TOTAL BENEFIT SOLUTIONS INC

2016 Year in Review

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New Guidance Tackles Various Employer Mandate Issues

Published: January 12, 2016

IRS Notice 2015-87 provides further guidance on the application of various provisions of the Affordable Care Act ("ACA") that affect applicable large employers ("ALEs") under the Employer Penalty.

Unless otherwise provided, the guidance in Notice 2015-87 applies for plan years beginning on or after January 1, 2016, but employers may rely upon this guidance for all prior periods.

Notably, the guidance:

- Announces 2015 inflation adjustments to the "A" and "B" Penalties for calendar year (CY) 2015, $2,080/$3,120 and CY 2016, $2,160/$3,240 respectively.
- Clarifies how to calculate hours of service in certain situations when no duties are performed.
- Requires some non-educational organizations, like a staffing firm, to follow special rules applicable to educational organizations when placing individuals in an educational organization if a meaningful opportunity to provide services is not available throughout the entire year.

Inflation Adjustment To Employer Penalty (Q/A-13)

Background. Under the ACA, the amount of the Employer Penalty was established for a 2014 effective date with an annual inflation adjustment. However, the government delayed any assessments for one year (until 2015) and did not announce inflation adjustments for calendar years beginning after 2014.

New Guidance. The Notice provides the adjustments to the annual assessment for calendar years 2015 and 2016 as follows:

Calendar Year	"A" Penalty	"B" Penalty
2015	$2,080 (or $173.33/month)	$3,120 (or $260/month)
2016	$2,160 (or $180/month)	$3,240 (or $270/month)

Penalties are paid annually but assessed monthly. Future adjustments will be posted at www.irs.gov.

Example 1

An ALE with 200 FTEs does not offer coverage in calendar year 2015 and 2016. One FTE receives a subsidy in the marketplace to purchase health insurance coverage for all 12 months of the calendar year.

For 2015: $2,080 × (200 – 80 FTEs) = $249,600

For 2016: $2,160 × (200 – 30 FTEs) = $367,200

Example 2

An ALE with 200 FTEs offers unaffordable coverage to all FTEs. Instead of taking the employer's coverage, 50 FTEs receive a subsidy in the Marketplace to purchase health insurance coverage for all 12 months of the calendar year.

For 2015: $3,120 × 50 FTEs = $156,000

For 2016: $3,240 × 50 FTEs = $162,000

Hours Of Service (Q&A-14)

Background. An FTE is an employee who is employed an average of at least 30 hours of service per week (or 130 hours of service a month) with an ALE. An hour of service is defined as:

- each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer; and
- each hour for which an employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

With respect to hours where an employee is paid or entitled to payment when no duties are performed, the existing regulations reference an hours of service definition from Department of Labor regulations. However, the extent to which these regulations are incorporated for purposes of the employer mandate has been unclear.

New Guidance. The IRS intends to issue regulations that will adopt a "source of payment rule" for purposes of determining whether an hour of service must be credited when no duties are performed by the employee.

Specifically, if the employer contributes toward the payment, directly or indirectly then an hour of service must be counted. This is the case regardless of whether the payment is made by or due from the employer directly, or indirectly through, among others, a trust fund or insurer to which the employer contributes or pays premiums, and regardless of whether contributions made or due to the trust fund, insurer, or other entity are for the benefit of particular employees or are on behalf of a group of employees in the aggregate.

Moreover, hours of service are counted without limitation if there is a single continuous period where the employee performs no duties if the hours of service would otherwise qualify as hours of service under the Employer Penalty. There is a limited exception for educational organizations.

The guidance provides the following specific examples to consider when identifying hours of service.

An hour of service includes:
Disability payments (e.g., LTD or STD) when the benefit is included as taxable income to the employee and the recipient employee retains status as an employee of the employer.

An hour of service does not include:
Any hours after the individual terminates employment with the employer.
Payments made solely for the purpose of complying with workers' compensation.
Payments from a state or local government to the employee in the form of workers compensation wage replacement benefits provided the employee is not performing services for the employer.
Payments made solely for the purpose of complying with unemployment insurance laws.
Payments made solely for the purpose of complying with disability insurance laws.
Payments made to reimburse an employee for medical or medically-related expenses.
A disability payment (e.g., STD or LTD) where the employee paid for the coverage with after-tax contributions.

Rehire Rules For Educational Organizations (Q/A-16)

Background. Under the applicable measurement method, rehired employees may be treated as new hires if there is a break in service of at least 13 weeks. Educational organizations must use 26 weeks instead of 13 weeks.

Additionally, educational organizations that use the look back measurement method to identify full-time employees must credit hours of service (up to 501) for any employment break.

New Guidance. In light of concern that some educational organizations are attempting to avoid application of the 26-week rule and the employment break rule by, for example, using a third-party staffing agency for certain individuals providing service, the regulators propose amending the existing rules to extend application of these special rules in certain circumstances in which the services are being provided to one or more educational organizations, even if the employer is not an educational organization and even if the employee is not a teacher.

For example, the special rule would apply to an employer with respect to a bus driver who is primarily placed to provide bus driving services, or a cafeteria worker who is primarily placed to provide services in a cafeteria, at one or more educational organizations and who is not provided a meaningful opportunity to provide services during one or more months of the calendar year (for example, the summer recess period).

In contrast, an employer that primarily places bus drivers or cafeteria workers at educational organizations would not apply the special rule to an employee if the individual was offered a meaningful opportunity to provide services during all months of the year (for example, in the case of a cafeteria worker, by working at a hospital cafeteria during the summer recess period of the educational organization at which the individual generally is placed).

This change will apply as of the effective date specified in the regulations (when issued), but in no event this be effective before the first plan year beginning after the date on which the proposed regulations are issued.

New Guidance Addresses Affordability and the Employer Penalty

Published: January 12, 2016

As background, applicable large employers ("ALEs") may be subject to the Employer Penalty if any full-time employee ("FTE") receives a subsidy to purchase Exchange coverage. There are two penalties, "A" and "B." The "B" Penalty can apply when the ALE offers at least 95% of FTEs and their dependent children minimum essential coverage ("MEC") but the coverage is not affordable, does not provide minimum value, or excludes 5% or fewer FTEs.

IRS Notice 2015-87 provides further guidance on the affordability component (and other topics to be summarized in future articles).

Unless otherwise provided, the guidance in Notice 2015-87 applies for plan years beginning on or after January 1, 2016, but employers may rely upon this guidance for all prior periods.

The concept of affordability is significant as it affects:

- whether an employer is subject to a "B" Penalty assessment; and
- how an employer reports the affordability of any group health plan coverage offered to full-time employees on Form 1095-C (Line 15) and the affordability safe harbor used for those who waive coverage (Line 16).

Inflation Adjustments To 9.5%

Background. The IRS provides three safe harbors the employer may use to establish affordable coverage in order to avoid the "B" Penalty. Under the safe harbors, an employer's offer of coverage is affordable with respect to an employee if the required contribution for self-only coverage in the lowest cost health plan that provides minimum value does not exceed 9.5% of:

- Form W-2 Safe Harbor. The employee's Form W–2 wages as determined at the end of the year.

- Rate of Pay Safe Harbor. the employee's rate of pay determined by multiplying 130 hours by the hourly rate of pay for an hourly employee, or by using monthly salary for non-hourly employees.

- FPL Safe Harbor. The monthly income for a single individual at 100% of the Federal Poverty Line ($93.18 per month for 2015).

New Guidance. In each of the safe harbors, the reference to 9.5% will be adjusted annually, consistent with the determination of affordable coverage for purposes of an individual's eligibility for subsidies. The rates for the first two years are as follows:

Calendar Year	Percentage (with adjustment)
2015	9.56%
2016	9.66%

Employers may rely upon the adjusted amounts for plan years beginning in 2015. Thus, the FPL safe harbor for 2015 is no more than $93.77 per month (slightly more than the unadjusted 2015 amount). The FPL for 2016 has not yet been issued.

These adjustments also apply with respect to the multiemployer plan interim relief, the requirement that employees be permitted to decline enrollment in coverage with a limited exception to affordable/minimum value coverage as determined under the FPL safe harbor, the definition of a Qualifying Offer for purposes of reporting on Line 14 of Form 1095-C (Code 1A), and use of alternative reporting methods for Qualifying Offers.

Flex Contributions And Affordability (Q/A-8)

Background. In some cases, employers provide flex contributions under a cafeteria plan. Employees can use these contributions toward the purchase of benefits.

New Guidance. Flex contributions reduce the amount of an employee's required contribution only if:

- the employee may not opt to receive the amount as a taxable benefit;

- the employee may use the amount to pay for MEC; and

- the employee may use the amount exclusively to pay for medical care (as defined under Code section 213).

This is referred to as a "health flex contribution."

Example 1

Employer offers employees coverage under a group health plan through a cafeteria plan. An employee electing self-only coverage under the health plan is required to contribute $200 per month toward the cost of coverage. Employer offers employer flex contributions of $600 for the plan year ($50 per month) that may only be applied toward the employee's share of contributions for the group health coverage or contributed to a health FSA.

The $600 employer flex contribution is a health flex contribution and reduces the employee's required contribution for the coverage. This affects the affordability determination for purposes of the employer mandate and applicable reporting. The $600 employer health flex contribution is taken into account as an employer contribution (and therefore reduces the employee's required contribution) regardless of whether the employee elects to apply the health flex contribution toward the employee contribution for the group health coverage or elects to contribute it to the health FSA.

The employee's required contribution for the group health coverage is $150 ($200 - $50) per month. Affordability is determined using $150 per month.

Example 2

Same facts as Example 1, but the employer flex contributions can be used for any benefit under the cafeteria plan (including benefits not related to health) but are not available as cash.

Because the $600 employer flex contribution is not used exclusively for medical care, it is not a health flex contribution and therefore does not reduce the employee's required contribution for the coverage. The employee's required contribution for the group health coverage is $200 per month. Affordability is determined using $200 per month.

Example 3

Same facts as example 2, but instead the flex contribution is available to pay for health benefits or to be taken as cash or other taxable compensation (and not available to pay for other types of benefits).

Same result as Example 2.

Transition Relief

For plan years beginning before January 1, 2017, a flex contribution that is not a health flex contribution (Examples 2 and 3 above) will be treated as reducing the amount of an employee's required contribution (affordability determined based on $150 as opposed to $200) provided:

- the employer offered the flex contribution arrangement (or a substantially similar flex contribution arrangement) for a plan year including December 16, 2015;
- a board, committee, or similar body or an authorized officer of the employer specifically adopted the flex contribution arrangement before December 16, 2015; or
- the employer provided written communications to employees on or before December 16, 2015 indicating that the flex contribution arrangement would be offered to employees at some time in the future.

1095-C Reporting

While employers eligible for the limited relief described above may reduce the amount of the employee's required contribution for purposes of Form 1095-C reporting (Line 15) by the amount of a non-health flex contribution, they are not encouraged to do so, as it may affect the employee's eligibility for the premium tax credit.

If an employee's required contribution is reported in this manner (that is, without reduction for the amount of a non-health flex contribution) and the employer is contacted by the IRS concerning a potential "B" Penalty assessment relating to the employee's receipt of a premium tax credit, the employer will have an opportunity to respond and show that it is entitled to the relief contain in this Notice to the extent that the employee would not have been eligible for the premium tax credit if the required employee contribution had been reduced by the amount of the non-health flex contribution or to the extent that the employer would have qualified for an affordability safe harbor if the required employee contribution had been reduced by the amount of the non-health flex contribution.

Opt-Out Bonuses And Affordability (Q/A-9)

Background. Under a cafeteria plan, an employer may offer an employee a "cash option," a taxable amount that is available if the employee declines coverage under the employer's health plan (also referred to as an "opt-out bonus").

New Guidance. Treasury and IRS intend to issue regulations that treat an unconditional opt-out arrangement (that is, an arrangement providing for a payment conditioned solely on an employee declining coverage under an employer's health plan) in the same manner as a salary reduction for purposes of determining an employee's required contribution.

Example

An employer offers employees group health coverage through a cafeteria plan, requiring employees who elect self-only coverage to contribute $200 per month toward the cost of that coverage and offers an additional $100 per month in taxable wages to each employee who declines the coverage.

For purposes of affordability, the employee cost would be $300. This is because the offer of $100 in additional compensation has the economic effect of increasing the employee's contribution for the coverage. In this case, the employee contribution for the group health plan effectively would be $300 ($200 + $100) per month, because an employee electing coverage under the health plan must forgo $100 per month in compensation in addition to the $200 per month in salary reduction.

It is anticipated that proposed regulations will also address and request comments on the treatment of opt-out bonuses that are conditioned not only on the employee declining employer-sponsored coverage but also on satisfaction of additional conditions (such as the employee providing proof of having coverage provided by a spouse's employer or other coverage).

Effective Date/"B" Penalty/1095-C Reporting

Any required inclusion will generally apply only for periods after the issuance of final regulations, except in the case of a non-relief-eligible opt-out arrangement. This means an opt-out
bonus (other than a payment made under a non-relief-eligible opt-out arrangement):

- will not be treated as increasing an employee's required contribution for purposes of a "B" Penalty assessment; and
- employers are not required to increase the amount of an employee's required contribution by the amount of an opt-out bonus for purposes of Form 1095-C reporting (Line 15).

An arrangement will be considered a non-relief-eligible opt-out arrangement requiring the inclusion of an amount offered or provided under an unconditional opt-out arrangement, unless:

1. 1. the employer offered the opt-out arrangement (or a substantially similar opt-out arrangement) with respect to health coverage provided for a plan year including December 16, 2015;

2. 2. a board, committee, or similar body or an authorized officer of the employer specifically adopted the opt-out arrangement before December 16, 2015; or

3. 3. the employer had provided written communications to employees on or before December 16, 2015 indicating that the opt-out arrangement would be offered to employees at some time in the future.

Service Contract Act ("Sca") And Davis Bacon Act And Davis Bacon Related Acts ("Dbra) Fringe Benefits And Affordability (Q/A-10)

Background. The SCA and DBRA require that workers employed on certain federal contracts be paid prevailing wages and fringe benefits. Under the SCA and DBRA, an employer generally can satisfy its fringe benefit obligations by:

- providing a particular benefit or benefits, as determined by the employer, that have a sufficient dollar value; or
- providing the cash equivalent of benefits or some combination of cash and benefits; or
- allowing employees to choose among various benefits or among various benefits and cash.

If an employer chooses to provide fringe benefits under the SCA or DBRA by offering an employee the option to enroll in health coverage provided by the employer (including an option to decline that coverage) and the employee declines the coverage, that employer then generally is required to provide the employee with cash or other benefits of an equivalent value. An employer that chooses to satisfy its obligation to provide fringe benefits under the SCA or DBRA by offering an employee the option to enroll in health coverage provided by the employer (including an option to decline that coverage) generally would need to provide a significant additional subsidy to make the offer affordable. While the SCA and DBRA require employers to pay covered employees no less than prevailing wage and fringe benefit rates, this additional subsidy would result in certain employees receiving amounts significantly in excess of SCA and DBRA minimum rates.

New Guidance. Until the applicability date of any further guidance, and in any event for plan years beginning before January 1, 2017, employer fringe benefit payments (including flex credits or flex contributions) under the SCA or DBRA that are available to employees covered by the SCA or DBRA to pay for coverage under an eligible employer-sponsored plan (even if alternatively available to the employee in other benefits or cash) will be treated as reducing the employee's required contribution for participation in that eligible employer-sponsored plan for purposes of affordability, but only to the extent the amount of the payment does not exceed the amount required to satisfy the requirement to provide fringe benefit payments under the SCA or DBRA.

Example

Employer offers employees subject to the SCA or DBRA coverage under a group health plan through a cafeteria plan, which the employees may choose to accept or reject. Under the terms of the offer, an employee may elect to receive self-only coverage under the plan at no cost, or may alternatively decline coverage under the health plan and receive a taxable payment of $700 per month. For the employee, $700 per month does not exceed the amount required to satisfy the fringe benefit requirements under the SCA or DBRA.

Until the applicability date of any further guidance (and in any event for plan years beginning before January 1, 2017), the required employee contribution for the group health plan for an employee who is subject to the SCA or DBRA is $0 for purposes of the "B" Penalty and reporting on Form 1095-C.

1095-C Reporting

Employers are encouraged to treat these fringe benefit payments as not reducing the employee's required contribution for purposes of reporting on Form 1095-C (thus reflect $700 as opposed to $0 on the Form 1095-C, Line 15).

If an employee's required contribution is reported without reduction for the amount of the fringe benefit payment and the employer is contacted by the IRS concerning a potential "B" Penalty, the employer will have an opportunity to respond and show that it is entitled to the relief contained in the Notice to the extent that the employee would not have been eligible for the premium tax credit if the required employee contribution had been reduced by the amount of the fringe benefit payment or to the extent that the employer would have qualified for an affordability safe harbor if the required employee contribution had been reduced by the amount of the fringe benefit payment.

Treasury and IRS continue to consider other methods for reporting the amount of the required contribution for employees subject to the SCA or DBRA, including the possible use of indicator codes. However, any new methods will not require implementation for reporting on plan years beginning before January 1, 2017.

Implications For Some Employees (Q/A-11)

Certain individuals may be affected by Q/A-8 through 10 because employers are permitted to report a lower amount as the employee's required contribution on the Form 1095-C. Specifically, employees who (1) enrolled in coverage through the Marketplace, (2) did not receive the benefit of advance payments of the premium tax credit, and (3) have household income is in the range for premium tax credit eligibility (100% - 400% FPL), may need additional information from their employers regarding their required employee contribution to determine eligibility for the premium tax credit.

Employers that use the available relief are encouraged to notify employees that they may obtain accurate information about their required contribution taking into account the modifications provided to the employer through the Notice using the employer contact telephone number provided to the employee on Form 1095-C. If the modified required contribution is not affordable and the employee is otherwise entitled to the premium tax credit, the employee may claim it on Form 8692, Premium Tax Credit, which is filed with the employee's annual income tax return (regardless of the required contribution or qualifying offer information reported on that employee's Form 1095-C).

Congress Enacts 2-Year Delay of Cadillac Tax

Published: January 13, 2016

On December 18, President Obama signed bipartisan legislation for a year-end spending and tax package. As part of the package, Congress enacted a two-year delay of the ACA Excise Tax ("Cadillac Plan Tax") provision. As such, the tax now goes into effect after December 31, 2019 (and not after December 31, 2017 as currently scheduled). This is welcomed news for employers who are currently looking at mechanisms to mitigate this potential tax burden.

The Cadillac Plan tax is a 40% non-deductible excise tax on the value of health insurance coverage that exceeds $10,200 for self-only coverage and $27,500 for coverage other than self-only (e.g., family coverage).

The legislation made the following additional ACA-related changes:

- Permits a tax deduction of any Cadillac Plan tax assessment (whereas the original version of the law did not permit a tax deduction);
- Authorizes a study of the age and gender adjustment benchmarks related to the Cadillac Plan tax;
- Suspends the medical device excise tax for two years and the annual fee on health insurance providers (the Health Insurer Tax) for one-year; and
- Extends parity between mass transit and parking benefits under Code section 132(f).

New Qualified Transit and Parking Guidance

Published: January 22, 2016

The Consolidated Appropriations Act, 2016 (the "Act") permanently changed the pre-tax transit benefits to be at parity with parking benefits. As a result, the Act retroactively increased the 2015 transit benefits from $130 to $250. For 2016, the transit and parking pre-tax benefits are $255.

On January 12th, the IRS issued Notice 2016-06, which provides alternative correction procedures for employers related to the 2015 pre-tax transit increase. Employers are required to correct Forms 941 and W-2 by amounts in excess of $130, whether provided by the employer or through a compensation reduction arrangement.

- For example, if an employer provided an employee with a transit pass worth $200, but taxed the employee $70 ($200-$130), then the employer is required to correct the 941 and the W-2 to reflect the $70 as tax free benefits.

