2nd Quarter 2016

# ACA REPORTING EXTENSIONS & PENALTY RELIEF

Employers that comply with the extended information reporting deadlines, provided in IRS Notice 2016-4, will not be subject to penalties if they can demonstrate they made a ***good faith effort*** to comply with the information reporting requirements for 2015.

Applicable large employers—generally those with **50 or more full-time employees**, including full-time equivalent employees (FTEs)—and other parties that provide minimum essential health coverage were required to furnish Forms 1095-B or 1095-C to employees/responsible individuals by **March 31, 2016**. In addition, Forms 1094-B, 1095-B, 1094-C, and 1095-C are required to be **filed with the IRS by May 31, 2016** (if not filing electronically) or **June 30, 2016** (if filing electronically).

These extensions apply automatically to all health coverage information return issuers and are longer than the 30-day extensions that would otherwise be obtained by submitting Form 8809, *Application for Extension of Time To File Information Returns*. Therefore, the IRS will not process any previously requested extensions of these deadlines for 2016. The longer automatic extensions do not require a formal request using Form 8809 or other documentation.

## Short-Term Penalty Relief

The IRS will not impose penalties under Internal Revenue Code sections 6721 and 6722 for ***incorrect or incomplete*** information reported on 2015 returns or statements that are filed and furnished in 2016 on reporting entities that can show that they have made good faith efforts to comply with the information reporting requirements for 2015.

**No relief is provided in the case of reporting entities that cannot show a good faith effort to comply** with the information reporting requirements ***or that fail to timely file an information return or furnish a statement***. However, the penalties may be waived if a failure to timely furnish or file a statement or return is due to reasonable cause.

For example, penalties would not be imposed if the reporting entity can demonstrate that it acted in a responsible manner and the failure was due to significant mitigating factors or events beyond the reporting entity's control.

Notice 2016-4 provides additional information on relief from penalties:

- Reporting entities that do not comply with the extended due dates are subject to penalties under Code Section 6721 or 6722. However, entities that do not meet the extended due dates are still encouraged to furnish and file, and the IRS will take this furnishing and filing into consideration when determining whether to decrease penalties for reasonable cause.
- The IRS will also take into account whether a reporting entity made reasonable efforts to prepare for reporting, such as gathering and transmitting the necessary data to an agent to prepare the data for submission to the IRS or testing its ability to transmit information to the IRS.
- The IRS will take into account the extent to which the employer or other coverage provider is taking steps to ensure that it is able to comply with the reporting requirements for 2016.

Additional information on the reporting extensions and penalty relief can be found in this IRS Q&A.

*Source: HR360/IRS/Zywave*

## DEPARTMENTS FINALIZE SBC TEMPLATE

Under the Affordable Care Act, group health plans, grandfathered and non-grandfathered, and health insurance issuers are required to provide a written Summary of Benefits and Coverage ("SBC") to plan participants and beneficiaries at specified times during the enrollment process and upon request.

The SBC provides a summary of what the plan covers and the cost sharing responsibility of the consumer. They are intended to help health plan consumers better understand the coverage they have and to help make easy comparisons of different options when shopping for new coverage.

SBCs must be provided in a prescribed form. Form language and formatting must be precisely reproduced, unless instructions allow or instruct otherwise.

On April 6, 2016, the Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Department of the Treasury (the "Departments") issued the final revised template and related materials for the SBC.

The new SBC template includes an additional coverage example as well as language and terms to improve individuals' understanding of their health coverage. Specifically, the new template includes more information about cost-sharing, such as enhanced language to explain deductibles, and requires plans to address individual and overall out-of-pocket limits. Changes have also been made to the SBC to improve readability.

Use of the new SBC template will be required starting with 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.

Visit the U.S. Department of Labor's webpage on the SBC and Uniform Glossary for the latest updates, and to access all available templates and related documents.

**WHAT EMPLOYERS SHOULD DO**

- ✓ Become familiar with the new template and related materials.
- ✓ Self-funded plan sponsors should ensure that they are using the new template on the appropriate effective date.
- ✓ Employers with insured plans should make sure the carrier is providing the correct version of the template once it is required.

## HHS RELEASES ANNUAL OUT-OF-POCKET LIMITS FOR 2017

A final Notice of Benefit and Payment Parameters from the U.S. Department of Health and Human Services (HHS) issued on March 1, 2016 addressed, among other things, the annual out-of-pocket (OOP) cost-sharing limits for coverage of essential health benefits under group health plans for 2017. The law requires that these limits be updated annually.

HHS updated the annual limits based on the premium adjustment percentage for 2017. As a result, annual out-of-pocket expenses may not exceed **$7,150 for self-only** coverage or **$14,300 for family** coverage in 2017.

An HHS Fact Sheet on the final rule is also available.

**HDHP Contribution and Out-of-Pocket Limits:** Federal tax law also imposes a minimum deductible and an OOP maximum on HDHPs that are compatible with health savings accounts (HSAs). The HDHP OOP maximum is typically less than the ACA's OOP maximum. In order for a health plan to qualify as an HDHP, the plan must comply with the lower OOP maximum for HDHPs. The OOP maximum for 2017 has just recently been released and remains unchanged from 2016 at **$6,550** for self-only coverage or **$13,100** for family coverage.

