On August 28, 2014, the U.S. Department of Treasury and the Internal Revenue Service (IRS) released draft instructions along with revised draft forms providing employers guidance on complying with the Affordable Care Act’s (ACA’s) employer mandate. The IRS initially released draft forms in July but without filing instructions. The recently released filing instructions address various tax forms employers must soon file in order to comply with the ACA. The first reporting is required in early 2016 for the 2015 calendar year although employers are encouraged to voluntarily report coverage information in 2015 for the 2014 calendar year.

Background
As explained in our previous newsletters, e-mails and our Town Hall meetings, under the ACA’s Pay or Play mandates (Internal Revenue Code §4980H), an applicable large employer (“ALE”) is subject to a penalty known as the “Employer Shared Responsibility Payment,” if the ALE either fails to offer its employees and their dependents minimum essential coverage (MEC) under an eligible employer sponsored plan and one of the ALE’s full-time employees receives a premium tax credit or the ALE fails to provide affordable health coverage that provides minimum value (MV) and one of the ALE’s full-time employees receives a premium tax credit.

Insurers and self-funded plan sponsors, regardless of their size, must report annually to the IRS and to those individuals named in the report whether the individual had MEC. This report confirms whether individuals have complied with the ACA’s “individual mandate.” For self-funded plans, employers may report for the individual and employer mandates on a single form. ALEs need to report on all employees offered coverage during the prior calendar year. This information must be provided to the IRS and all employees identified as being offered the employer-sponsored coverage.

Continued on Page 6

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1 An employer that employed an average of at least 50 full-time employees on business days during the preceding calendar year. 4980H(c)(2). Full-time equivalent employees are included along with full-time employees.
2 Minimum Essential Coverage has the same meaning as provided in § 5000A(f) and related regulations and guidance. Minimum Essential Coverage is generally employer group health plan coverage but does not include coverage consisting solely of excepted benefits.
3 §4980H(a) penalty.
4 A plan fails to provide MV if the plan’s share of the total allowed costs of benefits provided under the plan is less than 60 percent of those costs. §36B(c)(2)(C)(ii). HHS has provided an MV calculator available at: http://cciio.cms.gov/resources/regulations/index.html. Plans may also rely on a safe harbor or actuarial certification to determine MV.
5 §4980H(b) penalty.
Non-Grandfathered OOP Maximum Requires Programming

In 2015, non-grandfathered health plans will have to fully comply with the ACA mandate limiting the total out-of-pocket (OOP) maximum a plan can require before it pays eligible claims at 100%. Previous to this ACA requirement, most definitions of OOP maximum included only the deductible and any coinsurance cost sharing. However, under the ACA rules, the OOP maximum must include not only the medical plan deductible and coinsurance, but also any deductible for certain ancillary benefits paid by separate vendors, such as a pharmacy deductible imposed through a pharmacy benefit management vendor (PBM) and will include copayments under both the medical plan and copayments under separate plans such as pharmacy plans.

A large number of plans, both self-funded and insured, are impacted by this requirement. Copayments and separate deductibles for benefits such as pharmacy—not previously added to the plan’s OOP maximum—now must be included in the plan’s OOP maximum. After the medical plan’s OOP maximum is met, no additional copayment or separate deductible for separate benefits may be imposed. Once this occurs, all benefits (excluding HIPAA excepted benefits such as stand-alone dental and vision) must pay at 100% for the remainder of that benefit period. The OOP maximum can be no more than the applicable HDHP OOP maximum. Transitional relief gives plans with ancillary benefits such as pharmacy benefits through a PBM until the first benefit plan year in 2015. For 2015 non-grandfathered plans OOP maximum limits are:

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Grandfathered HDHP</td>
<td>$6,600</td>
<td>$13,200</td>
</tr>
<tr>
<td>HSA Compatible HDHP</td>
<td>$6,450</td>
<td>$12,900</td>
</tr>
</tbody>
</table>

The OOP maximum mandate and these limits will apply starting no later than the first day of a plan's 2015 plan year regardless of what the plan benefit period is.

All in-network cost sharing which includes deductible, co insurance, copayments and pharmacy cost sharing must all accrue towards the OOP maximum. There are two options for compliance:

Option #1: Allegiance does not recommend this option (except for HSA compatible HDHPs), but for all cost sharing for both medical claims and pharmacy claims they would both accrue to the same OOP maximum. Allegiance does not recommend this option because of the potential ‘lag time’ between the medical claims system and a pharmacy claims system even for claims data transmissions in real time. This lag time, in rare instances, could cause over application of the OOP maximum if only for a day.