- As another example, if an employee enrolled in a compensation reduction arrangement and purchased a $200 transit pass, $130 pre-tax and $70 post tax, the employer is required to correct the Form 941 and the employee's W-2 to treat the $70 as pre-tax.

Ordinarily, an employer is required to make corrections to the Forms 941 and W-2 by filing Forms 941-X for each quarter and the Form W-2C. However, Notice 2016-06 provides the following procedures to reduce administrative burden:

1. Repay or reimburse employees for over-collected FICA Tax (including any additional Medicare tax) for all four quarters of 2015;

2. The reimbursement or repayment must be completed prior to filing the Form 941 by the employer;

a. Taxable Medicare Wages and Tips on Line 5C;
b. Taxable Wages and Tips subject to additional Medicare Tax on Line 5D.

If the employer takes advantage of the administrative procedures outlined in the Notice, the employer will not have to file a Form 941-X or Forms W-2c (the Forms ordinarily filed to make corrections).

If an employer has not repaid or reimbursed employees for over-collected FICA Tax, then the employer must follow the ordinary correction procedures, meaning filing amended returns for each quarter and amended W-2s (Forms 941-X and W-2c, respectively).

Finally, the Notice also clarifies the following additional items:

- An employer is not required to provide additional transit benefits to its employees for 2015;
- An employee is not permitted to retroactively increase the 2015 salary reduction to take advantage of the increase provided by the Act;
- An employee is not permitted to have a salary reduction in excess of $255 for 2016 to compensate for the 2015 increase; and
- There continues to be a limitation on providing cash reimbursements for transit passes when transit passes are readily available for direct distribution by the employer to the employee.

For further information and details, please see IRS Notice 2016-6,

http://www.irs.gov/pub/irs-drop/n-16-06.pdf.

For implementation, please call your payroll service provider directly and discuss the Notice.

New Guidance Addresses Account-Based Plans

Published: January 25, 2016

IRS Notice 2015-87 provides further guidance on health flexible spending accounts (“health FSAs”) and health reimbursement arrangements (“HRAs”) (and other topics summarized in past articles).

Health FSAs And Carryovers

Background. An employer, at its option, may amend its health FSA to allow employees to roll over up to $500 of unused contributions to the immediately following plan year, provided the plan does not allow for a grace period.

New Guidance.

1. Unused amounts carried over from the prior year are subject to COBRA.

2. Unused amounts carried over from the prior year cannot be included in the COBRA premium.

Example

An employer maintains a calendar year health FSA. During open enrollment, an employee elected to reduce his salary by $2,500 for the year. In addition, the employee carries over $500 in unused benefits from the prior year. Thus, the maximum benefit that the employee can become entitled to receive under the health FSA for the entire year is $3,000. The employee terminates employment on May 31. As of that date, the employee had submitted $1,100 of reimbursable expenses under the health FSA.

Conclusion: If the employee elects COBRA, the maximum benefit that the employee could become entitled to receive for the remainder of the year is $1,900 ($3,000 minus $1,100).

The COBRA premium for a health FSA with a carryover is based solely on the sum of the employee's salary reduction election for the year (and any employer contribution) plus the allowed 2% administration fee.

Example

An employee elects salary reduction with respect to a health FSA of $2,000. The employer provides a matching contribution of $1,000. In addition, the employee carries over $500 in unused benefits from the prior year. The employee experiences a qualifying event that is a termination of employment on May 31.

Conclusion: The maximum amount the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the year is 102% of 1/12 of the applicable premium of $3,000 ($2,000 of employee salary reduction election plus $1,000 of employer contributions) times the number of months remaining in the year after the qualifying event. The $500 of benefits carried over from the prior year is not included in the applicable premium.

3. A health FSA must allow carryovers for COBRA continuees, subject to the same terms applicable to similarly situated non-COBRA participants.

Example

An employer maintains a calendar year health FSA. During open enrollment, an employee may elect to reduce salary by $2,500 for the year. In addition, the plan allows a carryover of up to $500 in unused benefits remaining at the end of the plan year. An employee elects salary reduction of $2,500 for the year. The employee terminates employment on May 31. As of that date, the employee had submitted $400 of reimbursable expenses under the health FSA. The employee elects COBRA continuation coverage and pays the required premiums for the rest of the year. As a qualified beneficiary, the former employee submits additional reimbursable payments in the amount of $1,600. At the end of the plan year, there is $500 of unused benefits remaining.

Conclusion: The qualified beneficiary is allowed to continue to submit expenses under the same terms as similarly situated non-COBRA beneficiaries in the next year, for up to $500 in reimbursable expenses. The maximum amount that can be required as an applicable premium for the carryover amount for periods after the end of the plan year is $0. The maximum period the carryover is required to be made available is the period of COBRA continuation coverage. In this case, the period is 18 months and terminates at the end of November of the next year. Thus, the health FSA need not reimburse any expense incurred after that November.

Note in the example above that if there were no carryover, this individual's health FSA benefits would have ended on December 31.

Due to the carryover, this individual has access to $500 for reimbursable expenses with no additional COBRA premium charged. While this does not appear to provide the individual the right to a new COBRA election effective January 1, it does mean that employers and third party administrators ("TPAs") need to continue to monitor these accounts until the entire COBRA period expires which may increase administration costs to the plan.

4. A health FSA may condition the ability to carry over unused amounts on participation in the health FSA in the next year (and even if the ability to participate in that next year requires a minimum salary reduction election to the health FSA for that next year).

Example

Employer sponsors a cafeteria plan offering a health FSA that permits up to $500 of unused health FSA amounts to be carried over to the next year, but only if the employee participates in the health FSA during that next year. To participate in the health FSA, an employee must contribute a minimum of $60 ($5 per calendar month). As of December 31, 2016, Employee A and Employee B each have $25 remaining in their health FSA. Employee A elects to participate in the health FSA for 2017, making a $600 salary reduction election. Employee B elects not to participate in the health FSA for 2015. Employee A has $25 carried over to the health FSA for 2017, resulting in $625 available in the health FSA. Employee B forfeits the $25 as of December 31, 2016 and has no funds available in the health FSA thereafter.

Conclusion: This arrangement is permissible.

5. A health FSA may limit the ability to carry over unused amounts to a maximum period. Thus, if an individual carried over $30 and did not elect any additional amounts for the next year, the health FSA may require forfeiture of any amount remaining at the end of that next year.

HRAs

Background. Employers can only offer HRAs that are integrated with a group health plan.

New Guidance.

1. An HRA cannot reimburse the medical expenses of an employee's spouse and/or dependents unless they are enrolled in the employer's group health plan. This is effective the first day of the 2016 plan year. However, an HRA that otherwise would be integrated based on the terms of the plan as of December 16, 2015 does not need to comply until the first day of the 2017 plan year.

2. May an HRA or similar employer-funded health care arrangement be used to purchase individual market coverage after the employee covered by the HRA ceases to be covered by other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms?
   - No for the typical HRA; an HRA covering two or more current employees fails to be integrated with another group health plan if the amounts credited to the HRA may be used to purchase individual market coverage.
   - Yes if the HRA covers fewer than two participants who are current employees (such as one covering only retirees or other former employees) as the HRA qualifies as an "excepted benefit."

A participant with available funds from an HRA for any month is not eligible for a premium tax credit for that month as he is deemed to be enrolled in minimum essential coverage.

For more information, visit:
https://www.irs.gov/pub/irs-drop/n-15-87.pdf.

2016 Federal Poverty Guidelines

Published: February 2, 2016

Background

Large employers may be subject to the employer penalty under the Affordable Care Act if they do not offer affordable, minimum value coverage to all full-time employees and at least one full-time employee receives a subsidy in the Exchange. The Federal Poverty Line ("FPL") is relevant to this penalty in two ways:

1. **Affordability Safe Harbor:** For affordability purposes, a large employer satisfies the FPL safe harbor with respect to an employee for a calendar month if the employee's required contribution for the large employer's lowest cost self-only coverage that provides minimum value does not exceed 9.5% (as indexed) of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12.

2. **Subsidy Eligibility:** An individual is only eligible for a subsidy in the Exchange if he or she is within 100-400% of the FPL and is not offered affordable, minimum value group coverage.

Indexed Amounts

The following are the 2016 HHS poverty guidelines:

2016 Poverty Guidelines For The 48 Contiguous States And The District Of Columbia

Persons in family/household	Poverty guideline
1	$11,880
2	$16,020
3	$20,160
4	$24,300
5	$28,440
6	$32,580
7	$36,730
8	$40,890

For families/households with more than 8 persons, add $4,160 for each additional person.

2016 Poverty Guidelines For Alaska

Persons in family/household	Poverty guideline
1	$14,840
2	$20,020
3	$25,200
4	$30,380
5	$35,560
6	$40,740
7	$45,920
8	$51,120

For families/households with more than 8 persons, add $5,200 for each additional person.

2016 Poverty Guidelines For Hawaii

Persons in family/household	Poverty guideline
1	$13,670
2	$18,430
3	$23,190
4	$27,950
5	$32,710
6	$37,470
7	$42,230
8	$47,010

For families/households with more than 8 persons, add $4,780 for each additional person.

Affordability Safe Harbor and Subsidy Eligibility 2016 Results

So as to provide employers with adequate time to establish premium amounts in advance of the plan's open enrollment period, a plan can use any of the poverty guidelines in effect within 6 months before the first day of the plan year. These new thresholds were announced in January 2016.

Based on 2016 levels:

- For affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The FPL is $11,880 for a single individual for every state (and Washington D.C.) except Alaska3 or Hawaii. So, if the employee's required contribution for the calendar month for the lowest cost self-only coverage that provides minimum value is $95.63 (9.66% of $11,880/12) or less, the employer meets the FPL safe harbor.

- For subsidy eligibility purposes, the applicable FPL is the FPL for the state in which the employee resides. 100 – 400% of the FPL is $11,880 - $47,520 for a single individual and $24,300 - $97,200 for a family of four for every state (and Washington D.C.), except Alaska or Hawaii.

Medicare Part D

Reminder to Notify CMS

Published: February 25, 2016

Employers sponsoring a group health plan are required to report information on the creditable status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services (CMS). Employers must use CMS's online reporting system to provide this information at:

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html.

As a reminder, notice must be provided by the following deadlines:

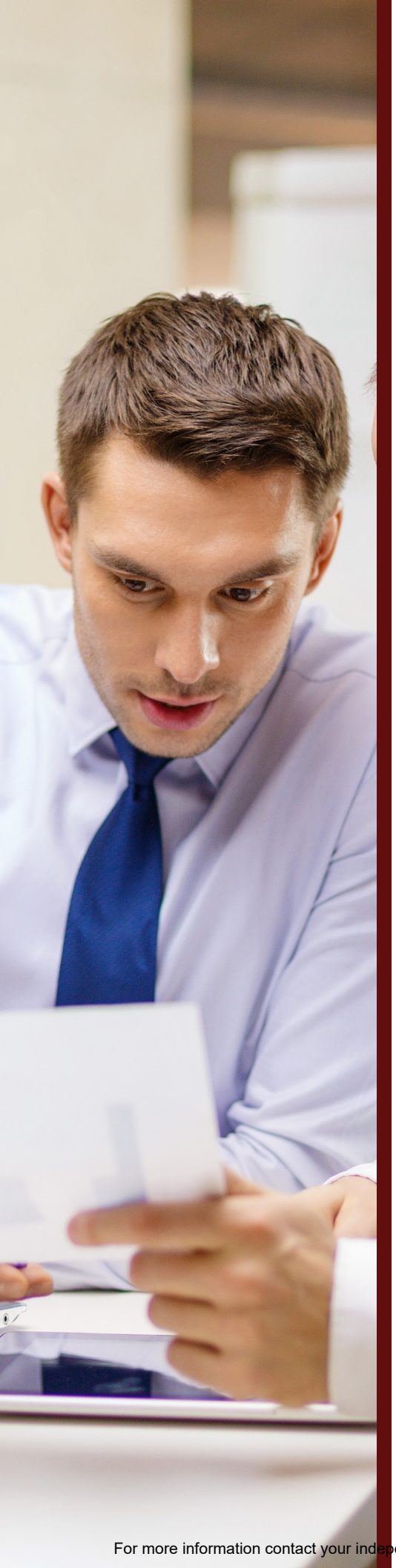
- Within 60 days after the **beginning** date of the plan year;
- Within 30 days after the **termination** of the prescription drug plan; and
- Within 30 days after any **change** in the creditable coverage status.

An employer with a calendar-year plan (January 1 – December 31, 2016) must complete this reporting no later than February 29, 2016.

You can find additional guidance on completing the form, including screen shots, at:

https://www.cms.gov/CreditableCoverage/40_CCDisclosure.asp#TopOfPage.

A Help Line is also available, should you experience technical issues or an error message when submitting the online disclosure form. The Help Line can be reached at (800) 633-4227.



HHS Finalizes Health Plan Out-of-Pocket Limits for 2017

Published: March 8, 2016

On March 1, 2016, the Department of Health and Human Services (HHS) released cost-sharing parameters setting the 2017 maximum annual out-of-pocket limits on non-grandfathered health plans at **$7,150** for self-only coverage and **$14,300** for coverage other than self-only. These limits take effect for the first plan year on or after January 1, 2017.

These limits generally apply with respect to any essential health benefits (EHBs) offered under the group health plan. The final regulations established that starting in the 2016 plan year, the self-only annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in other than self-only coverage, including family coverage.

As a reminder, the 2016 maximum annual out-of-pocket limits for all non-grandfathered plans are **$6,850** for self-only coverage and **$13,700** for coverage other than self-only.

California Insurance Legislation

Published: March 9, 2016

California enacted legislation affecting group health plans. Generally, these requirements apply if the employer purchases health coverage from a health plan or health insurer regulated by California (generally, insured health plan coverage). Self-insured health plans subject to ERISA and policies written in other states (and not regulated by California) are not subject to these requirements. Discuss with carriers for further information.

Unless otherwise noted, these requirements were effective January 1, 2016.

Minimum Value Plans (AB 248)

California prohibits insurance carriers from offering, amending or renewing a large group non-grandfathered health plan that does not meet at least 60% minimum value. This requirement does not apply to grandfathered plans and limited wrap around coverage.

For a copy of the legislation, visit:

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB248.

Cost Sharing Requirements (AB 1305)

California aligns state insurance rules to mirror federal requirements under the Affordable Care Act ("ACA") with respect to maximum out-of-pocket spending on essential health benefits ("EHBs"). Specifically, for plan years beginning on or after January 1, 2016, cost sharing limits must not exceed $13,700 for family coverage and such coverage must include an individual out-of-pocket limit of no more than $6,850.

California goes even further than the requirements under the ACA and imposes requirements on health plan deductibles.

- **Small group (1-100 employees) -** For plan years beginning on or after January 1, 2016, insured small employer group health plans in California must embed an individual deductible in the family coverage that is not greater than the limit for individual coverage. For example, a small group health plan has a $1,000 deductible for self-only coverage and a $2,000 deductible for family coverage. The family coverage must include an individual deductible of $1,000 so that once an individual incurs claims to reach the $1,000 individual deductible in the family coverage that individual's benefits are paid according to the terms of plan even though the family deductible of $2,000 is not fully satisfied. Carriers may apply for a one-year delay in the effective date.

- **Large group (101 or more employees) -** This same requirement will take effect for large group insurance contracts on January 1, 2017.

With respect to qualified High Deductible Health Plans ("HDHP"), carriers must take care to appropriately align state requirements with federal rules governing HDHPs. California generally prohibits deductibles in the small group health plan market that exceed $2,000 for single coverage and $4,000 for family coverage. Effective January 1, 2016, the indexing factor for these thresholds has changed. Specifically, a health plan that includes an embedded individual deductible in family coverage that is below the minimum family deductible required for qualified HDHP coverage ($2,600 for 2016) is not HSA qualified. The law requires the carrier to use the greater of the family HDHP minimum deductible or the deductible for individual coverage under the plan contract. Presumably, this will create a mechanism for carriers to continue to offer HSA-compatible health plans.

For a copy of the legislation, visit:

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB1305.

Supreme Court Finds State Reporting Law Is Preempted by ERISA

Published: March 10, 2016

On March 1, 2016, the Supreme Court decided in a 6-2 vote that a Vermont reporting law did not apply to ERISA-covered plans, which includes most benefit plans.

The Issue

Vermont established an "all payer claims database" which requires insurers, third party administrators ("TPAs") of self-funded plans, providers, and government agencies to report data on health care costs, prices, quality, and use of services to the state to examine health care utilization, expenditures, and performance. Seventeen states, including New York and Connecticut, also have or are developing all payer claims databases (although reporting is on a voluntary basis in some states).

Liberty Mutual has a self-funded plan for its employees with about 80,000 members across the U.S. Liberty Mutual directed its TPA to refuse to submit its data to Vermont. Vermont issued a subpoena ordering the TPA to transmit the files. The penalty for the TPA's noncompliance was $2,000 per day and suspension to operate in Vermont for up to 6 months.

Having in its contract with the TPA a hold harmless clause for judgments related to Liberty Mutual's failure to comply with any laws, Liberty Mutual filed suit in district court, seeking a declaration of preemption.

Preemption Arguments

- **Interference with plan administration.** ERISA Sec. 514 states that ERISA preempts any and all state laws that relate to employee benefit plans. Under ERISA, state laws should not interfere with the uniformity of plan administration. Employers are frustrated by multi-jurisdictional mandates that impose conflicting administrative obligations, subjecting them to administrative costs and wide-ranging liability.

- **Fiduciary responsibility and privacy.** Liberty Mutual argued that it was concerned about protecting the privacy of individuals' medical records per its fiduciary duties under ERISA.

Arguments against Preemption

- **Different objectives.** Vermont argued that its reporting scheme had objectives that differed from those of ERISA, which focus on (1) the financial solvency of plans and (2) fiduciary duties to protect participants (so that ERISA did not preempt the Vermont law).

What Happened?

The Court found that Vermont's all payer claims database does not apply to plans subject to ERISA. In the majority opinion, the Court identified reporting as a principal and essential feature of ERISA and plan administration. Vermont's requirement that ERISA plans report detailed information about the administration of benefits amounts to a direct regulation by the state of a fundamental ERISA function. As such, the Court ruled in favor of Liberty Mutual as such state laws are inconsistent with the central design of ERISA – to provide a single uniform national scheme without interference from the laws of the states. Justice Breyer suggested that the DOL could develop a similar reporting requirement to satisfy the states' needs. The privacy argument was not addressed.

Can Employers Disregard all State Laws Related to Benefits?

Not advisable. As employers subject to ERISA are well aware, there are many burdensome state laws that have been found to apply to their plans or have not been challenged in court.

Additionally, ERISA does not preempt state insurance laws that apply to carriers of ERISA-covered insured plans.

Employers wanting to disregard similar state laws related to benefits should consult counsel.

Form 1095-C Notification Reminder and Frequently Asked Questions

Published: March 15, 2016

As a reminder, important deadlines for most employers* are as follows:

- 2015 Forms 1095-C must be furnished to individuals by **March 31, 2016.**
- 2015 Forms 1095-C and Form 1094-C must be furnished to the IRS by:
  - **May 31, 2016** if not filing electronically; and
  - **June 30, 2016** if filing electronically.

Generally, if Forms 1094-C and/or 1095-C are incorrect and incomplete, a penalty may apply if not corrected by the due date and the employer cannot show reasonable cause. Briefly, the amount of penalties can range from $50/form with a $500,000 maximum penalty/year to $250/form with a maximum penalty of $3M/year.

* Applies to:

1. large employers (had 50 or more full-time employees (including full-time equivalent employees) on business days in 2014); and
2. small employers with self-funded medical plans.

