Year-End 2016 Regulatory Wrap Up

The following briefly summarizes some benefits-related issues that were addressed in the final days of 2016.

Opt-Out Provisions

The IRS issued final regulations – *Premium Tax Credit Regulation VI* – that contained comments relating to the treatment of employer opt-out arrangements (i.e. paying employees to decline enrollment in the employer's group health plan) with regard to the determination of "affordability" when assessing potential Affordable Care Act ("ACA") employer mandate penalties and ACA reporting.

In an earlier Notice of Proposed Rulemaking, the IRS indicated that employers who offer *conditional* opt-out arrangements which require documentation of other group health plan coverage from the employee and all tax dependents, do not have to include the dollar value of the opt-out payment in the determination of "affordability" under the ACA employer mandate. Conversely, employers that do not confirm other group health coverage would need to add the opt-out payment to the lowest cost for single coverage charged to employees to determine whether an affordable offer of coverage was made to the employee. The IRS anticipated the effective date to be for plan years beginning on and after January 1, 2017.

Treasury and IRS concluded the need to further examine the proposed opt-out rules and therefore, final opt-out rules will come at a later time. Until final regulations are issued, employers with opt-out arrangements established before December 16, 2015 may rely on transition relief in Notice 2015-87 and will not have to add the value of any opt-out payment in the determination of health plan affordability however; employers who established unconditional opt-out arrangements on and after December 16, 2016 would need to add the value of the opt-out payment when determining affordability.

2018 Maximum Out-Of-Pocket Limitation

The Department of Health and Human Services ("HHS") issued the Final 2018 Notice of Benefit Payments and Parameters which has set the maximum annual limitation on cost sharing for in-network essential health benefits to be $7,350 for self-only coverage ($7,150 for 2016) and $14,700 for other coverage levels ($14,300 for 2016) for *all non-grandfathered group health plans*.

FAQs About Affordable Care Act Implementation Part 35

FAQ 1 confirms that a special enrollment right exists when an otherwise eligible employee who declined enrollment in an employer's group health plan loses their eligibility under an individual plan, other than for lack of premium payment or fraudulent activity. This circumstance could arise when an employee moves out of the service area under an individual health insurance plan.

FAQ 2 confirms that the updated Women's Preventive Services Guidelines that were issued on December 20, 2016 will be required to be offered under non-grandfathered group health plans beginning with the first plan year that begins on and after December 20, 2017. The update is available here.

The FAQs can be found here.

Paying Disability Claims

The Department of Labor (DOL) has issued the final rules for Claims Procedures for Plans Providing Disability Benefits to strengthen current ERISA disability claims procedures and to better align the disability claims process with group health plan procedural protections that were contained in the ACA. The final rules generally adopt the proposed rules issued in November 2015 and apply to disability claims submitted on and after January 1, 2018.

The major provisions and protections addressed in this final rule are designed to ensure that:

- Claims and appeals are adjudicated to ensure independence and impartiality of the persons involved in making the decision;
- Benefit denial notices fully describe why the plan denied the claim, what standards were used in making the decision and why the denial disagreed with any views of medical or vocational experts involved in the decision or with Social Security determinations;
- Claimants have timely access to their entire claim file and relevant documents and are guaranteed the right to present evidence and testimony to support their claim during the review process;
- Claimants are notified of and have an opportunity to respond to any new evidence reasonably in advance of an appeal decision;
- If plans do not adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the plan and may pursue the claim in court, unless the violation was the result of a minor error;
- Certain rescissions of coverage are treated as adverse benefit determinations, thereby triggering the plan's appeals procedures; and
- Benefit denial notices are written in a culturally and linguistically appropriate manner when a claimant's address is in a county where 10% or more of the population is literate in the same non-English language by including a statement in the non-English language explaining the availability of language services.