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compliance ALERT

Agencies Issue New Load of End-of-Year ACA Rules

December 23, 2016

December was a busy month for the agencies implementing the Affordable Care Act (ACA). The Department of Labor (DOL), Department of Health and Human Services (HHS) and Internal Revenue Service (IRS) ("the Agencies") recently issued new rules and guidance on premium tax credits, out-of-pocket maximums, preventive services, special Health Reimbursement Arrangements (HRAs) for small employers and other topics. Set forth below are summaries of these new rules.

IRS Finalizes ACA Premium Tax Credit Regulation and Delays Opt-Out Rules

On December 19, 2016, the IRS issued a final regulation ("Final Rule") pertaining to the premium tax credit that is available to eligible individuals who enroll in Exchange coverage. The Final Rule finalizes many, but not all, of the provisions in the proposed rules issued in July (see our e-Alert on the proposed rules here).

While the Final Rule contains many provisions pertaining to individual coverage, several provisions of the Final Rule are important to employers since an employee's eligibility for a premium tax credit for Exchange coverage can lead to penalties for employers under the Employer Shared Responsibility provisions of the ACA (commonly referred to as the "Pay or Play" provisions or "Employer Mandate").

Most notably, the Final Rule delays the final regulation on the impact of opt-out arrangements on the ACA's "affordable coverage" requirement.

What are the Requirements of the Final Rule? How is the Final Rule different from the Proposed Regulation?

Below is a summary of the clarifications contained in the Final Rule:

No Annual Enrollment Opportunity. Employees are considered eligible for affordable, minimum value coverage under an employer-sponsored plan (and therefore, are ineligible for premium tax credits for an Exchange plan) if they have an annual opportunity to enroll in the employer's group health plan. Under the Final Rule, individuals who decline to enroll in employer-sponsored coverage are considered eligible for the coverage only for the remainder of that plan year. If the employer does not provide another opportunity to enroll at the end of the plan year, then they are no longer considered eligible for employer-sponsored coverage and become eligible for the premium tax credit. This rule applies to both calendar-year and non-calendar-year plans, and could also lead to Pay or Play penalties for the employer (under Code § 4980H) for failing to offer employees an "effective opportunity" to elect to enroll in coverage at least once per plan year.

Inaccurate Affordability Information. Coverage under an eligible employer-sponsored plan is generally considered minimum essential coverage that makes an individual ineligible for the premium tax credit, but an individual may still be eligible for the tax credit if the offer of employer coverage is not affordable or does not provide minimum value. However, there is an exception to this affordability/minimum value requirement that applies where the employee intentionally, or with reckless disregard for the facts, gives wrong or misleading information to the Exchange in order to receive an

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- **Final regulations clarify eligibility rules for premium tax credits.**
- **The IRS has delayed final regulations that explain how opt-out arrangements will impact an employer's "affordability" analysis under the ACA.**
- **CMS announced the ACA MOOP limits for 2018; these may differ from limits for qualified HDHPs during any year.**
- **The DOL, HHS and IRS jointly issued 3 new ACA FAQs about special enrollment, preventive services, and qualified small employer health reimbursement arrangements under the 21st Century Cures Act.**

advance payment of the premium tax credit. The Final Rule clarifies and expands on this exception by explaining that, where this situation occurs, the IRS will enforce a heightened review standard (referred to as the "intentional or reckless disregard" standard) during the examination of the individual's tax return.

Specifically, the Final Rule explains that the IRS will apply this heightened review standard where the individual knowingly provides inaccurate information to the Exchange or makes little or no effort to determine whether the information provided is accurate under circumstances that "demonstrate a substantial deviation from the standard of conduct a reasonable person would observe." The Final Rule further provides that an individual is only responsible for the information that he or she provides to the Exchange and is not liable for inaccurate information provided by third parties, such as an employer.

Opt-out Arrangements. Most notably, the Final Rule does not finalize the proposed rules on the affordability implications of opt-out arrangements—arrangements where employers provide additional compensation to employees who waive or decline the employer's offer of health insurance coverage. Under the proposed regulation, if an employer did not comply with the opt-out arrangement rules (by, for example, not verifying information from the employee pertaining to the reason for declining coverage), then the additional compensation, referred to as the "opt-out payment," would be added to the cost of the employer's single-tier coverage for purposes of determining the plan's affordability under the ACA's Pay or Play rules.

If employer coverage is not affordable because the amount of the available opt-out payment increases the employee's required contribution, more employees may then become eligible for premium tax credits on the Exchanges, thereby increasing an employer's exposure to Pay or Play penalties. While the proposed rules had indicated that the new opt-out rules would become effective for plan years beginning on or after January 1, 2017, in the Final Rule the IRS indicated that it is still examining the issues raised by opt-out arrangements and expects to finalize those proposed regulations in a separate regulation "at a later time." Until this final regulation on opt-out arrangements is released, employers do not have to comply with the new rules contained in the proposed regulation that were slated to go into effect on January 1, 2017.

These new rules, which required employers to maintain compliant "eligible opt-out arrangements," contained several new requirements and were difficult for many employers to comply with (see our e-Alert discussing "eligible opt-out arrangements" here).