New York City Transit Benefit Mandate

Published: March 16, 2016

As you know, beginning January 2016, a New York City employer with 20 or more Full Time Employees (FTEs) is required to provide its employees with a pre-tax qualified transportation benefit program up to the limit permitted by Federal Law. Currently, the Internal Revenue Service permits a pre-tax transit benefit of up to $255 for 2016. The Act does not include the pre-tax parking benefits.

The Affordable Transit Act (the Act) was signed into law in the fall of 2014 by New York City Mayor Bill de Blasio. The Act defines a FTE the same as the Affordable Care Act, or as an employee that works at least 30 hours per week. In addition, the Act specifically excludes government employers, employers not required to pay federal, state and city payroll taxes, and employees covered by a Collective Bargaining Agreement (CBA).

Penalties

Employers required to comply with the Act, but which fail to implement a transit program will be subject to penalties between $100-$250. An employer that fails to comply with the Act may receive a Notice of Non-Compliance. If so, the employer has a 90 day period to correct the violation without penalties. However, if the employer fails to correct the violation within the 90 day period, the employer will be subject to a $250 penalty for each 30-day period of non-compliance. Finally, employers have a 180 day grace period to comply with the Act, meaning employers **will not be subject to any penalties** until **July 1, 2016.**

Recordkeeping Requirement

Employers must keep records that demonstrate that each eligible FTE was offered the opportunity to use pre-tax income to purchase transit benefits and indicate whether the employee accepted or declined the offer. Employers may maintain these records electronically. Finally, the law requires employers to keep records for two years. Employers may use the form available on the Department of Consumer Affairs website to document compliance (See the “Common Questions” Section for link).

Benefit to Employers

Although the Act will require additional administration and associated costs, its pre-tax feature will also benefit employers because payroll costs may decrease. As a result, the employer may pay less in payroll taxes by excluding certain income paid to its employees.

Common Questions

Q1: Who must comply?

- A New York City Employer w/ 20+ employees
- A New York City Employer is an employer that is registered to do business in NYC and therefore, has employees working in NYC
- NYC includes 5 boroughs – Manhattan, Queens, Brooklyn, Staten Island, and the Bronx.

Q2: Do I count part time or full time employees?

An employee is defined as an employee working 30+ hours a week – the same as the Affordable Care Act (ACA)

Q3: Do I count employees working outside of NYC?

No, only employees working in NYC.

Q4: Do I count employees working outside of NYC?

Yes, the count is the number of employees working in NYC, regardless of where he/she resides.

Q5: Are there any Employers that are EXEMPT?

- Yes.
  - Employers whose employees are subject to a Collective Bargaining Agreement (CBA)
  - Government Entities – Federal Government, State Governments, and Local Governments
  - Employers exempt from Federal, State, and City payroll taxes.

Q6: Do I count part time or full time employees?

- Pre-tax transit benefits, up to the IRS limit – currently $255
- The employer does not have to offer parking pre-tax benefits, but can.

Q7: Can I send employees to the Department of Consumer Affairs to obtain benefits if I do not want to provide benefits?

No, the employer is responsible for providing the benefits.

Q8: There are administrative costs associated with establishing this program for my employees, can I charge the cost of administration to employees?

No, the employer is responsible for implementing this program.

Q9: How do I show compliance?

- Retention of any and all documents that show the employer offered commuter benefits.
- A sample form is available at: http://www1.nyc.gov/assets/dca/downloads/pdf/about/CommuterBenefits-EmployerComplianceForm.pdf

Q10: If I don't comply, what are the penalties?

$100-$250 for each 30-day period of non-compliance, beginning July 1, 2016

Q11: If I don't comply, will I be given a grace period to comply?

Yes, once an employer has received a non-compliance notice, the employer will have a period of 90 days to correct the violation without penalties.

Q12: Ok, I understand, I am ready to comply; Do you have a list of vendors?

Yes, for a list of vendors and contact information, visit:
http://www1.nyc.gov/site/dca/about/commuter-benefits-FAQs.page#7

Q13: Can I self administer this program?

- No.
  - Although the New York City Ordinance does not require the employer to have a vendor in place and technically permits self-administration, Federal Law disqualifies a transit reimbursement as a pre-tax benefit beginning January 1, 2016.
  - As such, an employer is no longer permitted to provide qualified transportation fringe benefits in the form of cash reimbursements in geographic areas where terminal restricted debit cards are readily available (Rev. Ruling 2014-32).
  - New York City has terminal restricted debit cards and therefore, transit reimbursements would no longer qualify as excluded tax income – meaning the employer cannot deduct the reimbursement pre-tax.

Q14: I offered the transit benefit to an employee who waived coverage initially, but now wants to join, can I let him/her?

Yes, an employee can waive initially and join at a later date.

New SBC Template Implementation Announced

Published: March 21, 2016

The Departments of Labor ("DOL"), the Internal Revenue Service ("IRS"), and Health and Human Services ("HHS") (collectively, "the Departments") announced through Affordable Care Act ("ACA") FAQ 30 that the new Summary of Benefits and Coverage ("SBC") template and associated documents, published by the Departments on February 26, 2016, should be used for the open enrollment period that begins on or after April 1, 2017.

As background, the ACA requires an SBC to be provided to plan participants at time of enrollment. Significant penalties (up to $1,000) may be imposed for each individual who does not receive this summary. If any material changes are made to the document outside of renewal, the participant must be notified 60 days prior to the effective date of the change.

As stated in FAQ 30, the Departments intend to review the comments and finalize the new SBC template and associated documents expeditiously (the comment period closes March 28, 2016). The Departments intend that health plans and issuers that maintain an annual open enrollment period will be required to use the new SBC template and associated documents beginning on the first day of the first open enrollment period that begins on or after April 1, 2017 with respect to coverage for plan years (or, in the individual market, policy years) beginning on or after that date. For plans and issuers that do not use an annual open enrollment period, the new SBC template and associated documents would be required beginning on the first day of the first plan year (or, in the individual market, policy year) that begins on or after April 1, 2017.

For further information, see FAQ 30:
http://www.dol.gov/ebsa/faqs/faq-aca30.html

Also, see the SBC regulations and templates available on the DOL's EBSA site at:
http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html

New York Small Group Market Update

Published: April 8, 2016

Prior to the enactment of the Affordable Care Act ("ACA"), New York Insurance Law Section 3231 classified an employer in the small group market if the employer had between 1-50 employees. However, with the enacted ACA, the federal definition of small employer and in effect, small group, changed from 1-50 to 1-100. The new definition of small employer would go into effect January 1, 2016.

Federal Agencies provided a number of transitional policies, which could be adopted by states to delay the application of the new federal definition of small employer, which would affect the definition of small group. New York was one of the few states that refused to adopt any transitional policies. Instead, in April 2015, New York opted to amend the New York Insurance Law, Section 3231, to permanently change the definition of small employer from 1-50 to 1-100. At the time, New York legislators were aligning the New York definition of small group with the federal definition of small employer.

However, in October 2015, Congress signed into law the Protecting Affordable Coverage for Employees Act ("PACE Act"), which would amend the federal definition of small employer from 1-100 back to 1-50, effective January 1, 2016. While many employers exhaled a sigh of relief, employers in the State of New York must still cope with the expanded New York small group definition, which includes employers with 1-100 employees.

Implications – Small vs. Large

Employers in the small group market are limited in plan design, administration, and cost. Under the ACA, an employer in the small group market may see premium rates vary based on only four categories:

1. coverage category;
2. rating area;
3. age; and
4. tobacco use.

A small group may not experience rate variations for any factor other than the four identified. In addition, an employer in the small group market is required to offer an Essential Health Benefits Package, which includes:

1. essential health benefits;
2. limited cost sharing; and
3. bronze, silver, gold, or platinum level coverage of the full actuarial benefits provided under the plan.

New York State Specific Provisions

Under New York State Insurance Law, an employer in the small group market is limited from self-insuring. Specifically, an employer may not purchase stop loss and may not receive administrative service from any carrier licensed in the State of New York. As a result, an employer that falls in the small group market in New York may self-insure without stop loss and by self-administering the plan. Finally, any group medical or group hospital insurance coverage obtained from an out-of-state trust covering between 1-50 employees, covering 1-100 employees (beginning 2016), or covering participating persons who are residents of New York, must be community rated regardless of the situs or delivery of the policy.

New York's Pending Change in Definition

New York is one of four states (the others are California, Colorado and Vermont) that maintain an expanded small group definition (1-100 employees). The imminent change of the law is unknown. However, there have been two recent efforts to effectuate a change to the New York state definition of small group:

- In January 2016, Bill No. A01154 was introduced. The Bill would amend the definition of small group market in the State of New York. However, since January, the Bill remains referred to Insurance.
- In March 2016, Bill No. S07104 was introduced. The Bill would also amend the definition of small group market in the State of New York. The Bill has also been referred to Insurance.

Both Bills are at the infant stages. We will continue to keep you apprised of this situation.

HIPAA Audits to Increase in 2016

Published: April 18, 2016

On March 21, 2016, Health and Human Service's Office for Civil Rights ("OCR") announced the launch of the second round of national HIPAA audits. These audits are focused on covered entities (health plans and health care providers) and business associates (e.g., brokers, TPAs). The audits will target enforcement of HIPAA Privacy, Security and Breach Notification rules. OCR plans to conduct desk and onsite audits for both covered entities and their business associates. The first set of audits will be desk audits of covered entities followed by a second round of desk audits of business associates. OCR intends to complete desk audits by the end of December 2016.

Importantly, OCR has indicated that the audit process will begin via email inquiry to a covered entity or business associate, and that some email systems may classify HHS' inquiry as spam:

> Communications from OCR will be sent via email and may be incorrectly classified as spam. If your entity's spam filtering and virus protection are automatically enabled, we expect you to check your junk or spam email folder for emails from OCR; OSOCRAudit@hhs.gov.
>
> Click here to view a sample email letter: http://www.hhs.gov/sites/default/files/ocr-address-verification-email.pdf
>
> http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/index.html

Why is OCR Conducting Audits?

As part of the HIPAA HITECH legislation passed in 2009, Congress tasked OCR to begin compliance enforcement of HIPAA's regulatory requirements. OCR began the first phase of the audit program (known as the "audit pilot program") in 2012. The limited number of audits conducted in that round were deemed to be a success, and after securing a $4 million increase in funding from Congress for fiscal year 2016, OCR announced phase two will begin effective March 21, 2016.

Who does this Impact?

HIPAA Privacy and Security applies to insured and self-funded group health plans (includes HRAs and health FSAs).

What does HIPAA Privacy and Security Require?

HIPAA regulations impose significant compliance obligations on covered entities. These include:

- Maintaining plan documents – updated for final rules issued in 2013
- Implementing HIPAA Privacy and Security policies and procedures and administrative safeguards – electronic and physical protection of protected health information ("PHI")
- Establishing procedures to (1) facilitate early detections of potential breaches of unsecured PHI and (2) upon the occurrence of an unauthorized use/disclosure of unsecured PHI have procedures in place to conduct appropriate risk analysis.

- Maintaining Business Associate Agreements ("BAAs") -- the covered entity should have a signed BAA between the plan and any service provider that handles PHI, such as brokers/consultants, TPAs, COBRA vendors, certain payroll vendors, accountants, law firms, etc.
- Distributing the Notice of Privacy Notice (self-funded plans only)
- Conducting regular Security risk assessments
- Complying with tracking and communication requirements of participant requests for PHI
- Conducting training for members of a workforce who handle PHI

Importantly, the OCR audits will cover only federal HIPAA Privacy, Security and Breach Notification rules. No state- or city-specific privacy rules will be included.

What are the Penalties?

According to OCR, the audits are meant to help improve HIPAA compliance, although serious compliance issues could prompt further investigation. HIPAA imposes significant non-compliance penalties on covered entities. Penalties can range from $100 per violation up to $50,000 per violation (in the case of willful neglect), with an annual maximum of $1,500,000 per violation.

What to Do?

Upon notification of an audit, OCR will provide covered entities 10 business days to demonstrate they are following HIPAA Privacy and Security rules.

Covered entities should review their HIPAA policies, procedures, notices and documents now to ensure they are updated for HIPAA HITECH and the final HIPAA omnibus rules. In addition, covered entities should ensure up-to-date business associate agreements have been signed with any service providers with access to PHI.

New York Paid Family Leave and Minimum Wage Increase

Published: April 18, 2016

On April 1, 2016, Governor Cuomo signed legislation as part of the state budget, which among other things, establishes Paid Family Leave and increases the Minimum Wage.

Paid Family Leave

New York has adopted the most expansive paid family leave policy in the nation. When fully phased in, employees will be eligible for 12 weeks of paid family leave when caring for an infant, a family member with a serious health condition or to relieve family pressures when someone is called to active military service.

The Paid Family Leave Act (the "Act") applies to all private sector employers of one or more employees and guarantees 12 weeks of paid leave, which would be funded by employees through payroll contributions. It is important to note that employers would not be required to make any contributions. Beginning in 2018, an employee will be able to receive benefits at 50% of the average statewide weekly wage for 8 weeks. By 2021, an employee will receive 67% of his/her average weekly wages for 12 weeks, capped at 67% of the average statewide weekly wage (for 2015, the New York State Average Weekly Wage was approximately $1,296.48).

While federal law permits unpaid leave, up to 12 weeks, it is often difficult for an employee to take advantage of the leave – many employees are unable to afford extended periods without wages. New York joins three other states that offer similar benefits for a maximum period of 6 weeks – New Jersey, California, and Rhode Island.

Minimum Wage

Under the state budget, the Governor approved a historic increase in the minimum wage to $15 per hour, up from $9 per hour. The minimum wage increase will be gradual and will reach full effect by 2021. The minimum wage increase will be applied as follows:

- For workers in New York City employed by large businesses (those with at least 11 employees), the minimum wage would rise to $11 at the end of 2016, then another $2 each year after, reaching $15 on 12/31/2018.

- For workers in New York City employed by small businesses (those with 10 employees or fewer), the minimum wage would rise to $10.50 by the end of 2016, then another $1.50 each year after, reaching $15 on 12/31/2019.

- For workers in Nassau, Suffolk and Westchester Counties, the minimum wage would increase to $10 at the end of 2016, then $1 each year after, reaching $15 on 12/31/2021.

- For workers in the rest of the state, the minimum wage would increase to $9.70 at the end of 2016, then another .70 each year after until reaching $12.50 on 12/31/2020 – after which will continue to increase to $15 on an indexed schedule to be set by the Director of the Division of Budget in consultation with the Department of Labor.

The Bill also provides that "food service workers" receiving tips shall receive a "cash wage" of at least 2/3 of the minimum wage rounded to the nearest .05 cents or $7.50, whichever is higher. The cash wage and the tips must equal the minimum wage in effect.

Finally, the Bill provides that beginning on January 1, 2019 and each year thereafter, the Division of Budget is required to conduct an analysis of the effect of the wage increase and determine if a temporary suspension is necessary.

Sick Pay Laws to Date

Published: April 21, 2016

States are free to draft sick pay laws that uniquely and diversely affect employers. Current sick pay laws may have common characteristics, but varied application. To date, there are six States and twenty municipalities with sick pay laws. In addition, the President signed Executive Order 13706, which requires entities contracting with the Federal government to provide employees with up to seven days of paid sick leave annually. The result is a hodgepodge of regulation that creates burdensome administration and increased expense for employers.

New Jersey

In 2014, Senate Bill 785 was introduced to mandate sick leave for employees. Bill 785 was amended various times, but never passed. It was re-introduced as Bill 799 on January 12, 2016. Since January the Bill has been amended, but has not yet passed. While Bills 785 and 799 have been contested and criticized for requiring sick leave State-wide, ten (10) municipalities within the State of New Jersey have passed sick pay laws applicable to each municipality.

The ten municipalities are Bloomfield, NJ; East Orange, NJ; Elizabeth, NJ, Irvington, NJ, Jersey City, NJ, Newark, NJ, Passaic, NJ, Paterson, NJ, Trenton, NJ, and Montclair, NJ.

The sick pay laws of these municipalities apply to all private employers and exclude federal and state employers and members of a union that have enrolled or graduated from a registered apprenticeship program covered by a Collective Bargaining Agreement (“CBA”). The municipalities provide up to 40 hours of sick leave annually. An employee is permitted to use sick leave earned after 90 days of employment for medical diagnosis, care, and/or treatment of their own or their family member. Accrual provisions apply as follows:

Specific Requirements of Municipalities – New Jersey		
Employer Size	**Accrual**	**Not to Exceed**
10+ Employees	1 hour of paid sick time for every 30 hours worked	40 hours per year
< 10 Employees	1 hour of paid sick time for every 30 hours worked	24 hours per year
Child Care Worker, Home Health Care Worker, Food Service Worker (Regardless of Hours Worked)	1 hour of paid sick time for every 30 hours worked	40 hours per year

Employers must provide advance notice to employees of the sick leave provisions applicable to each municipality. In addition, employers with a Paid Time Off ("PTO") policy may continue to use the policy so long as the accrual meets the municipal requirements.

New York City

In March 2014, Mayor de Blasio signed the New York City Earned Sick Time Act ("ESTA"), which mandates sick pay for employees of private employers and excludes employees of federal and state governments. In addition, any employee covered by a Collective Bargaining Agreement ("CBA") in effect on April 1, 2014 will be covered by ESTA beginning the date the CBA terminates.

ESTA applies to employees working in the City of New York, even if the employee lives in another State or if the employer is headquartered in another State. Any employer with five or more employees, working 80 or more hours a year, must provide paid sick leave. Employers with less than five employees must provide unpaid sick pay leave. Finally, any employer with one or more domestic workers who have worked for the employer for at least a year and who work more than 80 hours a calendar year must provide paid sick leave.

ESTA provides that an employee can accrue up to 40 hours of sick leave during a calendar year or 1 hour for every 30 hours worked. Once sick leave is earned, the employee may begin to use sick leave after 120 days of employment. ESTA permits a maximum carryover of 40 hours per year, available for immediate use.

Employers must also comply with additional recordkeeping and disclosure requirements, including:

Employer must have a written policy outlining the sick leave policy;

Any advance requirement for sick leave must be outlined in a sick leave policy;

Employer must distribute the sick leave policy to employees either by hand-delivery, mail, e-mail, or by posting the notice in a publicly accessible and visible place;

Additional documents to be distributed with Sick Leave Policy: 1) Employer's Calendar Year; 2) Right to be Free from Retaliation; and 3) Right to File a Complaint.

An employer may not ask the employee the reason for the leave, but may request 1) a doctor's note; 2) date of clearance to return to work; 3) certification of sick leave use. Finally, employers must keep records that show the leave provided, the leave requested, and any substantiation provided by employees.

Other States with Sick Pay Laws

As previously mentioned, six other States have sick pay laws, which provide for varied accruals sick leave accruals and maximum caps.

The six States are: 1) California; 2) Connecticut; 3) District of Columbia; 4) Massachusetts; 5) Oregon; and 6) Vermont. The requirements can be summarized as follows:

Other States with Sick Pay Laws

State	Eligibility	Accrual	Not to Exceed
California	EE must work 30+ days Covered after 90 days of employment	1 hour of paid sick time for every 30 hours worked	6 days / 48 hours Cannot take more than 3 days / 24 hours annually
Connecticut	Covers service workers for ERs with 50+ employees Required 680 hours of employment		5 days / 40 hours
District of Columbia	After 90 days of employment	1 hour of paid sick time for every 37 hours worked (ERs with 100+ EEs)	7 days / 56 hours (ERs with 100+ EEs)
Massachusetts	Covered after 90 days of employment ERs with 10 or less EEs have to provide unpaid sick leave		5 days / 40 hours
Oregon	Covered after 90 days of employment ERs with less than 10 EEs only have to provide unpaid sick leave	1 hour of paid sick time for every 30 hours worked **-OR-** 1.5 hour of paid sick time for every 40 hours worked	5 days / 40 hours
Vermont	EEs working at least 18 hours per week during the year	1 hour of paid sick time for every 52 hours worked	3 days/24 hours annually until 12/31/2018 5 days/40 hours annually for subsequent years
Municipalities	Emeryville, CA Oakland, CA San Francisco, CA Montgomery County, MD Philadelphia, PA Pittsburgh, PA Seattle, WA Spokane, WA Tacoma, WA	Varied	Varied

2017 Inflation Adjusted Amounts for HSAs

Published: May 5, 2016

The IRS released the inflation adjustments for health savings accounts (HSAs) and their accompanying high deductible health plans (HDHPs) effective for calendar year 2017. Most limits remained the same as 2016 amounts.