Option #2: Maintain separate OOP maximums for medical claims and for pharmacy claims. OOP maximums are required for both benefits. By using this method, the total OOP combined maximum between the medical and pharmacy OOP cannot exceed the maximum limits. For example, if a non HSA compatible High Deductible Health Plan has a $4,000 OOP maximum for medical claims, the most the plan could have for pharmacy claims would be $2,600. This would then be a total $6,600 single coverage OOP maximum for all benefits.

Because the OOP maximum will require programming, if your plan utilizes a pharmacy benefits manager (PBM), please contact your Allegiance Account Executive before October 1, 2014 to discuss the option your plan will use for this mandate.
In the Courts: Courts issue two conflicting decisions on availability of tax credits in FFEs

On July 22, 2014, two federal appellate courts reached two opposite conclusions on whether individuals who purchase health insurance through a federally-facilitated Exchange (FFE) are entitled to tax credits.

In the case of Halbig v. Burwell, a three-judge panel of the U.S. Court of Appeals for the D.C. Circuit, held that individual tax credits are available only through state-run Exchanges. Currently only fourteen states and the District of Columbia have established Exchanges. The remaining thirty-six states utilize FFEs.

For the Halbig court, the “crux” of the case was “whether an Exchange established by the federal government is an Exchange established by the State under §1311 of the [ACA].”¹ The two judge majority concluded that the ACA’s specific language requires Exchanges to be established by the State (not the federal government) in order to provide individual tax credits. An FFE, the court reasoned, does not meet this statutory criteria.

The Administration petitioned the U.S. Court of Appeals for the D.C. Circuit for a rehearing of the case by the entire court. Earlier this month that petition was granted. Oral arguments in the rehearing are presently scheduled for December 17, 2014.

Also on July 22, 2014, the Fourth Circuit Court of Appeals issued a completely contrary opinion to that of the DC Circuit by holding that tax credits are available in both state-run exchanges as well as FFEs. The Fourth Circuit Court in the case of King v. Burwell reasoned that the individual tax credit provisions of the ACA must be read in conjunction with the entire Act. The court concluded that the statutory provisions, the purpose, and legislative history of the ACA all favored the Administration’s position that Congress’ intent was not clear and that when a statute is ambiguous, a court should defer to the government’s interpretation provided that the interpretation is reasonable. The Fourth Circuit Court held that the Administration’s position was reasonable considering the overall importance individual tax credits have to the ACA’s objectives.

Plaintiffs in the King v. Burwell case have petitioned the U.S. Supreme Court for review of the Fourth Circuit’s decision. If the D.C. Circuit upholds its three-judge panel’s decision following the rehearing, these opposing circuit court decisions increase the possibility that the US Supreme Court will agree to decide the issue.

Michigan Tax Upheld
To support Michigan’s Medicaid program, the 2011 Michigan legislature passed the Health Insurance Claims

¹Halbig at p.16

Continued on Page 4

Business Associate Agreement Deadline

As reported in our spring 2013 newsletter, the HIPAA Final Rule became effective March 26, 2013. HIPAA covered entities and business associates had 180 days beyond the effective date (September 23, 2013) to come into compliance with most of the Final Rule’s provisions, such as the modifications to the Breach Notification Rule. For Business Associate Agreements (BAA) in effect as of January 25, 2013, covered entities and business associates have until September 22, 2014 to modify those BAAs to conform to the Final Rule (provided the BAA was not already renewed or modified between March 26, 2013 and September 23, 2013).
In the Courts (cont.)

Assessment Act (HICA) imposing a 1% tax to certain claims for medical services in Michigan. Effective January 1, 2012, HICA’s 1% assessment\(^2\) applies to claims paid by carriers or third party administrators for Michigan residents who receive medical care from providers in Michigan. The tax is capped at $10,000 per insured individual or covered life.\(^3\)

Michigan’s tax is unique because it applies to sponsors of ERISA health plans. The Self-Insurance Institute of America (SIIA) challenged the Michigan tax as applied to self-insured ERISA plans arguing that its application violated the federal law’s preemption clause. ERISA’s preemption clause generally precludes the application of state laws to ERISA plans.

A federal district court in Michigan dismissed SIIA’s challenge to the Michigan tax concluding that it did not violate ERISA’s preemption clause. SIIA appealed the district court’s ruling to the Sixth Circuit Court of Appeals. On appeal to the Sixth Circuit Court, SIIA argued that the Michigan tax violated ERISA by jeopardizing uniform ERISA plan administration, imposing additional administrative burdens on ERISA plans, and, interfering with relationships between ERISA-covered entities by requiring ERISA plans or their TPAs to collect residency information from beneficiaries. The Sixth Circuit disagreed with SIIA’s arguments, however, upholding the lower court ruling that Michigan’s tax is not preempted by ERISA (info).

