaining a benefit under an ERISA benefit plan. (See our [March 8, 2016](#) *For Your Information*.)

HHS Finalizes 2017 OOP Maximums and Marketplace Guidance

HHS finalized the ACA 2017 out-of-pocket maximums of \$7,150 for self-only coverage and \$14,300 for other than self-only coverage. It also provided guidance on marketplace notices (sent to employers when a subsidy-eligible employee has enrolled in a marketplace plan) and provided the marketplace open enrollment periods for 2017 and later years. (See our [March 14, 2016](#) *For Your Information*.)

Transition Relief Provided for Student Premium Reduction Arrangements



The departments provided guidance to colleges and universities that offer health coverage to student employees (and their dependents), confirming the applicability of ACA market reforms to premium reduction arrangements offered in connection with student health plans. The guidance also provides temporary transition relief for those premium reduction arrangements that might be viewed as employer payment plans subject to the ACA market mandates. (See our *For Your Information* from [March 16, 2016](#).)

Departments Finalize Market Mandate Guidance

The departments issued final regulations addressing grandfathered health plans, preexisting condition exclusions, lifetime and annual dollar limits, rescissions, coverage of dependent children to age 26, processes for internal claims and appeals, external review processes and patient protections requirements. These final regulations,

effective for plan years beginning on or after January 1, 2017, reflect comments, subregulatory guidance and proposed and interim final rules (dating back to 2010). (See our [March 31, 2016 For Your Information.](#))

Guidance on Retroactive Increase to 2015 Transit Benefits

The IRS issued guidance on the increase in the 2015 qualified transportation transit benefit, addressing employer questions on the retroactive application of the increased exclusion, establishing administrative procedures to alleviate reporting burdens for employers that allowed after-tax contributions for transit benefits in excess of \$130, and instructing employers on Form W-2 adjustments. (See our [January 12, 2016 FYI Alert.](#)) Legislation signed into law (the Consolidated Appropriations Act, 2016) extended parity for transit and parking benefits by retroactively increasing the transit benefit for 2015 (from \$130 to \$250) and provided permanent parity for 2016 and future years.



No ADA Violation When Wellness Plan Participation Is Condition of Health Plan Eligibility

A federal district court in Wisconsin ruled that a wellness program may require employees to timely complete health risk assessments and submit to biometric screenings as a condition of health plan eligibility without violating the ADA. (See our [January 19, 2016 For Your Information.](#)) This holding is contrary to a discussion in the EEOC's proposed ADA regulations and its position that the bona fide benefit plan exception is not the proper basis for allowing wellness program participation as a condition of eligibility for employer-provided health coverage.

Additional Guidance on Health FSA Carryovers

IRS guidance addressing the administration of FSA carryovers clarifies how carryovers must be treated for purposes of COBRA and discusses the conditions that a plan sponsor may impose on the availability of carryovers. (See our [January 28, 2016 For Your Information.](#))

Retiree Health Benefits Dispute Returns to Trial Court

The Sixth Circuit has remanded *M&G Polymers USA, LLC v. Tackett* to the trial court to make new factual determinations. (See our [February 11, 2016 For Your Information.](#)) Recall that last year the Supreme Court ruled that where a collective bargaining agreement (CBA) is silent on the duration of retiree health benefits, courts may not infer that the CBA parties intended the benefits to vest for life. Rather, general principles of contract law should be applied to determine the parties' intent. (See our [January 27, 2015 FYI Alert.](#))

High Court Halts State's Effort to Collect Health Data from Self-Funded ERISA Plans

The Supreme Court struck down a Vermont all-payer claims database law, as applied to self-funded ERISA plans, ruling that it interfered with nationwide ERISA plan administration by mandating that plans submit certain claims and enrollment information. With limited exceptions, ERISA preempts state law that relates to employee benefit plans or those conflicts with ERISA's substantive provisions. The Court suggested, however, that DOL may have authority to require ERISA plans to report this type of information to states. (See our [March 11, 2016 For Your Information.](#))

2017 Medicare Part D Benefit Parameters and Payments to EGWPs



The Centers for Medicare & Medicaid Services (CMS) released the proposed updates to Medicare Part D standard benefit parameters and the cost thresholds and limits for qualified retiree prescription drug plans for 2017. Plan sponsors that want to remain qualified for the employer retiree drug subsidy will have to determine if their 2017 prescription drug coverage is at least actuarially equivalent to the Medicare Part D coverage using the 2017 parameters. Importantly, CMS has proposed lowering payments to Medicare Advantage EGWPs in 2017. (See our [March 22, 2016 For Your Information.](#))

Creditable Coverage Disclosures to CMS by February 29

Each year, group health plan sponsors that provide prescription drug coverage to individuals eligible for Medicare Part D must disclose to CMS whether that coverage is "creditable" or "non-creditable." For calendar year plans, this year's disclosure was due by February 29, 2016. (See our [February 10, 2016 For Your Information.](#))

San Francisco's 2016 Minimum Healthcare Spending Requirements

San Francisco's Office of Labor Standards Enforcement issued the minimum healthcare spending requirements for 2016. (See our [February 10, 2016 For Your Information.](#)) The San Francisco Health Care Security Ordinance (HCSO) requires covered employers to make annual minimum healthcare expenditures on behalf of their San Francisco employees.

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