Annual Contribution Limitation

For calendar year 2017, the maximum contribution permitted to an HSA for an individual with self-only coverage under a high deductible health plan is $3,400 (up $50 from 2016). For calendar year 2017, the maximum contribution permitted to an HSA for an individual with family coverage under a high deductible health plan is $6,750 (no change from 2016).

High Deductible Health Plan

For calendar year 2017, a “high deductible health plan” is defined as a health plan with an annual deductible that is not less than $1,300 for self-only coverage or $2,600 for family coverage, and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) do not exceed $6,550 for self-only coverage or $13,100 for family coverage.

Non-calendar year plans: In cases where the HDHP renewal date is after the beginning of the calendar year (i.e., a fiscal year HDHP), any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date.

Catch-Up Contribution

Individuals who are age 55 or older and covered by a qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined by the statute, is $1,000 for 2009 and thereafter.

Final SBC Template and Related Materials Issued

Published: May 6, 2016

On April 6, 2016, the Departments of Labor (“DOL”), the Internal Revenue Service (“IRS”), and Health and Human Services (“HHS”) (collectively, “the Departments”) announced the final version of the new Summary of Benefits and Coverage (“SBC”) template and associated documents.

Health plans are required to use the April 2017 edition of the SBC template and associated documents beginning on the **first day of the first open enrollment period that begins on or after April 1, 2017** with respect to coverage for plan years beginning on or after that date.

Highlights of Changes

- The April 2017 template is five pages (two and one-half double-sided pages) compared to the current six page version.
- In the coverage examples on the template, the cost-sharing language is more specific when copayments and coinsurance are applied to coverage.
- The description of an embedded deductible has been clarified.
- Each of the terms in the uniform glossary of terms has an independent web link so the key terms in electronic versions of the SBC can be linked directly to their definitions.
- Coverage example calculators and their instructions have been updated.

Employer Action

Employers should continue to comply with the current rules and be ready to apply the new rules beginning April 2017.

- Employers with insured plans should make sure that the carrier is using the appropriate SBC template version.

- Employers with self-funded plans should make sure that they are using the correct SBC template version. If working with a TPA to develop the SBC, ensure the TPA is using the correct SBC.

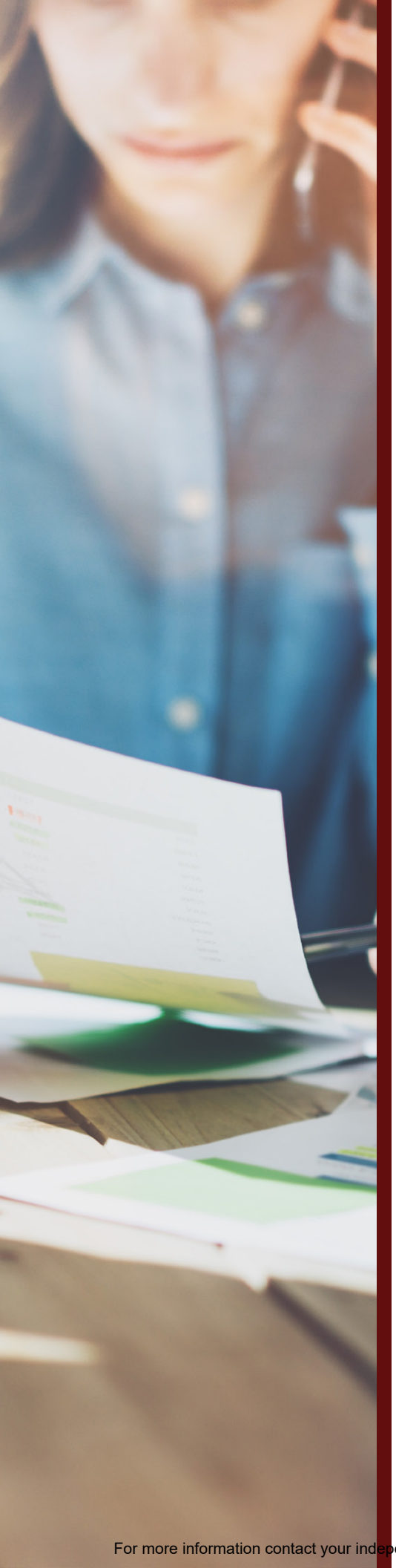
Further Information

For the SBC regulations and templates on the DOL's EBSA website, see "Templates, Instructions, and Related Materials – Currently Applicable" v. "Templates, Instructions, and Related Materials – for use on or after 04/01/17 (Final)" at:

http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html.

For the SBC materials and supporting documents on the HHS website, see "SBC Materials and Supporting Documents (Authorized for use on and after April 1, 2017)" v. "SBC Materials and Supporting Documents (Authorized for use prior to April 1, 2017)" at:

https://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html#Summary%20of%20Benefits%20and%20Coverage%20and%20Uniform%20Glossary.



Departments Issue 31st Set of FAQs

Published: June 3, 2016

The Departments of Labor, the Treasury, and Health and Human Services (collectively, the "Departments") have issued the 31st set of Affordable Care Act ("ACA") frequently asked questions ("FAQs"). This time, the Departments address a wide range of topics including preventive services, disclosure obligations, coverage in connection with approved clinical trials, reference-based pricing, the Mental Health Parity and Addiction Equity Act, and the Women's Health and Cancer Rights Act. Below is a brief summary of the guidance issued on these topics.

Preventive Care

All non-grandfathered group health plans must cover certain mandated preventive items and services in-network without cost-sharing.

- **Colonoscopy.** Colorectal cancer screening for adults over age 50 is a mandated preventive care service. This includes required preparation as an integral part of the procedure.

  FAQ 31 clarifies that bowel preparation medications are required to be covered without cost-sharing.

- **Contraceptives.** Plans that use reasonable medical management techniques ("MMTs") to control costs and promote efficient delivery of contraceptives (e.g., cover generic drugs without cost sharing and impose a copay for equivalent branded drugs) must have an exception process and the plan must defer to the determination of the attending provider.

  FAQ 31 suggests that the Medicare Part D Coverage Determination Request Form 3 can serve as a model notice for the exceptions process.

Out-of-Network Emergency Services

Non-grandfathered group health plans cannot impose cost-sharing on out-of-network emergency services (expressed as a copayment or coinsurance rate) in a greater amount than what is imposed for in-network emergency services. A plan must pay a "reasonable amount" before a patient is responsible for any balance billing.

FAQ 31 explains that a plan must disclose how it calculated the reasonable amount as a part of its ERISA plan documents and claims and appeals procedures.

Clinical Trials

Non-grandfathered group health plans may not deny a qualified individual from participating in an approved clinical trial with respect to the prevention, detection or treatment of cancer and certain life-threatening illnesses, including routine patient costs in connection with such participation.

The Departments believe this provision is self-implementing. Unless and until further guidance is issued, plans are expected to implement these requirements using a good faith, reasonable interpretation of the law.

FAQ 31 provides additional guidance with the following clarifications:

- A plan cannot deny (or limit or impose additional conditions on) the coverage of such item or service on the basis that it is furnished in connection with participation in an approved clinical trial such as a clinical trial for an anti-nausea medication.

- Routine patient costs include items and services to diagnose or treat complications or adverse events (e.g., side effects) arising from participation in an approved clinical trial and must be covered.

Referenced-based Pricing

Non-grandfathered health plans are required to ensure that any annual cost-sharing imposed with respect to essential health benefits is limited to the annual maximum out-of-pocket ("MOOP") limit (for 2016, $6,850 for self-only coverage and $13,700 for other than self-only coverage).

As previously announced, the Departments are concerned with a reference-based pricing structure (or similar network design) because such a pricing structure could be a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and an adequate network of providers. The Department outlined specific factors that will be considered whether evaluating whether a reference-based pricing program (or other similar design) is using a reasonable method to ensure adequate access to quality providers. These factors are restated in the appendix for reference.

Per FAQ 31, a plan that merely establishes a reference price without using a reasonable method to ensure adequate access to quality providers at the reference price will not be considered to have established a network. If there is not adequate access to quality providers willing to accept the price as payment in full, the plan is required to count an individual's out-of-pocket expenses for the provider who did not accept the reference price toward the MOOP limit.

Mental Health Parity and Addiction Equity Act ("MHPAEA")

MHPAEA applies to:

- Employers with at least 51 employees offering group health plan coverage that includes any mental health and/or substance use disorder ("MH/SUD" benefits)

- Non-grandfathered insured small group and individual health plans, as MH/SUD is considered an essential health benefit.

With respect to MHPAEA, the FAQs provide the following clarifications.

1. **Plan-specific data must be used when running the substantially all and predominant tests.** The financial requirements and treatment limitations imposed on MH/SUD benefits cannot be more restrictive than the predominant financial

requirements and treatment limitations that apply to substantially all medical and surgical benefits. The regulations outline specific requirements to demonstrate compliance with these requirements and permit "any reasonable method" to be used to determine the dollar amount of all plan payments under these tests.

In performing the substantially all and predominant tests, it is not reasonable to base the analysis on a carrier's (or TPA's) entire book of business. Rather, to the extent group health plan-specific data is available, each self-funded group health plan must use such data. For fully-insured group health plans, the issuer should use group health plan-specific data to make projections, or if none, then data from other similarly-structured group health plans with similar demographics.

2. **Disclosure requirements.** A plan administrator or issuer must disclose the criteria for medical necessity determinations with respect to MH/SUD benefits upon request and the reason for denial of reimbursement or payment for services. Such disclosure must be made to any current or potential participant, beneficiary, or contracting provider and must include the reason for any denial of reimbursement or payment for services with respect to MH/SUD benefits.

   FAQ 31 clarifies that, upon request, a group health plan must make available to any current or potential enrollee or contracting provider the criteria for medical necessity determinations.

   Additionally, a provider acting as a plan participant's authorized representative can request the following documents with respect to the plan's compliance with MHPAEA:

   - The summary plan description ("SPD") or other summary information;
   - The specific plan language regarding the imposition of the nonquantitative treatment limitation ("NQTL") (i.e., preauthorization requirement);
   - The specific underlying processes, strategies, evidentiary standards, and other factors considered by the plan in determining that the NQTL would apply to this particular MH/SUD benefit;
   - Information regarding the application of the NQTL to any medical/surgical benefits;
   - The specific underlying processes, strategies, evidentiary standards, and other factors considered by the plan in determining the extent to which the NQTL would apply to any medical/surgical benefits within the classification; and
   - Any analysis performed by the plan as to how the NQTL complies with MHPAEA.

3. **MHPAEA applies to opioid use disorder benefits.** Group health plans that offer any medication assisted treatment ("MAT") benefits for opioid use disorder must comply with MHPAEA, including the special rule for multi-tiered prescription drug benefits. The behavioral health services component of MAT should be treated as outpatient and/or inpatient benefits as appropriate.

Women's Health and Cancer Rights Act (WHCRA)

WHCRA provides protection for individuals who elect breast reconstruction in connection with a mastectomy. If a group health plan covers mastectomies, it must provide coverage for certain services in a manner determined in consultation with the attending physician.

FAQ 31 clarifies that such coverage must be provided for all stages of breast reconstruction, including coverage for nipple and areola reconstruction and repigmentation. Plans may impose deductibles and coinsurance for these benefits if consistent with those established for other benefits.

Appendix

The 31st set of ACA FAQs specifies the following factors will be considered as to whether the reference-based price structure (or similar network design) is a reasonable method:

1. **Type of service.** Plans should have standards to ensure that the network is designed to enable the plan to offer benefits for services from high-quality providers at reduced costs. For this purpose:
   a. In general, reference-based pricing should apply only to those services for which the period between identification of the need for care and provision of the care is long enough for consumers to make an informed choice of provider.
   b. Limiting or excluding cost-sharing from counting toward the Maximum Out-of-Pocket ("MOOP") is not reasonable with respect to emergency services.

2. **Reasonable access.** Plans should have procedures to ensure that an adequate number of providers that accept the reference price are available to participants and beneficiaries.

3. **Quality standards.** Plans should have procedures to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.

4. **Exceptions process.** Plans should have an easily accessible exceptions process, allowing services rendered by providers that do not accept the reference price to be treated as if the services were provided by a provider that accepts the reference price if:
   a. Access to a provider that accepts the reference price is unavailable (for example, the service cannot be obtained within a reasonable wait time or travel distance).
   b. The quality of services with respect to a particular individual could be compromised with the reference price provider (for example, if co-morbidities present complications or patient safety issues).

5. **Disclosure.** Plans should provide the following disclosures regarding reference-based pricing (or similar network design) to plan participants free of charge.
   a. Automatically. Plans should provide information regarding the pricing structure, including a list of services to which the pricing structure applies and the exceptions process. (This should be provided automatically, without the need for the participant to request such information, for example through the plan's Summary Plan Description or similar document.)
   b. Upon Request. Plans should provide:
      i. A list of providers that will accept the reference price for each service;
      ii. A list of providers that will accept a negotiated price above the reference price for each service; and
      iii. Information on the process and underlying data used to ensure that an adequate number of providers accepting the reference price meet reasonable quality standards.

Checking Your Employee Handbook for Benefit Provisions

Published: June 6, 2016

Handbooks are important for many reasons such as informing employees of their rights and duties, communicating available resources, and outlining paid time off policies. With respect to health and welfare benefits, here are a few things to consider:

Q1: Does your handbook go too far?

Handbooks cannot change the terms of governing benefit documents such as summary plan descriptions (“SPDs”). Handbook provisions should mirror plan terms and/or refer to plan documents. Any provisions purporting to amend plan documents are ineffective.

However, handbooks may fill in the blanks where the plan documents are silent or refer to outside policies. For example, an SPD may indicate that certain eligibility criteria is determined by the employer. In this case, that criteria may be explained elsewhere such as a handbook or benefit booklet.

Q2: Are all handbook provisions current?

A handbook should reflect current, compliant provisions such as those addressing benefits, eligibility, and termination.

Does your handbook exclude certain employee groups from benefits (e.g., temporary employees or interns)? If so, be aware of potential exposure under the Employer Penalty which defines a “full-time employee” as any employee who works at least 30 hours per week. There are no exclusions of categories of employees. However, if using the look back measurement method, part-time employees, seasonal employees, and variable hour employees can be asked to wait up to 13+ months to determine full-time employee status without penalty.

- Does the handbook contain an outdated waiting period (e.g., indicating that plan entry is the first day of the month following 90 days of continuous service)?

- A handbook should reflect current, compliant provisions such as those addressing benefits, eligibility, and termination.

- Does your handbook exclude certain employee groups from benefits (e.g., temporary employees or interns)? If so, be aware of potential exposure under the Employer Penalty which defines a "full-time employee" as any employee who works at least 30 hours per week. There are no exclusions of categories of employees. However, if using the look back measurement method, part-time employees, seasonal employees, and variable hour employees can be asked to wait up to 13+ months to determine full-time employee status without penalty.

- Does the handbook contain an outdated waiting period (e.g., indicating that plan entry is the first day of the month following 90 days of continuous service)?

- Does the handbook contain conflicting eligibility terms? For example, does the handbook indicate that an employee must work at least 40 hours per week to be eligible for benefits when an employee must only work at least 30 hours per week?

- If the look back measurement method rules are being used, are those referenced or outlined?

- Does the handbook indicate that same-sex spouses are excluded from benefit eligibility? Excluding same-sex spouses is not advisable due to recent court cases and EEOC discrimination inquiries and likely conflicts with plan terms. It may also conflict with the company anti-discrimination workplace policy.

Q3: Does the handbook demonstrate that an offer of coverage was made?

Under the Employer Penalty rules, an employee must be offered an effective opportunity to accept coverage at least once with respect to the plan year. Final regulations do not apply any specific rules for demonstrating that an offer of coverage was made.

Many employers require an affirmative waiver of medical benefits. This is the best method to prove an offer was made, provided that a waiver can be collected from every single employee waiving. Otherwise, any waiver not returned by the employee arguably proves that he was never made the offer.

When an affirmative waiver is not required, otherwise documenting information regarding the election process is key. An employer will want to show that employees received sufficient information about the offer so that they must have known medical coverage was available. A widely-distributed handbook with clear information about the offer and its terms can be a valuable part of an employer's distribution of information as well as benefit booklets, email correspondence, posters, mandatory meetings, etc., as applicable.

If you need assistance with creating or modifying your handbook, please contact us and we can help you with a solution.

PCOR Fee Filing Reminder for Self-Insured Plans

Published: June 14, 2016

The PCOR filing deadline is August 1, 2016 for all self-funded medical plans and HRAs for plan years ending in 2015.

The plan years and associated amounts are as follows:

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2014 – January 31, 2015	$2.08/covered life/year	July 31, 2016
March 1, 2014 – February 28, 2015	$2.08/covered life/year	July 31, 2016
April 1, 2014 – March 31, 2015	$2.08/covered life/year	July 31, 2016
May 1, 2014 – April 30, 2015	$2.08/covered life/year	July 31, 2016
June 1, 2014 – May 31, 2015	$2.08/covered life/year	July 31, 2016
July 1, 2014 – June 30, 2015	$2.08/covered life/year	July 31, 2016
August 1, 2014 – July 31, 2015	$2.08/covered life/year	July 31, 2016
September 1, 2014 – August 31, 2015	$2.08/covered life/year	July 31, 2016
October 1, 2014 - September 30, 2015	$2.08/covered life/year	July 31, 2016
November 1, 2014 – October 31, 2015	$2.17/covered life/year	July 31, 2016
December 1, 2014 - November 30, 2015	$2.17/covered life/year	July 31, 2016
January 1, 2015 - December 31, 2015	$2.17/covered life/year	July 31, 2016

For the Form 720 and Instructions, visit: http://www.irs.gov/uac/Form-720,-Quarterly-Federal-Excise-Tax-Return.

The information is reported in Part II.

Please note that Form 720 is a tax form (not an informational return form such as Form 5500). As such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third party administrators and USI, cannot report or pay the fee.

Short Plan Years

The IRS issued FAQs that address how the PCOR fee works with a self-insured health plan on a short plan year.

Does the PCOR fee apply to an applicable self-insured health plan that has a short plan year?

Yes, the PCOR fee applies to a short plan year of an applicable self-insured health plan. A short plan year is a plan year that spans fewer than 12 months and may occur for a number of reasons. For example, a newly established applicable self-insured health plan that operates using a calendar year has a short plan year as its first year if it was established and began operating beginning on a day other than Jan. 1. Similarly, a plan that operates with a fiscal plan year experiences a short plan year when its plan year is changed to a calendar year plan year.

What is the PCOR fee for the short plan year?

The PCOR fee for the short plan year of an applicable self-insured health plan is equal to the average number of lives covered during that plan year multiplied by the applicable dollar amount for that plan year.

Thus, for example, the PCOR fee for an applicable self-insured health plan that has a short plan year that starts on April 1, 2015, and ends on Dec. 31, 2015, is equal to the average number of lives covered for April through Dec. 31, 2015, multiplied by $2.17 (the applicable dollar amount for plan years ending on or after Oct. 1, 2015, but before Oct. 1, 2016).

See FAQ 12 & 13, http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers.

Form 5500 Filing Reminder

Published: June 15, 2016

For calendar year plans, the 2015 plan year Form 5500 is due to be filed electronically no later than **August 1, 2016.**

ERISA requires that Form 5500 be filed with the Department of Labor for most health and welfare plans (for example, medical, dental, and life insurance plans) by the last day of the seventh month following the end of plan year unless an extension (Form 5558) is completed and mailed to the IRS.