**Hobby Lobby Stores Inc.**

On June 30, 2014, the United States Supreme Court, in reviewing the Affordable Care Act’s (ACA) contraceptive mandate ruled 5 to 4 that the mandate violates the Religious Freedom Restoration Act of 1993 (RFRA) as it is applied to “closely held corporations” and thereby substantially burdens the free exercise of religion. The decision in *Burwell v. Hobby Lobby, Inc.*, combined separate cases involving companies owned by Christian families. Under the ACA, and its implementing regulations, many health plans must cover certain preventive services for women without cost sharing such as coinsurance, copayments, or deductibles. These preventive services are FDA approved contraceptive methods, sterilization procedures as well as education and counseling for women. This requirement does not apply to grandfathered health plans or to certain religious employers such as churches. The US Department of Health and Human Services (HHS) has also effectively exempted from this mandate religious nonprofit organizations with religious objections to providing coverage for contraceptive services. In those cases covered by the *Hobby Lobby* decision, the owners of closely held for-profit corporations argued that the mandate violated their religious principles by requiring them to facilitate access to contraceptive drugs, devices or services.

RFRA prohibits the Government from substantially burdening the exercise of religion unless the Government demonstrates that it furthers a compelling governmental interest and is the least restrictive means of doing so. Writing for the majority, Justice Samuel Alito explained that he accepted for the sake of argument that the government had a compelling interest in making sure women have access to contraception but that HHS failed to show that it lacked other means of achieving its goal of contraceptive coverage without imposing a substantial burden on the exercise of religion. The Court suggested that the government could, for example, assume the cost of providing the contraceptives to women unable to obtain coverage due to their employer’s religious objections or HHS could utilize the accommodation already in use for certain nonprofit religious organizations.

The Court makes clear that its decision in the *Hobby Lobby* case is very limited in its scope applying only to closely held corporations and concerns only the contraceptive mandate. The decision does not hold that all insurance coverage mandates fail necessarily if the mandate conflicts with an employer’s religious beliefs. Following the Hobby Lobby decision, HHS and the Departments of Labor and Treasury issued a joint FAQ concerning notification requirements for closely held corporations discontinuing contraceptive coverage. The FAQ can be found at: [http://www.dol.gov/ebsa/faqs/faq-aca20.html](http://www.dol.gov/ebsa/faqs/faq-aca20.html).

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\(^2\)This percentage has been revised. For dates of services between July 1, 2014 and December 31, 2017, every carrier and third party administrator will be levied an assessment of 0.75% of applicable paid claims.

\(^3\)Michigan’s Treasury interprets this provision to mean that the $10,000 cap will apply to an insurer or third party administrator.
In accordance with a health care reform requirement, in September 2012, the US Department of Health and Human Services (HHS) issued final regulations establishing a standard for a national, unique health plan identifier (HPID) and provisions for implementing it. An HPID is a ten digit code used to identify health plans in standard electronic transactions.

Most health plans and entities paying health claims must obtain a HPID. The HPID is intended to streamline electronic transactions between carriers, administrators, health care professionals, and financial institutions. All electronic transactions between health plans and providers will have a required field for this number to assist in tracking payments.

Health plans required to obtain an HPID include:
- Employer-sponsored self-funded group health plans considered Controlling Health Plans (CHPs)
- Health insurance issuers and HMOs; and
- Federal Employees Health Benefits (FEHB) program and governmental health plans.

An entity that meets the definition of CHP needs to obtain an HPID. A CHP means a health plan that:
1. Controls its own business activities, actions, or policies; or
2. (i) is controlled by an entity that is not a health plan; and
   (ii) if it has a subhealth plan(s), exercises sufficient control over the subhealth plan(s) to direct its/their business activities, actions, or policies.

The regulations suggest that the following considerations may be helpful in determining if an entity is a CHP:
- Does the entity itself meet the definition of health plan at 45 CFR 160.103?
- Does either the entity itself or a non health plan organization control the business activities, actions, or policies of the entity?

If the answer to both questions is ‘yes,’ the entity meets the definition of a CHP and needs to obtain an HPID.

A plan deemed to be a subhealth plan (SHP) does not need to obtain an HPID. A SHP means a health plan whose business activities, actions, or policies are directed by a controlling health plan. The regulation suggests the following considerations to determine whether an entity is a SHP:
1. Does the entity meet the definition of health plan at 45 CFR 160.103?
2. Does a CHP direct the business activities, actions, or policies of the health plan entity?

If the answer to both questions is ‘yes,’ the entity meets the definition of a SHP. A SHP is not required to obtain an HPID, but may choose to obtain an HPID, or its CHP may obtain an HPID on its behalf*.

Key compliance dates for obtaining an HPID:

<table>
<thead>
<tr>
<th>Plan</th>
<th>Compliance Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health plans with annual receipts of $5 million or</td>
<td>Must obtain HPID by November 5, 2014</td>
</tr>
<tr>
<td>Health plans with annual receipts of less than $5</td>
<td>Must obtain HPID by November 5, 2015</td>
</tr>
<tr>
<td>All plans generating electronic transactions</td>
<td>Must use HPIDs in transactions by November 7, 2016</td>
</tr>
</tbody>
</table>

HPI Deadline (cont.)
For self-funded health plans “annual receipts” means the total annual paid claims in 2013.

