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Too Little, Too Late? CMS Issues Proposed Rule to Stabilize the Individual and Small Group Health Insurance Markets

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On February 15, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for the 2018 coverage year designed to stabilize the individual and small group health insurance markets (the "Exchanges"). The proposed rule follows President Trump's January 20, 2017 executive order that directed agencies to minimize the economic and regulatory burdens of the Patient Protection and Affordable Care Act ("ACA"). In connection with efforts to repeal ACA, Republicans are trying to ensure that the Exchanges remain viable.

In general, health insurers have had difficulty attracting and retaining the healthy individuals necessary to provide a stable risk pool that will support stable premium rates. Concerns over the risk pool have led some health insurers to abandon the Exchanges in certain states, and/or request very large premium increases. The proposed rule, which is being published as health insurers develop their proposed benefit structures and premium rates for the 2018 coverage year, aims to provide flexibility to insurers to help attract healthy individuals to enroll in health coverage, improve the risk pool, and bring stability to the individual and small group markets. The rule proposes a variety of policy and operational changes to stabilize the Exchanges, including:

- **Shorten the Open Enrollment Period:** The proposed rule would shorten the annual open enrollment period for the individual market. The enrollment period would begin November 1 and end December 15; previously, the open enrollment period was a three month period that started November 1 and ended the following January 31. CMS anticipates that this change could improve the risk pool by reducing the opportunities for adverse selection by individuals who decide they need coverage in late December or January.

Our Practice

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- **Pre-Enrollment Verification for Special Enrollment Periods:** Special enrollment periods allow individuals to enroll outside of open enrollment if they incur certain qualifying events. In response to concerns from insurers about potential abuses of the special enrollment periods, the proposed rule would require individuals who enroll outside of the open enrollment period to submit supporting documentation in order to verify eligibility. CMS believes that this change will help decrease premiums, curb abuses, and encourage year-round enrollment.

- **Collection of Unpaid Premiums:** Currently, an individual whose coverage is cancelled due to a failure to pay premiums can elect, during the next open enrollment period, to enroll in new coverage under a different product offered by the same insurer without being required to pay the past due premiums. The proposed rule would allow insurers to collect premiums for prior unpaid coverage before the individual is allowed to enroll in any coverage option offered by that insurer for the next year. CMS believes this change will incentivize individuals to maintain continuous coverage throughout a year, and positively impact the risk pool by removing the economic incentive individuals may have had to pay premiums only when they need health care services.

- **Determining the Level of Coverage:** Under ACA, a health plan's coverage level, or actuarial value, is determined based on its level of coverage of "essential health benefits" which is certified at the bronze, silver, gold, or platinum plan level. For the 2018 coverage year, the rule proposes to adjust the *de minimis* range used for determining the level of coverage. Essentially, this lowers the actuarial value required to meet the various plan coverage levels. CMS says that expanding the *di minimis* range will allow insurers greater flexibility in designing new plans and to provide additional options to keep cost sharing the same from year to year. While CMS acknowledges that in the short term, this change "could reduce the value of coverage for consumers, which could lead to more consumers facing increases in out-of-pocket expenses… in the longer run, providing issuers with additional flexibility could help to stabilize premiums, increase issuer participation and ultimately provide some offsetting benefit to consumers."

- **Network Adequacy:** ACA requires health insurers to maintain a network that is sufficient in number and type of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without reasonable delay. For the 2018 coverage year, CMS proposes to defer to the states' determination of network adequacy.

- **Extend the Qualified Health Plan (QHP) Certification Calendar:** In the proposed rule, CMS announces that it will extend the timeline for the QHP certification and rate review process for the 2018 coverage year in order to give health insurers additional time to implement proposed changes that are finalized prior to the 2018 coverage year. These changes will give health insurers flexibility to incorporate benefit changes and maximize the number of coverage options available to consumers.

In developing the policies in the proposed rule, CMS indicated that they considered maintaining the status quo, but determined that the changes are urgently needed to stabilize health insurance markets, to incentivize insurers to enter or remain in the Exchanges, to ensure premium stability and to increase choices for consumers. However, CMS acknowledges that the net effect of the proposed rule is uncertain and may not have the desired effect on enrollment, premiums or overall healthcare spending. The proposed rule is open to public comment until March 7, 2017.

King & Spalding would be pleased to assist you with your health plans and any questions regarding the impact of these proposed rules.

IRS Eases the Individual Mandate Reporting Requirement

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The Patient Protection and Affordable Care Act ("ACA") requires individual taxpayers to maintain qualifying health coverage or pay a tax penalty for the months that the taxpayer did not have health coverage. For the 2014 and 2015 tax years, the IRS accepted individual tax returns even if the taxpayer failed to indicate whether he or she maintained qualifying health coverage during that tax year. For the 2016 tax year, however, the IRS set up a system to reject individual tax returns if the health coverage information is not provided.

Consistent with President Trump's January 20, 2017 executive order requiring federal agencies to reduce the burden of ACA, the IRS has announced that it will continue to accept individual tax returns (in both electronic and paper form) where the taxpayer does not provide information related to health care coverage. Instead of systemically rejecting silent returns at the time of filing, such returns (including those expecting a refund) will be processed, thereby minimizing the burden on taxpayers. If and when the IRS has questions about a tax return, taxpayers may receive follow-up questions and correspondence at a future date, after the filing process is completed. This is similar to how the IRS handled the individual mandate reporting issue for the 2014 and 2015 tax years.