A plan with fewer than 100 covered employees as of the first day of the plan year that is unfunded (no trust) or fully insured is exempt from this requirement. Certain other exceptions apply such as for church plans and governmental plans. Multiple employer welfare arrangement (MEWA) plans must file regardless of size.

Form 5500 also applies to retirement plans, regardless of employee count.

Final Regulations Shed Light on Wellness Programs

Published: June 15, 2016

Background

The Americans with Disabilities Act (ADA) generally prohibits employers with at least 15 employees from making disability-related inquiries or requiring medical examinations unless job-related and consistent with business necessity. There is an exception where participation is voluntary, a term which was not defined.

The Genetic Information Nondiscrimination Act (GINA) Title II prohibits all employers with at least 15 employees from using genetic information (which includes the current and past health status of a spouse and children) in making decisions about employment. It restricts employers from requesting, requiring, or purchasing genetic information, unless one or more of six narrow exceptions applies. It also limits the disclosure of genetic information.

On April 20, 2015, the Equal Employment Opportunity Commission (EEOC) issued proposed regulations providing the first guidance on how employers may use incentives in wellness programs and comply with the ADA. Similar guidance was subsequently released with respect to GINA.

On May 17, 2016, the EEOC announced final regulations under the ADA and GINA Title II regarding wellness programs. These regulations are similar to the proposed rules issued last year and more restrictive than the existing HIPAA rules. All three rules need to be carefully looked at when implementing incentive-based programs.

Bottom Line on Rewards

- Incentivized wellness programs with the reward at or below 30% of the total cost of self-only coverage generally are permissible under HIPAA, ADA, and GINA. Assuming compliance with the other requirements of these various laws, namely notice requirements, such rewards will not pose a risk.

- Employers intending to be more aggressive with their wellness program and offer incentives larger than the 30% self-only threshold require close review. While larger rewards are permissible in some cases, the specific features

of the wellness program will determine whether the reward meets the applicable requirements under HIPAA, ADA, and GINA.

- One caveat with rewards is if the employer is rewarding a spouse for completion of a risk assessment or tying the spouse's risk assessment to enrollment. GINA Title I prohibits a group health plan from collecting genetic information prior to or in connection with enrollment in health insurance coverage and for underwriting purposes. It is not clear whether a wellness program that provides rewards for a spouse's completion of a risk assessment (or ties the assessment to enrollment) violates GINA Title I as a spouse's medical history (which is collected in the spouse's risk assessment) is considered genetic information of the plan participant. More guidance on this issue is needed.

Highlights

Here are the highlights of the final regulations:

Applicability

The ADA rules on voluntary wellness programs apply to any employer wellness program that asks disability-related questions or requires medical examinations of employees. For example:

- Programs where employees must complete a health risk questionnaire, undergo an annual physical, or have other medical testing (e.g., biometric screenings) are subject to the ADA rules on voluntary wellness programs.

- Programs that require attendance in a nutrition class or a certain amount of exercise a week are not subject to the ADA voluntary rule. However, separate from these rules, the ADA requires employers to make reasonable accommodations to allow employees with disabilities to participate in any type of wellness program.

The final rules clarify that the safe harbor for insurance, that allows insurers and plan sponsors to use information, including actuarial data about risks posed by certain health conditions, to make decisions about insurability and the cost of health insurance coverage does not apply to wellness programs.

If the wellness program uses incentives to encourage a spouse to answer questions related to his/her current or past health status or complete a medical examination, GINA Title II applies. Such incentives are prohibited for children. The final rules clarify a "child" for this purpose includes an adult, minor, and adopted child. GINA also prohibits incentives tied to a spouse providing his or her own genetic information (e.g., results of a spouse's genetic tests).

Both the ADA and GINA apply to all wellness programs, regardless of whether the program is part of, or outside of, a group health plan.

Voluntary Wellness Programs

To qualify as a voluntary wellness program under the ADA, the employer:

- cannot require any employee to participate in the program;

- cannot deny any employee access to coverage under any group health plan for non-participation in the program or prohibit any non-participating employee from choosing a particular plan;

- cannot take any adverse action, retaliate against, or coerce employees who choose not to participate in the program; and

- must provide employees with a notice that clearly explains what medical information is obtained, who will receive it, how it will be used and the restrictions on disclosure (including whether the restrictions on disclosure comply with HIPAA Privacy Rule). The EEOC is expected to issue a model notice employers can use to meet this requirement.

The EEOC makes clear that certain tiered health benefit and cost-sharing structures that base eligibility for a particular health plan on completing the risk assessment or undergoing a medical exam will not meet this voluntary requirement. Two examples in the preamble help clarify this point:

- A program that allows employees who participate in the risk assessment to enroll in a comprehensive health plan, while non-participating employees are only eligible for a less comprehensive plan violates the ADA.

- However, such an arrangement would not violate the ADA if the non-participating employee could choose the more comprehensive program and pay more for the same comprehensive coverage than what a participating employee pays for the coverage (so long as the difference in cost does not exceed the permitted incentive limits).

Incentives

Unlike the proposed regulations, the final regulations adopt the same framework for establishing permissive incentive thresholds for purposes of the ADA and GINA Title II. Notably, these rules are more restrictive than what is permitted under the HIPAA rules.

The 30% Limit.

If a wellness program is available to the employee and includes medical examinations and/or health risk assessments, the maximum reward available is no more than 30% of the total cost of self-only coverage.

If the wellness program is available to the employee and spouse and includes medical examinations and/or health risk assessments, the maximum reward available is 30% of the total cost of self-only coverage for the employee PLUS 30% of the cost of self-only coverage for the spouse.

No incentive may be offered for a child to provide information about his or her current or past health status.

The ADA and GINA rules do not permit the employer to use family coverage when calculating the 30%.

The 30% threshold takes into account all incentives. This includes financial incentives (e.g., premium reductions or surcharge, cash, or gift cards) and in-kind incentives (e.g., t-shirts, water bottles, or fitness trackers).

How is the cost of coverage determined?

The cost of coverage is determined based on the total cost of self-only coverage (this includes employer and employee costs).

When participation in the wellness program is limited to employees (and spouses) who are enrolled in the health plan, the cost of coverage is based on the plan in which the employee is enrolled.

The final regulations provide a framework to determine the cost of coverage when the wellness program is available to all employees (and their spouses) regardless of enrollment in a health plan option:

- When the employer offers one health plan option and allows both enrolled and non-enrolled employees to participate in the wellness program, then the permissible incentive is determined using 30% of the cost of self-only in the sole health plan option.

- When the employer offers multiple health plans and allows both enrolled and non-enrolled employees to participate in the wellness program, then the permissible incentive is determined using 30% of the cost of self-only coverage in the lowest cost health plan option.

Tobacco use.

When an employer uses medical tests to detect nicotine (e.g., through a blood draw or mouth swab), then the ADA's 30% limit is triggered.

A wellness program that merely asks employees about their tobacco use is not a program that asks disability-related inquiries. It is not subject to the 30% threshold.

However, to the extent the program is tied to a group health plan, the maximum reward is capped at 50% of the total cost of coverage and a reasonable alternative standard must be provided under HIPAA.

GINA does not apply to tobacco use.

Reasonable Design

Under both the ADA and GINA Title II, the wellness program must be reasonably designed to promote health and prevent disease.

This means the program cannot require an overly burdensome amount of time for participation, involve unreasonably intrusive procedures, be subterfuge for violating the ADA, GINA, or other employment discrimination laws, or require employees to incur significant costs for medical examination.

- A program that asks employees (and their spouses) to answer questions about health conditions or have a biometric screening or other medical examination for the purposes of alerting them to health risks (like elevated cholesterol) is reasonably designed.

- Asking employees (or their spouses) to complete a risk assessment without providing additional feedback or follow-up or advice about risk factors or using the aggregate information to design programs to treat specific conditions is NOT reasonably designed.

- A program that merely shifts costs to the employees based on their health or is used only to predict future costs is NOT reasonably designed.

Confidentiality

The two rules also make clear that the ADA and GINA provide important protections for safeguarding health information. The ADA and GINA rules state that information from wellness programs may be disclosed to employers only in aggregate terms except as necessary to administer a health plan.

The ADA rule requires that employers give participating employees a notice that describes what information will be collected as part of the wellness program, with whom it will be shared and for what purpose, the limits on disclosure, and the way information will be kept confidential. GINA includes statutory notice and consent provisions for health and genetic services provided to employees and their family members.

Both rules prohibit employers from requiring employees or their family members to agree to the sale, exchange, transfer, or other disclosure of their health information to participate in a wellness program or to receive an incentive.

The guidance published along with the final ADA rule and the preamble to the GINA final rule identify some best practices for ensuring confidentiality, such as adopting and communicating clear policies, training employees who handle confidential information, encrypting health

information, and providing prompt notification of employees and their family members if breaches occur. A wellness program that is part of a group health plan may satisfy its obligation by adhering to the HIPAA Privacy Rule.

Effective date

The ADA and GINA provisions are effective for plan years beginning on or after January 1, 2017 (except that ADA provisions related to denying a plan option or failing to make a reasonable accommodation are simply clarifying language and should be followed now).

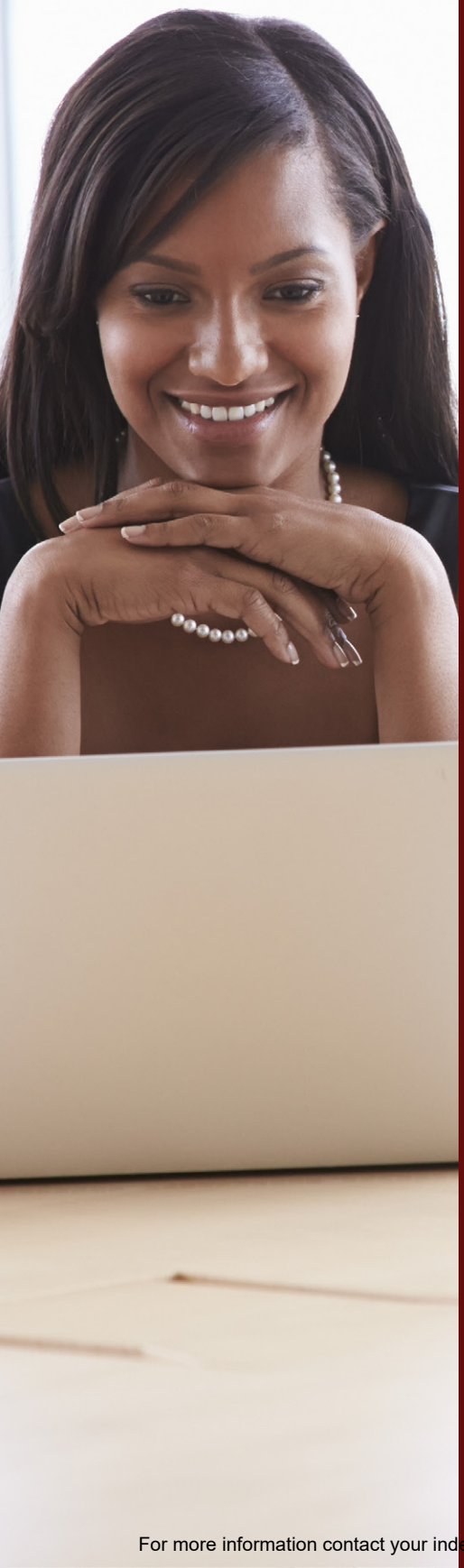
Employer Action

- Employers with rewards at or under 30% of the total cost of self-only coverage generally will not need to alter their approach to incentives.

- Employers that extend wellness program incentives to employees who do not participate in the group health plan and/or have participatory wellness programs should review whether the incentives are set at the appropriate level in light of the new guidance.

- Employers looking to be more aggressive with incentives will need to carefully review the coordination of HIPAA, ADA, and GINA provisions to ensure compliance with the various applicable limits for plan years that begin on or after January 1, 2017.

- For plan years beginning on or after January 1, 2017, a new notice will be required if the employer's wellness program includes medical exams and disability-related inquiries.



Notice of Subsidies in the Federal Marketplace

Published: June 16, 2016

The Affordable Care Act ("ACA") requires each Health Insurance Marketplace ("Marketplace") to notify any employer whose employee was determined to be eligible for Advance Premium Tax Credits ("APTC") and Cost Sharing Reductions ("CSR") because the employee attested that he or she was not:

- enrolled in employer sponsored coverage, or
- eligible for employer coverage that is affordable and meets minimum value requirements.

In 2016, the Federally-Facilitated Marketplace ("FFM") will begin issuing these notices to employers. State-based Marketplaces began this notification process in 2015.

Briefly, these notices serve as an initial "heads-up" to the employer if any employee receives a subsidy and buys coverage in the Marketplace during the current calendar year.

Following are some frequently asked questions.

Q1: What states have an FFM?

Alabama, Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin, Wyoming.

Q2: Which employers will be notified through FFM's employer notice program?

The FFM will send notices to employers whose employees received an APTC in 2016 and whose employees provided FFM with information identifying the employer (e.g., the employer's address).

Any employer (regardless of size) may receive a notice from FFM. The notice will identify the specific employee and include a statement that the employee is enrolled in FFM coverage with APTC. The notices will not contain the employee's personal health information or federal tax information.

After 2016, the Department of Health and Human Services ("HHS") will evaluate and determine whether to further expand and improve the notification program.

Q3: When can employers expect to receive notices?

The FFM will send notices in batches. The first batch will likely be released in the spring of 2016. HHS anticipates this will be the largest batch of notices as it will include employers whose employees enrolled in Marketplace coverage with APTC during Open Enrollment which ended on January 31, 2016. Additional batches of notices are expected throughout 2016.

Q4: Is there an appeal process?

Yes. An employer may appeal a notice and assert that it provides its employee access to affordable, minimum value employer sponsored coverage or that its employee is enrolled in employer coverage, and therefore ineligible for APTC. If the employer is successful, FFM will notify the employee to encourage him or her to update their information to reflect access to, or enrollment in, other coverage. Employees will be notified that their failure to update this information with the Marketplace may result in a tax liability.

Q5: How does the employer submit an appeal?

In the FFM, the employer has 90 days from the date of receipt of the notice to request an appeal. The appeal request form is available here: https://www.healthcare.gov/downloads/marketplace-employer-appeal-form.pdf. Note, employers will need to use the correct appeals form identified by state.

An employer must either mail or fax an appeal request to FFM. The address and fax number are available on the form.

Q6: Is this a penalty assessment notice?

For applicable large employers, subject to the employer mandate, this is not a notice of a penalty assessment. Penalty assessment determinations are made by the Internal Revenue Service ("IRS") in the year that follows the calendar year to which any assessment relates.

However any applicable large employer that receives a notice from the FMM or a state Marketplace should carefully review current year records to determine whether the employee identified in the notice is an ACA full-time employee.

Q7: What about the appeals process for state-based Marketplaces?

Some states, including California, Colorado, the District of Colombia, Maryland, Massachusetts, New York and Vermont, use the Federal appeals process.

Other states, including Washington and Connecticut, have adopted their own appeals process.

Q8: Where can I get more information?

For more information, visit:

- FAQs on FFM notice process. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Employer-Notice-FAQ-9-18-15.pdf

- How to appeal a Marketplace decision. https://www.healthcare.gov/marketplace-appeals/

Mental Health Parity Non-Compliance Triggers

Published: June 17, 2016

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") requires a group health plan that offers mental health and substance use disorder benefits to be at parity with medical and surgical benefits. As such, financial requirements and treatment limitations for mental health and/or substance use disorder benefits cannot be more restrictive than the medical and/or surgical benefits offered.

Non-Quantitative Treatment Limitations

While employers can easily discern differences between financial ($30 copay vs. $50 copay) and quantitative treatment limitations (3 visits vs. 5 visits), ensuring parity of non-quantitative treatment limitations ("NQTLs") is more difficult to detect. As such, NQTLs require an in-depth review of plan documents and plan administration.

Examples of NQTLs include:

- Network tier designs;
- Formulary design for prescription drugs;
- Fail first policies or step therapy protocols;
- Network participation standards, including reimbursement rates;
- Exclusions based on failure to complete a course of treatment;
- Plan methods to determine usual, customary, and reasonable charges;
- Limits or exclusion of benefits based on experimental or investigative treatments; and
- Limits or exclusion of benefits based on medical necessity or medical appropriateness.

Recently, the DOL issued a list of “trigger” phrases that require additional review of plan documents and administration to ensure parity of benefits. In January, the Department of Labor issued a report to Congress describing the importance of mental health and substance use disorder benefits, compliance concerns, and future enforcement activity. Employers should expect to see a rise in investigations focusing on mental health and substance abuse disorder benefit provisions.

To read the warning signs, visit:

https://www.dol.gov/ebsa/pdf/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf

ACA Information Returns May Continue to Be Filed After June 30, 2016

Published: July 1, 2016

The IRS just announced that although the deadline to electronically file ACA information returns (Form 1094-C with related Forms 1095-C) with the IRS is midnight ET on June 30, 2016, the ACA Information Returns (AIR) system will remain up and running after the deadline. If an employer is not able to submit all required ACA information returns by June 30, 2016, the IRS has indicated that the employer should complete the filing after the deadline.

It is important to note the following:

- The AIR system will continue to accept information returns filed after June 30, 2016. In addition, an employer can still complete required system testing after June 30, 2016.
- If any of an employer's transmissions or submissions were rejected by the AIR system, an employer has 60 days from the date of rejection to submit a replacement and have the rejected submission treated as timely filed.
- If an employer submitted and received "Accepted with Errors" messages, the employer may continue to submit corrections after June 30, 2016.

Penalties For Late Filing

The IRS acknowledges that some filers are still in the process of completing their 2015 tax year filings. The IRS has reiterated that filers of Forms 1094-B, 1095-B, 1094-C and 1095-C that miss the June 30, 2016 due date will not generally be assessed late filing penalties under section 6721, if the reporting entity has made legitimate efforts to register with the AIR system and to file its information returns, and it continues to make such efforts and completes the process as soon as possible. In addition, consistent with existing information reporting rules, filers that are assessed penalties may still meet the criteria for a reasonable cause waiver from the penalties.

If an employer is not an electronic filer and missed the May 31, 2016, paper filing deadline for ACA information returns, that employer should also complete the filing of its paper returns as soon as possible.

EEOC Issues Model Notice for Wellness Programs

Published: July 6, 2016

New rules published on May 17, 2016 under the Americans with Disabilities Act ("ADA") provide a helpful roadmap to designing an incentive-based wellness program that will not run afoul of the ADA's general rule that employers are prohibited from requiring medical exams or asking disability-related inquiries unless job-related and consistent with business necessity.

In order for such program to be "voluntary" under the ADA, the employer, in part, must provide a notice that clearly explains what medical information is obtained, who will receive it, how it will be used and the restrictions on disclosure (including whether the restrictions on disclosure comply with HIPAA Privacy Rule).

The EEOC recently published a model notice and FAQs regarding the notice that can be used by employers for purposes of complying with the ADA. The following summarize the highlights.

- **Effective date.** The requirement to provide the notice takes effect as of the first day of the plan year that begins on or after January 1, 2017 for the health plan an employer uses to calculate any incentives it offers as part of the wellness program.

- **Timing.** This notice must be provided to employees before providing any health information and with enough time to decide whether to participate in the program. Waiting until after an employee has completed a health risk assessment ("HRA") or medical examination to provide the notice is illegal.

- **Format.** The notice can be given in any format that will be effective in reaching employees being offered an opportunity to participate in the wellness program. For example, it may be provided in hard copy or as part of an email sent to all employees with a subject line that clearly identifies what information is being communicated (e.g., "Notice Concerning Employee Wellness Program"). Avoid providing the notice along with a lot of information unrelated to the wellness program as this may cause employees to ignore or misunderstand the contents of the notice.