The law requires self-funded employers or group health plans to obtain their own HPIDs. Self-funded employers must also calculate their annual receipts. Self-funded plans with more than $5 million in receipts in 2013 should start the application process to apply for an HPID as soon as possible. Allegiance will have staff available to assist you with this process. For our Allegiance Life and Health (AL&H) customers, AL&H is the payer, so AL&H will register for you.

HPID applications are available through the Centers for Medicare and Medicaid Services (CMS) website. Specific information on how to apply for an HPID may be found here: Videos that walk through each step of the application process to obtain a HPID for a controlling health plan (CHP), a subhealth plan (SHP), and an other entity identifier (OEID)* are available on this site.

The application process also requests a Payer ID number, but CMS has advised that self-funded employers who do not have these numbers may enter “not applicable” in this field on the application and will still be able to apply for their HPIDs successfully. Once in the website you will need to register and obtain a password which will then allow you into the application portion of the website. That section of the website is identified as the HIOS/HPOES section.

If you have questions concerning the HPID please contact your Allegiance Account Executive. Allegiance encourages you to start the process of obtaining an HPID now in order to have it by the deadline. The website frequently closes for “maintenance” for days at a time.

* A non-health plan entity that needs to be identified in standard transactions such as a TPA, a claims repricer, or a health care clearinghouse, is permitted, but not required, to obtain an OEID. An entity is eligible to obtain an OEID if the entity (1) needs to be identified in a transaction for which a standard has been adopted by HHS; (2) is not eligible to obtain an HPID or NPI; and (3) is not an individual.

Revised Draft Forms (cont. from pg. 1)

Important Webinars
To assist our customers, Allegiance is conducting a series of webinars to finalize plan designs for Employer Responsibility compliance. For Allegiance customers subject to this rule, it is time to discuss specific compliance options that are available so plan amendments can be created as necessary to implement those options. It is critical, especially for our customers with Plan years from January to June, to attend one of the following webinar sessions and contact your Allegiance Account Executive after the webinar to finalize your plan’s compliance options so amendments can be issued and employees can be informed.

The webinars can be accessed at here. Meeting details are below:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Meeting Number</th>
<th>Passcode</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 23rd</td>
<td>10:00am</td>
<td>682 322 756</td>
<td>PPACApayorplay1</td>
</tr>
<tr>
<td>November 2022</td>
<td>10:00am</td>
<td>685 907 218</td>
<td>PPACApayorplay2</td>
</tr>
<tr>
<td>September 25th</td>
<td>10:00am</td>
<td>683 296 474</td>
<td>PPACApayorplay3</td>
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<tr>
<td>September 30th</td>
<td>10:00am</td>
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<td>PPACApayorplay4</td>
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<tr>
<td>October 1st</td>
<td>10:00am</td>
<td>687 522 257</td>
<td>PPACApayorplay5</td>
</tr>
</tbody>
</table>

The webinars will last approximately 90 minutes.
New IRS Guidance

On September 18, 2014, the IRS issued new guidance on several topics.

Proposed Approach to Application of Look-Back Period

IRS Notice 2014-49 sets forth a proposed approach to the application of the look-back measurement method, which may be used to determine if an employee is a full-time employee for purposes of §4980H of the Internal Revenue Code, in situations in which the measurement period is applicable to an employee changes.

Cafeteria Plan Election Changes and Marketplace Coverage

IRS Notice 2014-55, effective September 18, 2014, expands the permitted election changes under a cafeteria plan for participants who may wish to revoke an election in order to purchase a plan through the health insurance Exchange/Marketplace.

1. If an employee's hours of service are reduced so that the employee is expected to average less than 30 hours of service per week, Notice 2014-55 allows employees to prospectively revoke coverage (even if the reduction in hours does not render the employee ineligible for the group health plan).
2. The notice permits an employee to revoke the cafeteria plan election to pay the coverage pre-tax when an employee seeks to buy coverage in the Marketplace.

PCORI Fee Adjusted Amounts

IRS Notice 2014-56 addresses Patient-Centered Outcomes Research Institute (PCORI) adjusted applicable dollar amounts. For policy years and plan years ending on or after October 1, 2014 and before October 1, 2015, the adjusted applicable dollar amount is $2.08.

For policy and plan years ending on or after October 1, 2015, and before October 1, 2019, the adjusted applicable dollar amount will be published in future guidance.

Notice: This newsletter is intended for information purposes only. The information does not constitute legal advice or opinion. For additional information call (406) 721-2222

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