Additionally, the IRS explained that until this final regulation is issued, the affordability safe harbor announced in IRS Notice 2015-87 (in Q&A #9 of this Notice) continues to apply, as well as the transition relief for collectively bargained plans announced in the Preamble of the proposed regulation (see our discussion of these rules in our e-Alert on the proposed regulations here).

Employers should be sure to understand and comply with each new rule and requirement.

The Final Rule also finalizes a number of other proposed rules that primarily affect individuals who enroll in an Exchange and claim the premium tax credit—including rules pertaining to enrolling family members who reside in different states and enroll in separate qualified health plans, and determining the amount of the applicable silver-level benchmark plan (which may cap the amount of the premium tax credit).

How Does This Affect Employers?

While the final premium tax credit rules will have an impact on employers' exposure to possible Pay or Play penalties, it is difficult to tell at this time how the incoming Trump administration, and any new ACA replacement law or regulation, will treat the Exchanges and these rules for premium tax credit eligibility. Based on our review of the Republican-proposed ACA replacement plans, it is likely that the Republicans in power will seek to eliminate, or at least simplify, these premium tax credit rules.

The really good news in the Final Rule for most employers pertains to the delay of the opt-out arrangement rules. Many employers found these new rules to be overly complicated, and can now breathe a big sigh of relief that they will most likely not have to comply with them on January 1, 2017.

CMS Announces 2018 ACA Maximum Out-of-Pocket Limits

On December 16, 2016, the Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) issued a final regulation announcing the maximum annual out-of-pocket (MOOP) limitations for health insurance coverage under the Affordable Care Act (ACA) for 2018. These out-of-pocket limits apply to all non-grandfathered group health plan coverage for plan years beginning on or after January 1, 2018.

The MOOP limit for plan years beginning in 2018 is $7,350 for self-only coverage, and $14,700 for family coverage. This represents an increase of 2.8% from 2017, or a $200 increase for individual coverage and a $400 increase for family coverage.

CMS also announced cost-sharing parameters and reductions for Federal and State-based Exchange plans, and affirmed that these MOOP limits under the ACA may differ from MOOP limits for qualified High Deductible Health Plans (HDHPs) during any year, since HDHP MOOP limits are based on different standards utilized by the IRS.

Agencies Issue FAQ Guidance on New HRAs for Small Employers; Other ACA Rules

On December 20, 2016, the Agencies jointly issued three new ACA-related FAQs about special enrollment, preventive services, and qualified small employer health reimbursement arrangements (QSEHRAs). The new rules for QSEHRAs, the new type of Health Reimbursement Arrangement (HRA) for small employers announced in the 21st Century Cures Act (see our recent e-Alert on this topic here) are much welcomed by employers eager to adopt the more flexible HRAs.

Below is a brief summary of the new guidance:

QSEHRAs. Q&A #3 affirms that prior guidance on the application of the ACA to HRAs and employer payment plans (EPPs)—which generally prohibits HRAs and EPPs from being used to purchase individual health insurance coverage unless that coverage is limited to excepted benefits or unless the arrangement is offered only to retirees—remains in effect.

Importantly, however, that guidance does not apply to QSEHRAs because QSEHRAs, as defined by the 21st Century Cures Act for years beginning after December 31, 2016, are not group health plans. Specifically, this Q&A #3 clarifies that the Cures Act's retroactive extension of IRS Notice 2015-17's reporting and excise tax relief for EPPs is limited to EPPs that pay or reimburse only individual health insurance premiums or premiums for Medicare Part B or Part D.

The coverage in EPPs that qualify for this relief (applicable to plan years beginning on or before December 31, 2016) will be considered minimum essential coverage that prevents covered individuals from qualifying for ACA premium tax credits under Code § 36B. The Q&A also explains that the Cures Act extension has no effect on the relief in Notice 2015-17 (in Q&A #2 of this Notice) for certain S corporation health care arrangements for 2% shareholder-employees.

Special Enrollment. Q&A #1 confirms that if employees and their dependents lose eligibility in individual market coverage (including in Exchange coverage), then they are entitled to a mid-year special enrollment in an employer-sponsored group health plan for which they are otherwise eligible and had previously declined to enroll.

This special enrollment opportunity applies if the loss of eligibility is for reasons other than failure to timely pay premiums or for termination of coverage for cause (e.g., for making an intentional misrepresentation of a material fact). Individuals are entitled to special enrollment in group health plan coverage regardless of whether they may enroll in other individual market coverage inside or outside of the Exchange.

Preventive Services. Q&A #2, which notes that the Health Resources and Services Administration (HRSA) updated its Women's Preventive Services Guidelines on December 20, 2016, explains that the updated guidelines apply for plan years beginning on or after December 20, 2017. The updated guidelines address a number of preventive services, including breast cancer screening, breastfeeding services and supplies and well-woman preventive visits. Until the applicability date of the new guidelines, non-grandfathered group health plans and insurers are required to provide coverage without cost-sharing consistent with the previous HRSA guidelines for any items or services that continue to be recommended.

What Should Employers Do Next?

As the Agencies continue to issue ACA-related regulations and guidance in the final days of 2016, employers should review and comply with these new rules and requirements, even if busy with year-end deadlines and coordinating work during the holidays.

Our account managers and consultants are here to help guide you through all of the new rules.

If you have any additional questions, please call your Corporate Synergies Account Manager or 866.CSG.1719.

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