- **Responsibility to provide.** The employer is responsible for providing the notice, but may have its wellness program provider give the notice to employees. However the employer is ultimately responsible for ensuring employees receive it.

- **HIPAA and ADA notice interaction.** Generally, the current HIPAA notice applicable to health-contingent programs does not disclose the information required under the ADA. To the extent the employer's wellness program is health-contingent (meaning outcomes-based or activity-based and tied to a group health plan) and requires medical exams or disability-related inquiries, employers are required to comply with both the ADA and HIPAA notice obligations. It is not clear whether the ADA model notice (specifically, the third paragraph) is sufficient to meet the HIPAA disclosure rules for purposes of a health-contingent program. Additional guidance would be welcome. In the case of a program that is participatory or not part of a health plan, but requires medical exams or disability-related inquiries, only the ADA notice is required.

- **Model notice language can be adapted.** As long as the notice tells employees, in language they can understand, what information will be collected, how it will be used, who will receive it, and how it will be kept confidential, the notice is sufficient. Employers do not have to use the precise wording in the EEOC sample notice. The EEOC notice is written in a way that enables employers to tailor their notices to the specific features of their wellness programs.

- **No signed authorization requirement.** The ADA rule only requires a notice, not signed authorization, though other laws may require authorization. Title II of the Genetic Information Nondiscrimination Act ("GINA") requires prior, written, knowing, and voluntary authorization when a wellness program collects genetic information, including family medical history.

- **Spousal HRAs.** The ADA does not apply to HRAs for spouses. However, GINA is applicable. Under GINA, an employer that requests current or past health status information of an employee's spouse must obtain prior, knowing, written, and voluntary authorization from the spouse before the spouse completes a health risk assessment. The GINA authorization has to be written so that it is reasonably likely to be understood by the person providing the information. It also has to describe the genetic information being obtained, how it will be used, and any restrictions on its disclosure.

Employer Action

An employer that uses an HRA and/or medical exams (e.g., physicals, biometric screenings, etc.) as part of a wellness program will need to provide notice to employees effective for plan years that begin on or after January 1, 2017. Remember, this notice must be provided before an employee is asked to provide any health information or undergo a medical exam.

For the EEOC's sample notice, visit https://www.eeoc.gov/laws/regulations/ada-wellness-notice.cfm

For the FAQs, visit https://www.eeoc.gov/laws/regulations/qanda-ada-wellness-notice.cfm

FAQ Suggests Employers Include Marketplace Options with COBRA Notices

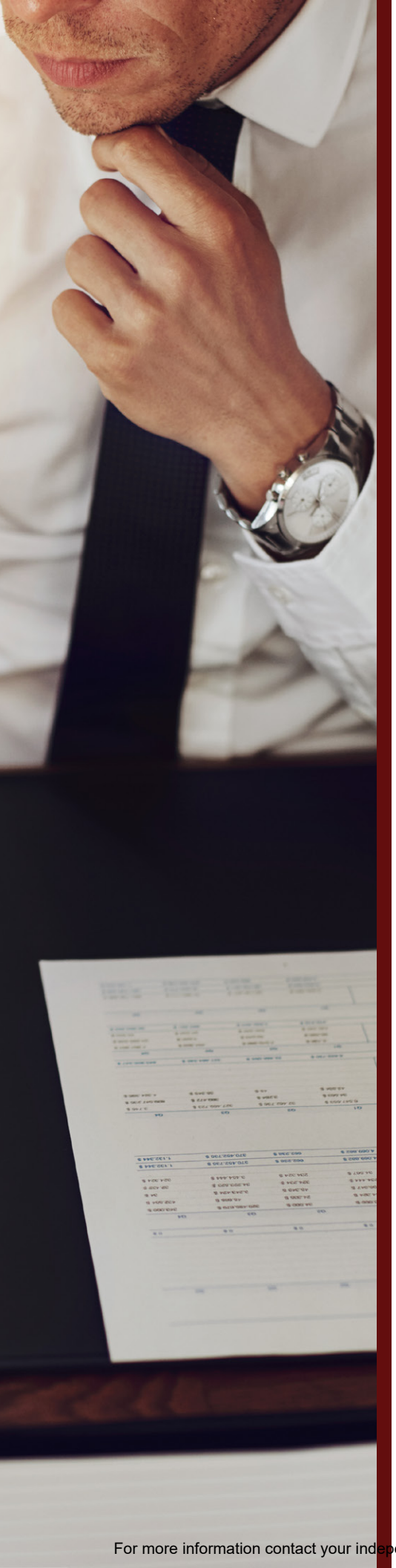
Published: July 12, 2016

On June 21, 2016, the Departments of Labor, Health and Human Services, and the Treasury (collectively, the "Departments") issued the 32nd Affordable Care Act ("ACA") FAQ describing information that may be appropriate to include with COBRA notices. Many wondered if it were appropriate to provide information and if so, what kind of information could be provided about the Health Insurance Marketplaces/Exchanges ("Marketplaces") so that COBRA-eligible individuals could consider health coverage alternatives available through the Marketplaces and possibly investigate whether they may be eligible for premium tax credits and cost-sharing reductions. The current model COBRA notice includes some information to help make qualified beneficiaries aware of other coverage options available in the Marketplaces, but that information is limited. Note that employers also should send a Notice of Coverage Options to all employees at time of hire. That document describes Marketplace options as well.

Under this new FAQ, the DOL indicated that it would be appropriate for an employer to provide additional information about the availability of Marketplace coverage provided that any communication can be "easily understood by the average participant." In that vein, any additional information should not be too lengthy or difficult to understand. Specifically, plan administrators are encouraged to include with the COBRA election notices additional information about the Marketplaces such as: how to obtain assistance with enrollment (including special enrollment), the availability of financial assistance, information about Marketplace websites and contact information, general information regarding particular products offered in the Marketplaces, and other information that may help qualified beneficiaries choose between COBRA and other coverage options. In addition, communications may include information that is specifically tailored to particular groups such as young adults aging out of dependent coverage on their parents' health plan.

Employers should consider adding more detailed information about the availability of Marketplace coverage to assist COBRA qualified beneficiaries in making informed elections and understanding available options. For those using COBRA administration vendors, employers can request that additional Marketplace information be included with notices being sent to COBRA qualified beneficiaries.

For the FAQ, visit:
https://www.dol.gov/ebsa/pdf/faq-aca-32.pdf



DOL Penalties Increase

Published: July 25, 2016

In 2015, Congress passed the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (the “Inflation Adjustment Act”) to direct federal agencies to adjust the civil monetary penalties for inflation every year. Civil penalties ensure compliance with federal regulation by incentivizing employers not to violate federal regulation and providing federal agencies the power to ensure compliance. However, when penalties are too low, or have failed to be increased for inflation, compliance with federal regulation remains stagnant.

Following the directive of the Inflation Adjustment Act, the Department of Labor’s Employee Benefits Security Administration (“EBSA”) published an Interim Final Regulation that increases certain penalties applicable to employee benefit plans to match other penalties that remain unchanged.

The updated penalties go into effect on August 1, 2016 and apply to assessments after August 1, 2016 whose associated violations occurred after November 2, 2015.

Updated Penalties

The following updated penalties are applicable to health and welfare plans subject to ERISA.

Description	Current Penalty	Updated Penalty
Failure to file **Form 5500**	Up to $1,100 per day	Up to $2,063 per day
Failure of a **MEWA** to file reports	Up to $1,100 per day	Up to $1,502 per day
Failure to provide **CHIP Notice**	Up to $100 per day per employee	Up to $110 per day per employee
Failure to disclose CHIP/Medicare Coordination to the State	$100 per day, per violation (per participant/beneficiary)	$110 per day per violation (per participant/beneficiary)
Failure to provide **SBCs**	Up to $1,000 per failure	Up to $1,087 per failure
Failure to furnish **plan documents** (including SPDs/SMMs)	$110 per day $1,100 cap per request	$147 per day $1,472 cap per request
Genetic information failures	$100 per day	$110 per day
De minimis failures to meet genetic information requirements (Minimum)	$2,500 minimum	$2,745 minimum
Failure to meet genetic information requirements – not de minimis failures (Minimum)	$15,000 minimum	$16,473 minimum
Cap on unintentional failures to meet genetic information requirements (Maximum)	$500,000 maximum	$549,095 maximum

Employer Action

Private employers, including non-profits, should ensure employees receive required notices timely (SBC, CHIP, SPD, etc.) to prevent civil penalty assessments. In addition, employers should ensure Form 5500s are properly and timely filed. Finally, employers facing document requests from EBSA should ensure documents are provided timely, as requested.

Form 5500 Proposed Changes

Published: July 27, 2016

The US Department of Labor's Employee Benefits Security Administration (EBSA) issued a "Proposed Revision of Annual Information Returns/Reports" that would make changes to the Form 5500. If adopted, the proposed changes will be effective for plan years beginning on or after January 1, 2019 (filings due in 2020).

EBSA is requesting comments on the proposed changes due by October 4, 2016. Any comments received will be available for public review.

Background

An employee benefit plan established by a private employer must comply with the Employee Retirement Income Security Act (ERISA). ERISA requires pension, health and welfare plans to file an annual return, the Form 5500. The Form 5500 contains information related to an employee benefit plan's operation, funding, asset, and investment information. EBSA, federal and state agencies, private entities, and participants use the Form 5500 to obtain information related to the plan.

The proposed changes would serve five purposes:

1. to modernize financial reporting;
2. to provide greater information related to group health plans;
3. enhance data mineability;
4. improve service provider fee information; and
5. enhance compliance with ERISA and the Internal Revenue Code.

Proposed Changes

The following outlines the changes applicable to health and welfare plans only. However, a number of proposed changes apply to retirement plans, including defined contribution, defined benefit, profit sharing and ESOPs. These changes are not discussed in this summary.

All Health Plans Require a Form 5500 Filing

A small health and welfare plan is a plan with fewer than 100 participants on the first day of the plan year. Currently, small health and welfare plans are exempt from filing the Form 5500 if the plan is unfunded or fully insured.

Large health and welfare plans (those with at least 100 participants on the first day of the plan year) are subject to a Form 5500 filing. However, as noted in the preamble to the proposed rule, information reported in the Form 5500 is generally very limited (particularly for self-funded health plans).

The proposed rule requires all health plans (regardless of size) to file the Form 5500 and required schedules. Small, insured health plans will have a limited reporting obligation as compared to large plans and self-funded plans.

All Health Plans Must Provide a Schedule J – Group Health Plan Information

According to EBSA, existing Form 5500 requirements related to group health plans fail to consider laws enacted after the initial reporting regulations, including:

- Health Insurance Portability and Accountability Act (HIPAA);
- Title I of the Genetic Information and Non-discrimination Act of 2008 (GINA);
- Mental Health Parity Act and Mental Health Party and Addiction Equity Act (MHPAEA);
- The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA);
- The Women's Cancer Rights Act of 1998 (WHCRA);
- Michelle's Law; and
- The Affordable Care Act (ACA).

Due to the number of laws enacted that affect group health plans governed by ERISA, EBSA determined changes to the Form 5500 are necessary to ensure proper documentation of compliance with these various laws. As such, the EBSA is proposing a new Schedule J.

The Schedule J would require the following information:

- **COBRA**
  information related to the COBRA coverage, including number of persons covered, eligibility (employees, spouses, children, retirees, etc.), and type of benefits (medical/surgical, pharmacy, prescription drug, mental health/substance use disorder, wellness program, preventive care, vision, dental, etc.).

- **Funding & Benefit Arrangements**
  information related to plan funding and benefit arrangements (insured, self-insured, trust, or general assets of employer), policy number, and employer and/or participant contributions.

- **Group Health Benefit Design**
  information related to the grandfathered status and type of benefit offered (high deductible health plan, health flexible spending account (Health FSA), health reimbursement arrangement (HRA)).

- **Rebates**
  information related to the plan's receipt of rebates, refunds, reimbursements, or offsets (e.g. Medical Loss Ratio Rebates), including the amount received and distribution method to participants (check, premium holiday, payment of benefits, or other).

- **Service Providers**
  information related to service providers not already listed on Schedule A or C, including the name, address, contact information, employer identification number, and National Insurance Producer Registry (if applicable).

- **Stop Loss**
  information related to the premium paid and individual and aggregate claim limits.

- **Claims Payment Data**
  information related to pre and post service benefit claims submitted, claims approved, claims denied, claims appealed, claims upheld at denials, claims payable after appeals, and claims not adjudicated within the required time frames.

- **Inability to Pay Claims**
  information related to a plan's inability to pay claims at any time during the year; if fully insured, delinquent payments to an insurance carrier; and if a lapse of coverage occurred.

- **Plan Assets**
  information related to plan funding including trust, insurance company, or employer assets.

- **Plan Documents**
  information related to content requirements of plan documents, summary plan descriptions (SPD), summaries of material modifications (SMM), and summary of benefits and coverage (SBC).

- **Specific Legal Compliance**
  specific questions requesting certification of compliance with applicable federal laws (HIPAA, GINA, MHPAEA, NMHPA, WCRA, Michelle's Law, and ACA).

Claims Adjudication Data

In addition to the information to be collected on Schedule J, EBSA is specifically requesting comments on the collection of additional claims data that would provide information related to adjudication practices and policies.

Data to be collected would include:

- Dollar amount of claims denied;
- Denial codes;
- Benefits denied (e.g. mental health/substance abuse or medical/surgical benefits);
- Uniform classification of denial codes (for example, provider's point of service fee; schedule of negotiated fee; Medicare reimbursement rates; state prevailing fees; or other reasonable method.)

DFE Reporting – GIAs

A Group Insurance Arrangement (GIA) filing as a Direct Filing Entity (DFE) would have no changes to its Form 5500 requirements. The GIA must file the same forms, schedules and attachments required of a large group health with a trust. A fully insured group health plan participating in a GIA would continue to be exempt from the reporting requirements of the Form 5500 if the GIA files a Form 5500. In addition, the GIA would be required to file a Schedule J for each separate employer's participating plan.

Employer Action

These proposed changes are significant and, if adopted in the current form, will create a substantial burden on all employers, carriers and third-party administrators supporting group health plans.

For now, employers should review health and welfare plans to ensure compliance with all applicable federal regulations.

ACA Section 1557 Nondiscrimination Provisions Affect Group Health Plans

Published: August 1, 2016

On May 18, 2016, the Department of Health and Human Services (HHS) Office of Civil Rights (OCR) published a final rule implementing Section 1557 of the Affordable Care Act (ACA). Section 1557 prohibits discrimination in health care programs or activities on the basis of race, color, national origin, sex, age, or disability. Notably, this rule expands on prior civil rights law to prohibit sex discrimination in health care.

This article highlights the effect of the final rule on employer-sponsored group health plans. As the guidance also applies to certain business practices of covered entities, affected employers should carefully review it.

Applicability

The rule applies to covered entities. A covered entity is any health program or activity that receives funding from HHS (e.g., hospitals that accept Medicare or doctors who receive Medicaid payments, insurance carriers that participate in the Marketplaces and health programs administered by HHS).

The final rule clarifies that the rule shall apply to all of the operations of the covered entity, including third party administrator (TPA) services.

Section 1557 does not provide an exemption for religious entities. However, application of the final rule is not required if doing so would violate applicable federal statutory protections for religious freedom and conscience.

What's Prohibited?

The final rule prohibits covered entities from discriminating on the basis of race, color, national origin, sex, age or disability when providing or administering health-related insurance or other health-related coverage.

Discriminatory Actions

The final rule clarifies that discriminatory actions specifically include:

- Denying or limiting health coverage;
- Denying a claim;
- Employing discriminatory marketing or benefit designs; and
- Imposing additional cost sharing.

Sex Discrimination

The final rule also provides detail on the prohibition of discrimination based on sex; specifically, discrimination on the basis of sex stereotyping and gender identity.

- Individuals cannot be denied health care or health coverage based on their sex, including their gender identity and sex stereotyping.
- Women must be treated equally with men in the health care they receive and the insurance they obtain.
- Categorical coverage exclusions or limitations for all health care services related to gender transition are discriminatory.
- Individuals must be treated consistent with their gender identity, including in access to facilities. However, providers may not deny or limit treatment for any health services that are ordinarily or exclusively available to individuals of one gender based on the fact that a person seeking such services identifies as belonging to another gender.
- Sex-specific health programs or activities are permissible only if the entity can demonstrate an exceedingly persuasive justification, that is, that the sex-specific health program or activity is substantially related to the achievement of an important health-related or scientific objective.

TPAs

An insurer's TPA services will be subject to Section 1557 when the insurer (1) receives federal financial assistance and (2) is principally engaged in providing health insurance and TPA services.

A TPA of a self-insured plan is not automatically subject to Section 1557. The final rule provides that the OCR will review to determine whether the discriminatory decision or conduct was the result of the TPA or the employer's actions. If the conduct is related to the administration of the plan, then OCR will process a complaint against the TPA if the TPA is a covered entity. If the conduct is related to the decision or action by the employer, the OCR will proceed with a complaint against the employer if the employer is a covered entity subject to Section 1557. If the employer is not a covered entity under Section 1557, OCR will refer the matter to the EEOC for additional consideration.

Enforcement

Enforcement mechanisms available for other federal civil rights laws will be available for Section 1557 violations. This means that noncompliance can result in termination of federal financial assistance or referral to the Department of Justice to bring proceedings. Additionally, the rule provides a private right of action for damages for violations of Section 1557.

Effective Date

The final rule is effective July 18, 2016.

However, if changes to health insurance or a group health plan design (e.g., cost sharing, covered benefits, or benefit limitations and restrictions) are required in order to comply with the provisions set forth in Section 1557, the rule will be effective on the first day of the first plan year beginning on or after January 1, 2017.

Implications for Employer-Sponsored Group Health Plans

- Employers should determine whether they are considered covered entities under Section 1557. Employers in the health care services industry should pay special attention to Section 1557, as many receive Federal funding which will make them subject to these rules.
- Effective for plan years that begin on or after January 1, 2017, most group health plans will need to remove any exclusion, restriction or limitation on coverage for specific health services related to gender transition (e.g., an exclusion for reassignment surgery). Employers intending to exclude transgender services from their group health plan should consult with counsel to understand potential ramifications.

Opt-Out Bonuses May Affect Affordability

Published: September 14, 2016

On July 8, 2016, the Internal Revenue Service (IRS) issued proposed regulations that, among other things, address affordability determinations for individuals who are eligible for employer-sponsored health coverage. This proposed rule builds on earlier guidance, Notice 2015-87, describing the effect an opt-out payment has on affordability. This latest guidance likely signals the direction the IRS will take in their final rule with respect to the affordability of employer-sponsored health plans.

According to this guidance, the IRS anticipates issuing final regulations on opt-out arrangements and affordability prior to the end of 2016.

For employers that qualified for limited relief (defined below), this guidance is not effective until the issuance of final regulations. For employers that did not qualify for relief (as described later in the article), these requirements currently apply.

Background

Applicable large employers ("ALEs") may be subject to the Employer Penalty if any full-time employee ("FTE") receives a Premium Tax Credit ("PTC") to purchase Exchange coverage. There are two penalties, "A" and "B." The "B" Penalty can apply when the ALE offers at least 95% of FTEs and their dependent children minimum essential coverage ("MEC") but the coverage is not affordable, does not provide minimum value, or excludes 5% or fewer FTEs and an FTE receives a PTC.

The concept of affordability is significant as it affects:

- whether an employer is subject to a "B" Penalty assessment;
- how an employer reports the affordability of any group health plan coverage offered to FTEs on Form 1095-C (Line 15); and
- how the affordability safe harbor is used for those who waive coverage (Line 16).

Under a cafeteria plan, an employer may offer an employee a "cash option," a taxable amount that is available if the employee declines coverage under the employer's health plan (also referred to as an "opt-out bonus" or "opt-out arrangement").