With this reporting requirement change, the IRS seems to be easing off on enforcing the ACA individual mandate. However, the IRS emphasized that the provisions of ACA are still in force, and until changed by the Congress, all taxpayers must continue to follow the law and pay any associated penalties. It remains to be seen whether Congress will repeal the ACA individual mandate or the associated penalty, whether any such ACA repeal would be applied retroactively, or whether the IRS would attempt to enforce penalties for past violations of the ACA individual mandate.

King &Spalding would be pleased to assist you with your health plans and any questions regarding the impact of the reporting changes.

March and April 2017 Filing and Notice Deadlines for Qualified Retirement and Health and Welfare Plans

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Employers and plan sponsors must comply with numerous filing and notice deadlines for their retirement and health and welfare plans. Failure to comply with these deadlines can result in costly penalties. To avoid such penalties, employers should remain informed with respect to the filing and notice deadlines associated with their plans.

The filing and notice deadline table below provides key filing and notice deadlines common to calendar year plans for the next two months. If the due date falls on a Saturday, Sunday, or legal holiday, the due date is generally delayed until the next business day. Please note that the deadlines will generally be different if your plan year is not the calendar year.

Please also note that the table is not a complete list of all applicable filing and notice deadlines (including any available exceptions and/or extensions), just the most common ones. King & Spalding is happy to assist you with any questions you may have regarding compliance with the filing and notice requirements for your employee benefit plans.

Deadline	Item	Action	Affected Plans
March 1 (60 days after the beginning of the plan year)	Medicare Part D Creditable Coverage Disclosure	Deadline for employers that provide prescription drug coverage to Medicare Part D eligible individuals to disclose to the Centers for Medicaid and Medicare Services (CMS) whether the coverage is "creditable prescription drug coverage" by completing the Online Disclosure to CMS Form at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html	Health and Welfare Plans that provide prescription drug coverage to Medicare Part D eligible individuals
March 2	IRS Form 1095-B Individual Statements	Deadline for providers of minimum essential coverage to distribute forms used to report to responsible individuals the months during the year that the individuals satisfied the individual mandate by enrolling in minimum essential coverage. This deadline was extended from its original deadline of January 31. Note that self-insured ALEs can report this information on Form 1095-C. Fully insured plan sponsors that are not ALEs are not required to distribute Form 1095-B, which are distributed by the group health plan insurers.	Self-Insured Group Health Plans and Group Health Plan Insurers
	IRS Form 1095-C Individual Statements	Deadline for ALEs to report to provide a written statement to employees indicating whether the ALEs offered an opportunity to enroll in (and whether the employee did enroll in) minimum essential coverage under the ALE's sponsored plan. This deadline was extended from its original deadline of January 31.	Applicable Large Employers

Deadline	Item	Action	Affected Plans
March 15	Plan Contribution Deadline	Deadline for corporate employer contributions to be made to plan trusts in order for such amounts to be deductible on corporate tax returns (assuming the employer is operating on a calendar-year fiscal year). Note that this deadline may be extended if an extension is obtained for the corporate tax return.	Qualified Retirement Plans*
March 15 (2 ½ months after the plan year)	Excess Contributions	Deadline for plan administrator to distribute any excess contributions and earnings from the prior year to avoid 10% excise tax on employer (other than eligible automatic contribution arrangements (EACAs)).	401(k) Plans Other Than EACAs
March 31 (last day of 3rd month following the end of the prior plan year)	Certification of Adjusted Funding Target Attainment Percentage (AFTAP)	Deadline for actuary to certify AFTAP to avoid presumption that AFTAP is 10 points less than prior year AFTAP.	Defined Benefit Plans
March 31 (if filing electronically)	IRS Form 1094-B Transmittal Forms	Deadline for providers of minimum essential coverage to transmit forms to IRS reporting the months during the year that individuals enrolled in the group health plan satisfied the individual mandate by enrolling in minimum essential coverage.	Self-Insured Group Health Plans and Group Health Plan Insurers
	IRS Form 1094-C Transmittal Forms	Deadline for ALEs to transmit forms to IRS reporting whether the ALEs offered an opportunity to enroll in (and whether employees did enroll in) minimum essential coverage under the ALE's sponsored plan.	Applicable Large Employers

* Qualified Retirement Plans include all defined benefit and defined contribution plans that are intended to satisfy Internal Revenue Code §401(a).

Deadline	Item	Action	Affected Plans
April 1	Age 70 ½ Distribution Requirements	Deadline for plan administrator to distribute prior year's required minimum distribution for any terminated employee who reached age 70 ½ or older during the prior year.	Qualified Retirement Plans
April 15	Excess Deferrals	Deadline for plan to distribute prior year's deferrals in excess of Internal Revenue Code (IRC) §402(g) annual dollar limit and related earnings.	401(k) Plans
April 16 (105 days after the end of the plan year)	PBGC 4010 Filing	Deadline for contributing sponsors (and each controlled group member) to file PBGC Form 4010 if: 1) Any single-employer plan in the contributing sponsor's controlled group had a prior year AFTAP of less than 80%; 2) Any single-employer plan in the contributing sponsor's controlled group fails to make a required installment or other required payments to a plan, and as a result, a lien is imposed pursuant to ERISA section 303(k)(1) or IRC section 430(k)(1); or 3) The IRS has granted funding waivers of more than $1 million to any single-employer plan in the contributing sponsor's controlled group and any portion of such waiver is still outstanding.	Defined Benefit Plans
April 30 (no later than 120 days after the end of the plan year)	Annual Funding Notice	Deadline for the plan administrator to provide a plan funding notice to the PBGC, to each plan participant and beneficiary and to each employer that has an obligation to contribute under the plan.	Defined Benefit Plans