On December 16, 2015, the IRS issued Notice 2015-87 where it specified situations that would affect the determination of affordability by either increasing or decreasing the employees cost of self-only coverage. The Notice discussed opt-out arrangements, but requested public comments to issue proposed regulations.

Opt-Out Arrangements

The proposed regulations specify when an opt-out arrangement affects the cost of coverage and therefore, affordability.

- **Rule:** A conditional opt-out payment does NOT affect affordability. To qualify as a conditional opt-out payment, the employee must:
  - decline the employer sponsored coverage, and
  - provide reasonable evidence that the employee and the expected tax family have MEC, other than individual coverage (whether or not obtained in the Marketplace).

For this purpose, the "expected tax family" is composed of the individuals for whom the employee can claim a personal exemption on his/her tax return.

Reasonable evidence includes an attestation that the employee and the expected tax family have MEC or other reasonable proof of coverage. Such documentation must be furnished by the employee at least annually and within a reasonable amount of time prior to the start of the plan year. Providing documentation during the annual open enrollment period would be reasonable.

If an opt-out arrangement meets the requirements above, the payment will not affect the cost of coverage.

- **Rule:** An unconditional opt-out payment affects affordability. For example, if an employee declines coverage and receives a taxable payment with no other conditions, this is not a conditional opt-out payment and the amount of that payment is added to the employee's cost of coverage when determining affordability.

Effective Date

Employers that qualified for relief contained in Notice 2015-87 (generally those employers with opt-out arrangements in effect or communicated prior to December 16, 2015) are not required to include unconditional opt-out payments into the cost of coverage for purposes of affordability until final regulations are issued; this delay includes reporting the employee contribution amount on line 15 of the 1095-C.

Employers that implemented opt-out payments on or after December 16, 2015 are currently subject to these requirements and will report the amount including the unconditional opt-out bonus on line 15 of the 1095-C.

Collectively Bargained Plans

The proposed rule clarifies and expands the relief provided under Notice 2015-87 for opt-out arrangements provided under collective bargaining agreements in effect before December 16, 2015. Until the later of (1) the beginning of the first plan year following the expiration of the collective bargaining agreement in effect before December 16, 2015, or (2) the applicability date of these regulations with respect to the employer mandate and applicable reporting, employers participating in the collective bargaining agreement are not required to increase the amount of an employee's required contribution by amounts made available under an opt-out arrangement.

Employer Action

Employers should review any opt-out arrangements in place and determine if the arrangement meets the conditional opt-out arrangement requirements. If so, the employer should ensure proper disclosure to employees of the arrangement and annual collection of proof of other coverage.

If an employer determines its opt-out arrangement does not meet these requirements, the employer should consider amending the opt-out arrangement requirements to meet eligibility. Otherwise, employers will have to consider the opt-out in their affordability calculation.

Medicare Part D

Reminder to Distribute Creditable Coverage Notice

Published: September 15, 2016

Employers who sponsor a group health plan with prescription drug benefits are required to notify their Medicare-eligible participants and beneficiaries as to whether the drug coverage provided under the plan is “creditable” or “non-creditable.” This notification must be provided **prior to October 15th each year.**

Below you will find detailed information regarding these requirements.

Background

Medicare Part D, the Medicare prescription drug program, imposes a higher premium on beneficiaries who delay enrollment in Part D after initial eligibility unless they have employer-provided coverage that is creditable (meaning equal to or better than coverage provided under Part D).

Employers that provide prescription drug benefits are required to notify Medicare-eligible individuals annually as to whether the employer-provided benefit is creditable or non-creditable so that these individuals can decide whether or not to delay Part D enrollment.

Notice to Participants

CMS has issued participant disclosure model notices for both creditable and non-creditable coverage, which can be found at:

http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html
(notices were last updated by CMS for use on or after April 1, 2011).

Spanish notices are also provided at the above link.

Who must receive the Participant Notice?

Notice should be sent to all Part D-eligible participants. This includes active employees, COBRA qualified beneficiaries, retirees, spouses, and other dependents of the employee covered by the plan. In many cases, the employer will not know whether an individual is Medicare eligible or not. Therefore, employers may wish to provide the notice to all plan participants (including COBRA qualified beneficiaries) to ensure compliance with the notification requirements.

When Should the Participant Notice be Sent?

Participant disclosure notices should be sent at the following times:

- Prior to **October 15th** each year;
- Prior to an individual's Initial Enrollment Period for Part D;
- Prior to the effective date of coverage for any Medicare eligible individual under the plan;
- Whenever prescription drug coverage ends or changes so that it is no longer creditable or it becomes creditable; and
- Upon a beneficiary's request.

If the disclosure notice is provided to all plan participants annually, prior to the October 15th, CMS will consider the first two bullet points satisfied. Many employers provide the notice either during or immediately following the annual group plan enrollment period.

In order to satisfy the third bullet point, employers should provide the participant notice to new hires and newly eligible individuals under the group health plan.

How Should the Participant Notice be Sent?

The employer may provide a single disclosure notice to a participant and his or her family members covered under the plan. However, the employer is required to provide a separate disclosure notice if it is known that a spouse or dependent resides at an address different from the address where the participant's materials were provided.

Mail

Mail is the recommended method of delivery, and the method CMS initially had in mind when issuing its guidance.

Electronic Delivery

The employer may provide the notice electronically to plan participants who have the ability to access the employer's electronic information system on a daily basis as part of their work duties (consistent with the DOL electronic delivery requirements 29 CFR § 2520.104b-4(c)(1)).

If this electronic method of disclosure is chosen, the plan sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare eligible dependents covered under the group health plan.

In addition to having the disclosure notice sent electronically, the notice must be posted on the entity's Web site, if applicable, with a link to the creditable coverage disclosure notice.

Sending notices electronically will not always work for COBRA qualified beneficiaries who may not have access to the employer's electronic information system on a daily basis. Mail is generally the recommended method of delivery in such instances.

Open Enrollment Materials

If an employer chooses to incorporate the Part D disclosure with other plan participant information, the disclosure must be prominent and conspicuous. This means that the disclosure portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded or offset on the first page of the provided information.

CMS provides sample language for referencing the creditable or non-creditable coverage status of the plan per the requirements:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page xx for more details.

How is Creditable Coverage Determined?

Most insurance carriers and TPAs will disclose whether or not the prescription drug coverage under the plan is creditable for purposes of Medicare Part D.

CMS's guidance provides two ways to make this determination, actuarially or through a simplified determination.

Actuarial Determination

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general this is determined by measuring whether the expected amount of paid claims under the employer's drug program is at least as much as what is expected under the standard Part D program. This can be determined through an actuarial equivalency test, which generally requires the hiring of an actuary to perform.

Simplified Determination

Most entities will be permitted to use the simplified determination of creditable coverage status to annually determine whether coverage is creditable or not.

A prescription drug plan is deemed to be creditable if:

- It provides coverage for brand and generic prescriptions;
- It provides reasonable access to retail providers;
- The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
- It satisfies at least one of the following:
  - The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000;
  - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual; or
  - For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000, and has no less than a $1,000,000 lifetime combined benefit maximum.

An integrated plan is any plan of benefits where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

- a combined plan year deductible for all benefits under the plan,
- a combined annual benefit maximum for all benefits under the plan, and/or
- a combined lifetime benefit maximum for all benefits under the plan.

HHS Penalties Increase

Published: September 21, 2016

On September 6, 2016, the Department of Health and Human Services ("HHS") issued an interim final regulation that adjusts civil penalties for inflation. The interim final regulation does not follow the usual procedures that offer a notice and comment period. As such, a Notice of Proposed Rulemaking has not been issued and a comment period is not provided due to potential delay in the applicability of the regulation.

The adjusted penalties are applicable to penalties assessed after August 1, 2016, whose associated violations occurred after November 2, 2015.

The following chart contains updated penalties applicable to group health plans only:

Description	Current Penalty	Updated Penalty
Pre-February 18, 2009 violation of HIPAA administrative simplification provisions	$100 per violation $37,561 annual cap	$150 per violation $37,561 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision w/ out knowledge	$100 min. $50,000 max. $1,500,000 annual cap	$110 min. $55,010 max. $1,650,300 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision w/ reasonable cause and not to willful neglect	$1,000 min. $50,000 max. $1,500,000 annual cap	$1,100 min. $55,010 max. $1,650,300 annual cap

Description	Current Penalty	Updated Penalty
February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND corrected during 30-day period	$10,000 min. $50,000 max. $1,500,000 annual cap	$11,002 min. $55,010 max. $1,650,300 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect AND NOT corrected during 30-day period	$50,000 min. $1,500,000 max. $1,500,000 annual cap	$50,000 min. $1,500,000 max. $1,500,000 annual cap
Failure to Provide the Summary of Benefits Coverage	$1,000 per day	$1,087 per day
Penalty for an employer or other entity to offer financial or other incentive to individual entitled to Medicare/Medicaid benefits not to enroll under a group health plan that would be primary	$5,000	$8,908
Penalty for entity serving as insurer, TPA, or fiduciary for a group health plan that fails to provide information to HHS Secretary identifying when the GHP was primary payer to Medicare	$1,000	$1,138

2016 Transitional Reinsurance Fee Form Now Available

Published: October 14, 2016

By November 15, 2016, employers with self-insured medical plans must report annual enrollment counts to Health and Human Services (“HHS”) in order to pay the 2016 Transitional Reinsurance Fee. Now in its final year, the fee for 2016 is $27 per covered life per year. Payment is due by January 17, 2017 (and November 15, 2017 if paying in two-installments).

The 2016 Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form is now available at https://www.pay.gov/public/form/start/77704988. If you go directly to www.pay.gov, search for “2016 ACA Transitional Reinsurance” to access the 2016 Form.

For further information, you can visit the CMS/CCIIO’s 2016 Benefit Year Form announcement page for important links, training modules, reference materials, and aids. For a more detailed overview, click here:

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/2016-Benefit-Year-Page.html.

Final 2016 Forms 1094-C and 1095-C Available

Published: October 25, 2016

The Internal Revenue Service ("IRS") recently released final versions of the 2016 Forms 1094-C and 1095-C and associated instructions. These forms will be used in early 2017 by Applicable Large Employers ("ALEs") to report whether the ALE offered (or did not offer) a full-time employee ("FTE") health insurance coverage during the calendar year. Additionally, for ALEs with self-insured plans, these Forms reflect coverage provided under a self-insured group health plan to individuals (FTEs and non-FTEs) during calendar year 2016. Generally, the forms and instructions are substantially similar to their draft versions and the 2015 forms, with the exception of two new reporting codes, removal of certain transition relief that is no longer available and additional clarifications contained in the instructions.

Notable changes are summarized below.

The Forms

Form 1095-C Clarifications and Changes

- **New codes.** Codes 1J and 1K have been added for use on Line 14 to report a "conditional offer of spousal coverage." A conditional offer is an offer of coverage that is subject to one or more reasonable, objective conditions (for example, an offer to cover an employee's spouse only if the spouse is not eligible for coverage by a group health plan sponsored by another employer). Employers that have a spousal carve-out arrangement will need to be aware of these two new codes (specifically, 1K).
  - **1J:** MEC providing minimum value ("MV") offered to employee and at least MEC conditionally offered to spouse; MEC not offered to dependent(s).
  - **1K:** MEC providing MV offered to employee; at least MEC offered to dependents; and at least MEC conditionally offered to spouse.

- **Codes that are no longer applicable.** Codes 1I and 2I, used on the 2015 Form 1095-C in Lines 14 and 16 respectively, are no longer applicable and have been reserved. These Codes should not be used on the 2016 filings.

- **Qualifying Offer Method (Code 1A).** A "Qualifying Offer" means an offer of MEC providing MV to one or more FTEs for all calendar months during the calendar year for which the employee was an FTE, where the employee contribution for each month does not exceed (for 2016) 9.66% ($95.63) of the mainland single federal poverty line, provided the offer of coverage includes an offer of MEC to the employee's spouse and children. If this is the case, the employer may use Code 1A in Line 14 and leave Lines 15 and 16 blank. A corresponding Box "A" in Line 22 of Form 1094-C must also be checked. ALEs qualifying for this relief are not required to use Code 1A.

- **Line 15 of Form 1095-C.** Only complete if using Code 1B, 1C, 1D, 1E, 1J, or 1K on Line 14. If any other code is on Line 14 (e.g., 1A, 1F, 1G, or 1H), leave Line 15 blank.

- **"Do not attach to your tax return. Keep for your records."** Language has been added to the top of Form 1095-C reminding recipients to keep this statement for recordkeeping purposes. A copy should not be submitted with an individual's annual tax filing.

Transitional Relief – Form 1094-C, Line 22

- For the 2016 calendar year, the transition relief described below is applicable only if an ALE offers coverage under a health plan with a non-calendar plan year, and only for calendar months in 2016 that fall within the 2015 plan year.

- Check Box "C" if the ALE is eligible for the following relief for one or more months of the 2016 calendar year:
  - ALE employed fewer than 100 FTEs (50-99 Transition Relief), or
  - For employers with 100 or more FTEs, qualified for relief on the "A" penalty (applicable when there was an offer of coverage to at least 70% of FTEs as opposed to 95%).

The Instructions

Aggregated ALE Groups

The instructions include an expanded discussion regarding instructions for filings made by ALE members that are part of an aggregated ALE group (i.e., controlled group or affiliated service group).

- There is no aggregated reporting or authoritative transmittal for all members of an aggregated ALE group (controlled group). Each ALE member must file its own Forms 1094-C and 1095-C under its own separate EIN, even if the ALE member is part of an aggregated ALE group.

- Only one Form 1094-C may be the authoritative transmittal for an ALE.

Electronic Filing

- Generally, if an employer must file at least 250 information returns, the employer must file electronically. The 250-or-more filing requirement applies separately to each type of form and separately for original and corrected forms. If you were required to file your forms electronically because you filed more than 250 forms and you have 150 corrected Forms 1095-C to file, you may file the corrected returns on paper.

Failure to file a correct information return.	**$260**/each return for which a failure occurs (maximum penalty for all failures during the calendar year cannot exceed $3,193,000).
Failure to provide a correct payee statement.	**$260**/each return for which a failure occurs (maximum penalty for all failures during the calendar year cannot exceed $3,193,000).
Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and to furnish the required statements.	
Waiver of penalties. Penalties may be waived if the failure was due to reasonable cause and not willful neglect.	

COBRA Coverage

An offer of COBRA coverage is reported differently depending on whether or not the offer is made due to an employee's termination of employment.

- If an employee is terminated, then the COBRA offer is reported as no offer of coverage using Code 1H on Line 14 and Code 2A on Line 16 with Line 15 blank.

- If there is an offer of COBRA coverage made to an employee who remains employed by the ALE (e.g., an offer of COBRA coverage due to a loss of group health plan coverage because of a reduction in hours), then the COBRA offer is reported using the appropriate code to indicate the offer of coverage to all eligible individuals. For example, use Code 1E if coverage is offered to employee, spouse, and dependents or Code 1B if coverage is offered to employee only.

Example

During the applicable open enrollment period for its health plan, Employer makes an offer of MEC providing MV to Employee and to Employee's spouse and dependents. Employee elects to enroll in employee-only coverage starting January 1. On June 1, Employee experiences a reduction in hours that results in loss of eligibility for coverage under the plan. As of June 1, Employer terminates Employee's existing coverage and makes an offer of COBRA continuation coverage to Employee, but does not make an offer to Employee's spouse and dependents.
Employer should enter Code 1E (MEC providing MV offered to employee and at least MEC offered to dependent(s) and spouse) on Line 14 for months January – May, and should enter Code 1B (MEC providing MV offered to employee only) on Line 14 for months June – December.

Counting FTEs for the ALE

Column (b) in Section III of Form 1094-C requests the number of FTEs for each month of the calendar year.

- **Monthly measurement method.** Employee should be counted as an FTE for a month if the employee satisfied the FTE definition under the monthly measurement method (as applicable) on any day of the month.

- **Look-back measurement method.** If the employee is identified as an FTE during the measurement period, then the employee is considered an FTE for each month of the stability period so long as the employee remains employed by the employer.

Be sure to use the definition under the employer mandate for an FTE (determined under one of the two applicable measurement methods) and not any other definition.

Example

Employer uses the look-back measurement method to determine the full-time status of its employees.
Employee, who is not in a Limited Non-Assessment Period, averaged over 130 hours of service per month during the measurement period that corresponds with the stability period starting January 1, 2016, and ending December 31, 2016. Employee terminates employment with Employer on February 15, 2016. Employer must include Employee in the number of FTEs reported in column (b) for January and February.

Post-Employment (non-COBRA) Coverage

An offer of post-employment coverage to a former employee upon termination of employment (i.e., a retiree) should not be reported as an offer of coverage on Line 14. Use Codes 1H in Line 14 and 2A in Line 16 if the ALE is required to file Form 1095-C for the former employee (for example, the employee was an FTE for part of the calendar year in which the termination of employment occurred).

Employee Required Contribution

The Employee Required Contribution is the employee's share of the monthly cost for the lowest-cost self-only MEC providing MV that is offered to the employee by the ALE.

To determine the amount of the employee's share of the monthly cost, the ALE may divide the total cost to the employee for the plan year by the number of months in the plan year. This monthly amount of the employee's share of the cost would then be reported for any months of that plan year that fall within the 2016 calendar year.

Self-Funded Plans

The instructions provide the following clarifications:

- Complete Part III of Form 1095-C ONLY if the ALE offers employer-sponsored self-insured health coverage in which the employee or other individual enrolled.

- If the ALE offers both insured and self-insured coverage, complete Part III only for employees who enroll in the self-insured coverage.

- Part III must be completed by the ALE offering self-insured health coverage for any individual who was an employee for one or more calendar months of the year, whether full-time or not, and who enrolled in the coverage.
  - The employee should be listed on Line 17 and any other family members who enrolled in the coverage offered to the employee should be listed on subsequent lines.

- Part III may be completed by the ALE offering self-insured health coverage for any other individual who enrolled in the coverage under the plan for one or more calendar months of the year but was not an employee for any calendar month of the year, such as a retired employee who retired in a previous year, a terminated employee receiving COBRA continuation coverage (or any other form of post-employment coverage) who terminated employment during a previous year, and a non-employee COBRA beneficiary (but not including an individual who obtained coverage through the employee's enrollment, such as a spouse or dependent obtaining coverage when an employee elects COBRA continuation coverage that is family coverage).
  - If using Form 1095-C for this purpose, use 1G in the "all 12 months" box or the box for each month of the calendar year.
  - If Form 1095-C is not used, the ALE must use Forms 1094-B and 1095-B.

Reporting Offers of Coverage under a Multiemployer Plan

For reporting offers of coverage for 2016, an ALE relying on the multiemployer interim guidance should enter Code 1H on Line 14 for any month for which the ALE enters 2E on Line 16.

- For reporting for 2016, Code 1H may be entered without regard to whether the employee was eligible to enroll or enrolled in coverage under the multiemployer plan.

- For reporting for 2017 and future years, ALE relying on the multiemployer arrangement interim guidance may be required to report offers of coverage made through a multiemployer plan in a different manner.

Other Clarifications

- Code 1G (used on Form 1095-C in Line 14) applies for the entire year or not at all. According to the instructions, there would not be an instance where 1G would be used with another Line 14 Code during the year.

- The "affordability" safe harbors for 2016 are based on 9.66%.

- Do not use an affordability safe harbor Code (e.g., 2F, 2G or 2H) if the ALE did not offer MEC to at least 95% of FTEs and their dependents (e.g., if NO is checked on Form 1094-C, Part III, column (a)).

- An FTE that experiences a break in service where no hours of service were credited should be reported as an employee only if the individual remained an employee during the break in service.

- A plan does not provide MV if it fails to offer substantial coverage of inpatient hospitalization and physician services.

Additional Information

Additional information on this employer reporting may be found here:

https://www.irs.gov/affordable-care-act/employers/questions-and-answers-about-information-reporting-by-employers-on-form-1094-c-and-form-1095-c

The 2016 instructions may be found here:

https://www.irs.gov/pub/irs-pdf/i109495c.pdf

The final Forms 1094-C and 1095-C can be found here:

https://www.irs.gov/pub/irs-pdf/f1094c.pdf

https://www.irs.gov/pub/irs-pdf/f1095c.pdf

The 2016 Forms 1094-B and 1095-B and Instructions have been released and are available here, https://www.irs.gov/pub/irs-pdf/i109495b.pdf. They are not addressed in this summary.

2017 Cost of Living Adjustments

Published: November 1, 2016

On October 25 and 27, 2016, the IRS released cost of living adjustments for 2017 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans

For plan years beginning in 2017, the dollar limitation under Section 125 for voluntary employee salary reductions for contributions to health flexible spending arrangements increases to **$2,600.**

The Affordable Care Act (ACA) amended Section 125 to place a $2,500 limitation under Section 125(i) on voluntary employee salary reductions for contributions to health flexible spending arrangements, subject to inflation for plan years beginning after December 31, 2013.

Qualified Transportation Fringe Benefits

For calendar year 2017, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Section 132(f)(2)(B)) is **$255.**

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Requirement To Maintain Minimum Essential Coverage

For calendar year 2017, the applicable dollar amount used to determine the penalty under Section 5000A(c), for failure to maintain minimum essential coverage is **$695.**

This is also referred to as the individual mandate under the ACA. Any assessed penalty tax is the greater of $695 or 2.5% of modified adjusted gross income in excess of the filing threshold and capped at the average premium amount for bronze coverage available on the health insurance exchange. The penalty is collected from an individual's tax refund due after filing their personal income tax return with the IRS.

Highly Compensated

The compensation threshold for a highly compensated individual or participant (as defined by Code Section 414(q)(1)(B) for purposes of Section 125 nondiscrimination testing) again remains unchanged at **$120,000** for 2017.

Under the cafeteria plan rules, the term highly compensated means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B).

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2017 increases to **$175,000.**

For purposes of cafeteria plan nondiscrimination testing, a key employee is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year.

Non-Grandfathered Plan Cost-Sharing Limits

The 2017 maximum annual out-of-pocket limits for all non-grandfathered plans are **$7,150** for individual coverage and **$14,300** for family coverage.

These limits generally apply with respect to any essential health benefits (EHBs) offered under the group health plan. The final regulations established that starting in the 2016 plan year, the self-only annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in other than self-only coverage, including in a family HDHP.

Health Savings Accounts

As announced in May 2016, the inflation adjustments for health savings accounts (HSAs) for 2017 were provided by the IRS in Rev. Proc. 2016-28.

Annual Contribution Limitation.

For calendar year 2017, the limitation on deductions for an individual with **self-only coverage** under a high deductible health plan is **$3,400.** For calendar year 2017, the limitation on deductions for an individual with **family coverage** under a high deductible health plan is **$6,750.**

High Deductible Health Plan.

For calendar year 2017, a "high deductible health plan" is defined as a health plan with an **annual deductible that is not less than $1,300 for self-only coverage** or **$2,600 for family coverage,** and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) **do not exceed $6,550 for self-only coverage** or **$13,100 for family coverage.**

Non-calendar year plans: In cases where the HDHP renewal date is after the beginning of the calendar year, any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date.

Catch-Up Contribution.

Individuals who are age 55 or older and covered by a qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined in Code 223(b)(3)(B), is $1,000 for 2009 and thereafter.

Relief Extended for Premium Reimbursement Programs for Student Employees

Published: November 2, 2016

On October 21, 2016, the Departments of Labor, the Treasury and Health and Human Services (collectively, the "Departments") issued FAQ 33, providing an indefinite extension of the enforcement relief available to colleges and universities for certain premium reduction arrangements offered in connection with student health plans. In February 2016, the Departments had announced a one-year non-enforcement period in the event a premium reduction arrangement is an impermissible Employer Payment Plan ("EPP"). This relief was limited to a plan or policy year that begins before January 1, 2017.

The Departments will not assert that a premium reduction arrangement offered by an institution of higher education fails to comply with the Affordable Care Act ("ACA") prohibition on annual dollar limits and preventive care mandate. Colleges and universities that offer students working for the school premium reduction programs, which may pay for some, or all, of the costs of individual student health insurance coverage (insured or self-insured) may continue to offer such program until (and unless) there is further guidance.

Following is a more detailed summary of the issue.

The Issue

Student health insurance is a type of individual health coverage that is generally offered to students and their dependents by an institution of higher learning (e.g., college or university). This coverage can be insured or self-insured.

Some students, typically graduate students, receive reduced cost (or no cost) student health insurance coverage as part of their student packages. In many cases, these students are performing services for the school (such as teaching or research) in connection with those packages. For these students, the bill they receive from the school for their health insurance coverage may take into account the premium reduction.

Generally, employers are prohibited from paying for (or reimbursing) an employee's individual health insurance policy. As student health insurance is considered to be individual coverage, there is concern that these premium

reduction arrangements, in some circumstances, might be considered employer-sponsored group health plan coverage and, as a result, might be viewed as prohibited EPPs.

In many cases when the college or university offers a premium reduction arrangement to its students, the payment will not constitute an EPP (i.e., where the student is not an employee of the college or university).

However, in cases where the student is an employee of the school, such an arrangement may constitute an impermissible EPP. For example, if a university pays for a student-employee's student health insurance coverage as part of the student's employment as a research assistant for the university; this may be an impermissible EPP.

Employer Action

No specific action items at this time. Educational organizations that employ student employees should continue to monitor guidance in this area.

Updates Regarding the NJ Small Employer Health Benefits Program

Published: November 7, 2016

The New Jersey Small Employer Health Board recently met and re-adopted the NJ small group regulations (which sunset every 7 years), with certain changes and/or clarifications. These regulations will be effective for new and renewal business as of January 1, 2017. Briefly, the re-adopted regulations:

Remove the state definition of a small employer and require use of the federal small employer definition.

Clarify that an employer must have at least one common law employee enrolled to qualify as a group.

Clarify that a C corporation owner is not a common law employee.

Below you will find additional information about the significant changes and clarifications in the regulations.

Small Employer Defined

The "A" definition (the state definition) of a small employer has been eliminated. Beginning January 1, 2017, we will only see the federal definition which was the "B" definition. Under the federal definition, a small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. As a result of using the "B" definition, part-time employees will be included in the count for defining the group as small or large, which may result in some small groups now being considered to be large groups.

A new annual certification form will be issued taking into account the new definition. Insurance carriers are required to resend the new approved NJ annual certification form to everyone that may have received the old form. In the event an employer already completed the old certification form for a January or February renewal and utilized the "A" definition of small employer, they must complete the new certification form which only allows the federal definition.

Insurance carriers will be given until April 1, 2017 to provide new policy forms with all the new re-adoption changes for all new and renewal business. In the interim, the carriers are allowed to issue a Compliance and Variability Rider to new policyholders.

The employer application has also been updated as follows:

Question 14 (Waiting period) may have been changed by some of the carriers. They may now include check boxes (Ex .The ☐ 1st or ☐ 15th of the month following the waiting period of ☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ exactly 90 Days). They might separate New or Rehire Employees.

Question 16 – What percentage of the total premium will the employer pay?

The final NJ annual certification forms and employer application are posted at:

www.state.nj.us/dobi/division_insurance/ihcseh/index.html

Who is an Employee?

For purposes of small employers in New Jersey, "employee" means a common law employee of the policyholder. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, two percent shareholders in a Subchapter S corporation, sole proprietors and independent contractors are not employees of the Policyholder.

An employer must have one common law employee covered to have a Small Employer plan.

Other Changes

Small Group – out of network reimbursements

The PHCS database is used for out of network reimbursements and hasn't been updated since 2010. Recognizing this, the Board has stated that, effective for new business and renewals beginning January 1, 2017, carriers are permitted to use other databases (such as Fair Health and Medicare) to determine reimbursements.

The Board requires transparency and consumers must be able to find the allowed charged information. By allowing carrier to choose the reimbursement method, it is likely that this will result in potentially higher balance billing to consumers, especially with regard to specialists.

SEH Program Buyer's Guide

The New Jersey DOBI website has been updated with 2017 rates and a preliminary 2017 version of the Buyer's Guide. See:

http://www.state.nj.us/dobi/division_insurance/ihcseh/shop_seh.htm

and

http://www.state.nj.us/dobi/division_insurance/ihcseh/whichindividualplanbest/whichplan.html

For more information, see Advisory Bulletin 16-SEH-02 with the Compliance and Variability Rider at:

http://www.nj.gov/dobi/division_insurance/ihcseh/bulletins/seh16_02.pdf

Also, see the proposal and adoption at:

http://www.state.nj.us/dobi/division_insurance/ihcseh/sehrulesadoptions.htm

http://www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html

Election Results and the ACA:

Preliminary Thoughts

Published: November 10, 2016

With the outcome of the 2016 elections now official, the Republicans will hold the majority in both chambers of Congress and control of the White House beginning in 2017. Since President-elect Trump ran on a platform of "Replace and Repeal" of the Affordable Care Act (ACA), we anticipate that acting on this campaign promise will be one of the top priorities of the new Trump administration. We anticipate there will be significant disruption for individuals, employers, brokers and carriers across the country.

Republicans will likely need to use the process of Budget Reconciliation to pass legislation through the Senate, given the party did not secure enough seats to control a filibuster-proof supermajority. In other words, the legislation can pass in the Senate with a simple majority vote and not a super majority (which requires 60 votes). Reconciliation can be used to take away some, but not all, of the ACA. It is anticipated that certain provisions of the ACA would be targeted such as Medicaid expansion, the availability of subsidies and premium tax credits in the Marketplace, and the employer and individual mandate. It cannot be used to remove non-budgetary provisions (for example, insurance mandates like "to age 26"). In addition, it is conceivable that a Trump administration may simply direct various federal agencies (such as the Department of Labor) to not enforce certain ACA provisions.

The Republicans have not laid out a specific plan on what will replace the ACA. Generally, the party has supported the existing employer-based system (with some party members calling for limits on the tax exclusion). Based on published white papers on the President-elect Trump's website, other aspects of a healthcare overhaul plan may include:

- Tax credits for purchasing individual health insurance;
- Expansion of Health Savings Accounts and High Deductible Health Plans;
- Continuation of the prohibition on pre-existing condition exclusions from health insurance;
- High risk pools;
- Interstate sales of insurance; and
- Medical malpractice reform.

The process to repeal and replace the ACA will take time and nothing will happen between now and the New Year. Open enrollment is currently underway in the Marketplaces across the country and it is expected that individual policies (and subsidies for lower and middle-income individuals) will be available to enrollees as of January 1, 2017. What is unknown is whether the Trump administration and subsequent legislation will affect the Marketplace and subsidies in mid-2017 or instead phase out this coverage after the 2017 calendar year.

Right now it is too early to tell how all of this will play out. However, for employers preparing for their 2017 plan year renewals, nothing has changed. Employers should be prepared to comply with the various requirements including:

- The employer mandate (for applicable large employers);
- Form 1094-C and 1095-C reporting for Calendar Year 2016;
- Any ACA taxes and fees for self-funded plans to pay directly (such as reinsurance fees); and
- Plan design changes applicable to plan years that begin on or after January 1, 2017.

In addition, all other federal law mandates impacting employer health and welfare plans such as ERISA, HIPAA, COBRA, Code Section 125, the Mental Health Parity and Addiction Equity Act, and the Service Contract Act / Davis Bacon and Related Acts are still good law. There has been no indication that these non-ACA laws are targeted for repeal or replacement.

We are carefully following these political developments and will keep you updated on next steps.

Extension of Deadline for 2016 Forms 1095-C

Published: November 21, 2016

On November 18, 2016, the IRS issued Notice 2016-70 which provides a limited extension of time for employers to provide 2016 Forms 1095-C to individuals. It also extends good-faith transition relief from certain penalties for the 2016 reporting year.

Q1: What Was Extended?

2016 Forms 1095-C statements must be furnished to individuals by March 2, 2017 (rather than January 31, 2017).

This extension of time also applies to carriers providing Forms 1095-B to individuals in insured plans.

Q2: Were The Deadlines For Reporting To The IRS Extended?

No.

The 2016 Form 1094-C and all supporting Forms 1095-C (collectively, "the return") is due to the IRS by March 31, 2017 if filing electronically (or February 28, 2017 if filing by paper). These deadlines **were not extended** as part of the relief announced in Notice 2016-70. Per the Notice, the government determined there was no similar need for additional time for employers to file these Forms with the IRS.

As a reminder, employers that file at least 250 Forms 1095-C must file electronically. The IRS encourages all filers to submit returns electronically.

Q3: Is There Penalty Relief?

Yes

Notice 2016-70 extends transition relief from penalties to reporting entities that have made good-faith efforts to comply with the information reporting requirements for the 2016 reporting year, both for furnishing the Form 1095-C to individuals and for filing with the IRS. Specifically, this relief applies to missing or inaccurate taxpayer identification numbers and dates of birth, as well as other information required on the return or statement.

No relief is available if the reporting entity does not make a good-faith effort to comply with the regulations or for a failure to file a return or furnish a statement by the applicable due dates.

This relief does not absolve an employer from correcting an incorrect Form if so instructed by the IRS.

Q4: What If The Submissions Are Late?

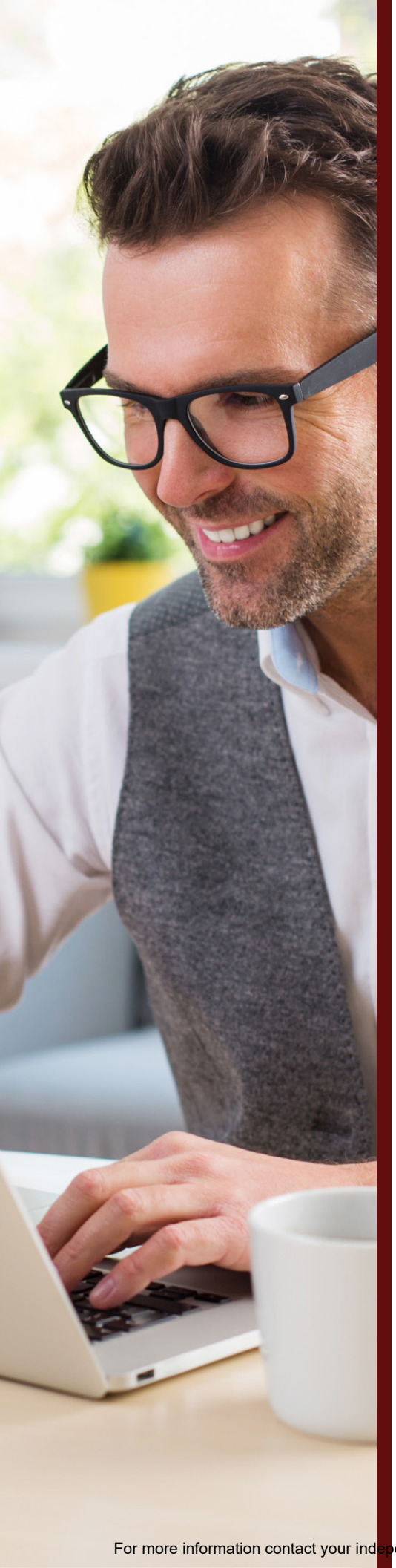
Employers that do not comply with these due dates are subject to penalties. However, employers should still furnish and file the forms and the IRS will take such furnishing and filing into consideration when determining whether to abate penalties.

Q5: What If Employees Do Not Have Forms 1095-C (Or Forms 1095-B From The Carrier) Before They File Their Tax Returns?

Some taxpayers may not receive their Form 1095-C (or 1095-B from the carrier) by the time they are ready to file their personal tax return for 2016. Taxpayers do not need to wait until they receive their Form 1095-C (or 1095-B) to file their annual tax return, and may rely on other information from their employer (or carrier) for purpose of filing individual taxes. Individuals need not send this information to the IRS when filing their returns but should keep it with their tax records.

Q6: Will The IRS Offer This Relief For 2017 Reporting?

According to the Notice, the IRS does not anticipate extending this transition relief, either with respect to the due date for furnishing the Form 1095-C to individuals and good-faith relief from certain penalties, to reporting in 2017.



Adjusted PCOR Fee for Fifth Filing Year Released

Published: November 22, 2016

The Internal Revenue Service (IRS) recently released Notice 2016-64, which provides the adjusted applicable dollar amount for the fifth filing of the PCOR fee. The adjusted dollar amount for plan years ending on or after October 1, 2016 and before October 1, 2017 is $2.26.

For self-insured plans and HRAs, the PCOR fee is due by July 31st of the calendar year following the end of the applicable plan year. The fee is paid using the 2nd quarter Form 720. The next payment and filing deadline is July 31, 2017.

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2015 – January 31, 2016	$2.17/covered life/year	July 31, 2017
March 1, 2015 – February 29, 2016	$2.17/covered life/year	July 31, 2017
April 1, 2015 – March 31, 2016	$2.17/covered life/year	July 31, 2017
May 1, 2015 – April 30, 2016	$2.17/covered life/year	July 31, 2017
June 1, 2015 – May 31, 2016	$2.17/covered life/year	July 31, 2017
July 1, 2015 – June 30, 2016	$2.17/covered life/year	July 31, 2017
August 1, 2015 – July 31, 2016	$2.17/covered life/year	July 31, 2017
September 1, 2015 – August 31, 2016	$2.17/covered life/year	July 31, 2017
October 1, 2015 – September 30, 2016	$2.17/covered life/year	July 31, 2017
November 1, 2015 – October 31, 2016	$2.26/covered life/year	July 31, 2017
December 1, 2015 – November 30, 2016	$2.26/covered life/year	July 31, 2017
January 1, 2016 – December 31, 2016	$2.26/covered life/year	July 31, 2017
February 1, 2016 – January 31, 2017	$2.26/covered life/year	July 31, 2018

March 1, 2016 – February 28, 2017	$2.26/covered life/year	July 31, 2018
April 1, 2016 – March 31, 2017	$2.26/covered life/year	July 31, 2018
May 1, 2016 – April 30, 2017	$2.26/covered life/year	July 31, 2018
June 1, 2016 – May 31, 2017	$2.26/covered life/year	July 31, 2018
July 1, 2016 – June 30, 2017	$2.26/covered life/year	July 31, 2018
August 1, 2016 – July 31, 2017	$2.26/covered life/year	July 31, 2018
September 1, 2016 – August 31, 2017	$2.26/covered life/year	July 31, 2018
October 1, 2016 – September 30, 2017	$2.26/covered life/year	July 31, 2018

For plan years that are less than 12 months long, look to the plan year ending date to determine the applicable fee and due date.

For more information, see IRS Notice 2016-64,

https://www.irs.gov/pub/irs-drop/n-16-64.pdf

Beware of Phishing Email Disguised as HIPAA Privacy Audit Letter

Published: December 13, 2016

The Office of Civil Rights ("OCR") of the Department of Health and Human Services ("HHS") has posted an alert warning employers and others of a fake communication involving the OCR audit program under HIPAA. The email falsifies HHS departmental letterhead and the signature of the OCR Director and directs individuals to a non-governmental website marketing the cybersecurity services of a firm that is not associated with HHS or OCR.

This phishing email originates from the email address OSOCRAudit@hhs-gov.us and directs individuals to a URL at http://www.hhs-gov.us. This is a subtle difference from the official email address for the real HIPAA audit program, OSOCRAudit@hhs.gov. Phishing is a scam typically carried out through unsolicited email and/or websites that pose as legitimate sites and lure unsuspecting victims to provide personal and financial information.

Employers should alert their employees of this issue and take note that official communications regarding the HIPAA audit program are sent to selected auditees from the email address OSOCRAudit@hhs.gov.

If you question any communication regarding a HIPAA audit, please contact OCR at: OSOCRAudit@hhs.gov.