# PHASE 2 OF THE HIPAA AUDIT PROGRAM

As indicated in our April 25, 2016 Observer Alert the Department of Health and Human Services (HHS) has launched the second phase of its HIPAA audit program, which focuses on compliance with HIPAA's Privacy, Security and Breach Notification Rules.

**This phase affects covered entities and business associates.** If an audit reveals a serious compliance issue, HHS' Office for Civil Rights (OCR) may investigate. The entities selected for an audit will have ***10 business days to submit the requested information, and another 10 business days to respond to draft findings.***

Communications from OCR will be sent via email and may be incorrectly classified as spam, so OCR expects covered entities and business associates to check their spam folders for emails from OSOCRAudit@hhs.gov. An entity that does not respond to OCR may still be selected for an audit or be subject to a compliance review.

Covered entities and business associates should prepare for a possible audit by reviewing their compliance with HIPAA's Privacy, Security and Breach Notification Rules.

## PREPARE NOW FOR AN AUDIT

The turnaround time for providing documents and other information, if selected for an audit, is very short. Covered entities and business associates should prepare now for the possibility of an audit. Important tasks include:

- Inventory all HIPAA documentation: policies and procedures, privacy notice, business associate agreements and complete list of business associates with contact information, training materials, security risk assessments and breach notifications.
- Remediate any deficiencies in HIPAA documentation or procedures
- Review the recently updated OCR audit program webpage including the audit pre-screening questionnaire, which will be sent by OCR to pools of covered entities and business associates to help identify candidates for audit.
- Compile responsive information to the questionnaire, which includes general questions about the respondent and then specific questions for different types of covered entities and for business associates.
- Regularly check spam and junk e-mail folders for communication from OCR

*Source: Zywave*

# MARKETPLACE NOTICES & SUBSIDY APPEALS

Beginning this spring, employers will begin receiving notices if any of their employees are deemed eligible for health insurance subsidies through the Marketplace (Exchange). Click here for a link to the publication from CMS regarding the 2016 Employer Notice Program. Employers who receive these notices will have **90 days** from the date the notice was sent to file an appeal, if they feel the eligibility determination was made in error.

Department of Health and Human Services (HHS) regulations require appeals to be accepted online, by phone, by mail and in person. However, guidance issued in March 2016, delayed (for the second time) the Exchanges' deadline to implement electronic appeals processes.

***Why is this important?***

Under the ACA, applicable large employers (ALEs) may be subject to employer shared responsibility payments (also known as pay-or-play penalties) if they do not offer affordable, minimum value health coverage to their full-time employees. The Internal Revenue Service (IRS) will assess these penalties if a full-time employee receives subsidies to help pay for the cost of health insurance purchased through the Exchange.

An Exchange will determine whether an individual is eligible for these subsidies when he or she applies for coverage. This determination does not establish whether the individual's employer is liable for shared responsibility penalties, but it may provide a basis for the IRS to assess penalties against an ALE.

For this reason, as well as to help ensure that individuals do not mistakenly receive health insurance subsidies, the ACA gives all employers the right to appeal Exchange eligibility determinations. An appeal will allow an employer to correct any inaccurate information the Exchange may have about the health coverage it offered to an employee who was deemed eligible for subsidies.

***Action Steps:***

- **Become familiar with the notice and appeals process;**
- **Put documented procedures in place for addressing notices once received so that appeals are filed within the required 90 day timeframe;**
- **Maintain complete and accurate records regarding the health insurance coverage offered to employees;**
- **Watch for notice letters! Right now, it is unclear whom they will come from or to whom they will be addressed.**

*Source: Zywave*

## *Moratorium on Health Insurance Providers Fee*

On Dec. 18, 2015, President Barack Obama signed a federal budget bill for 2016 into law, which imposes a one-year moratorium on the collection of the ACA's health insurance providers fee, for 2017. **As a result, no health insurance issuers are required to pay this fee for 2017.**

Employers are not directly subject to the health insurance providers fee. However, in many instances, providers of insured plans have been passing the cost of the fee on to the employers sponsoring that coverage. As a result, this one-year moratorium may result in significant savings for some employers on their health insurance rates.

# AGENCIES PROVIDE GUIDANCE ON PREVENTIVE SERVICES, RESCISSIONS, MENTAL HEALTH PARITY, AND MORE

The DOL, HHS, and IRS have jointly issued FAQs with guidance on several health care reform requirements, along with mental health parity and the Women's Health and Cancer Rights Act (WHCRA). Here are highlights:

- **Preventive Services (Q/As-1 & -2).** Q/A-1 confirms that the required preparation for a preventive screening colonoscopy is an integral part of the procedure and must be covered without cost-sharing, subject to reasonable medical judgment. This includes bowel preparation medications when medically appropriate and prescribed by a provider. Q/A-2 allows plans, as part of utilizing reasonable medical management techniques, to develop a standard exception form that providers may use to prescribe particular services or FDA-approved items based on a medical necessity determination for an individual.
- **Rescissions (Q/A-3).** This Q/A describes a fact pattern involving a teacher who was employed under a ten-month contract from August 1 to May 31 but had health coverage for the entire August 1–July 31 plan year. (The teacher had fully paid premiums during this period and had not committed fraud or intentional misrepresentation.) According to the FAQ, if the teacher resigned on July 31, termination of coverage retroactive to May 31 would constitute a prohibited rescission. The plan could, however, terminate coverage prospectively, subject to other applicable laws.
- **Out-of-Network Emergency Services (Q/A-4).** This Q/A confirms that plans are generally required to disclose on request how they calculate payments for out-of-network emergency services (e.g., the usual, customary, and reasonable (UCR) amount) to comply with ERISA's disclosure provisions, as well as health care reform's appeals process and external review requirements.
- **Clinical Trials (Q/As-5 & -6).** If a plan generally covers chemotherapy to treat cancer, it may not limit that coverage for chemotherapy provided in connection with an individual's participation in an approved clinical trial for a new anti-nausea medication. Similarly, if a plan typically covers items or services to diagnose or treat certain complications or side effects, the plan may not deny coverage of these items or services to diagnose or treat complications or side effects in connection with an approved clinical trial. The agencies also confirm that the nondiscrimination requirement relating to participation in clinical trials is self-implementing and, until further guidance is issued, plans are expected to follow a good faith, reasonable interpretation of the law.
- **Cost-Sharing Limits (Q/A-7).** Prior FAQ guidance addresses how the overall cost-sharing limit applies to plan designs that use reference-based pricing (i.e., where the plan pays a fixed amount for a particular procedure and providers accept it as payment in full). Consistent with that guidance, if a plan merely establishes a reference price without using a proper method to ensure reasonable access to quality providers, the plan will not be considered to have established an adequate network and would be required to count an individual's out-of-pocket expenses for providers who do not accept the reference price toward the maximum annual out-of-pocket limit.
- **Mental Health Parity (Q/As-8 through -11).** Clarification is provided as to how to perform the "substantially all" and "predominant" tests for financial requirements and quantitative limitations under the mental health parity requirements. The agencies note that these requirements apply to any benefits a plan may offer for medication-assisted treatment for opioid use disorder. The agencies also address disclosure requirements relating to providers and the individual insurance market.
- **Reconstructive Surgery After Mastectomy Under WHCRA (Q/A-12).** The WHCRA protections require that the plan provide coverage for nipple and areola reconstruction as a required stage of breast reconstruction.

These FAQs continue the agencies' trend of addressing specific issues in implementing health care reform and other federal group health plan mandates. They augment some of the guidance previously provided in regulations and other FAQs, and provide important information for those involved with group health plan design and administration.

*Source: EBIA*

## New FMLA Poster and Employer's Guide

The U.S. Department of Labor (DOL) has released an updated version of the "Employee Rights Under the [Federal] Family and Medical Leave Act" poster (often referred to as the "General FMLA Notice"), along with a new employer's guide to help employers comply with the law.

### Background

The FMLA provides eligible employees of covered employers with unpaid, job-protected leave for specified family and medical reasons, with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave. The law also includes certain family military leave entitlements.

Private sector employers who employ **50 or more employees** for at least 20 workweeks in the current or preceding calendar year must comply with the FMLA.

### New Poster

The DOL released an **April 2016 version of the FMLA poster** that covered employers are required to display in a conspicuous place where employees and applicants can see it. A poster must be displayed at all locations **even if there are no employees eligible for FMLA leave**. If a covered employer has any eligible employees, it must also provide the general notice to each employee by including it in employee handbooks or other written guidance concerning employee benefits or leave rights (if such written materials exist—otherwise, the employer may distribute a copy of the general notice to each new employee upon hire).
(Note: According to the DOL, **the February 2013 version of the FMLA poster is still valid and can be used to fulfill the posting requirement**.)

### Employer's Guide

An employer's guide was also released, which is designed to provide information about employers' obligations under the law and the options available to employers in administering FMLA leave. Specific areas covered include:

- Covered employers under the FMLA and their general notice requirements;
- What to do when an employee needs FMLA leave;
- Qualifying reasons for leave;
- The certification process;
- Military family leave;
- What to do during an employee's FMLA leave; and
- FMLA prohibitions.

The guide contains additional resources, including charts, examples, and citations for further information. Click here to view the guide.

## One to Watch

A New York district court will hear the first case on whether employers may reduce their employees' work hours in order to avoid providing health benefits required under the Affordable Care Act (ACA).

The case is Marin v. Dave & Busters—a class action lawsuit claiming that the restaurant chain, Dave & Busters, violated federal law by intentionally interfering with its employees' eligibility for health benefits.

The ACA requires applicable large employers (ALEs) to offer affordable, minimum value health insurance coverage to their full-time employees, or to pay a penalty. For this purpose, a "full-time employee" is defined as an employee that works, on average, at least 30 hours of service per week. In addition, Section 510 of the Employee Retirement Income Security Act (ERISA) prohibits employers and plan sponsors from interfering with an employee's rights to health benefits under the plan.
According to the group of about 10,000 employees who filed suit, their hours were significantly reduced for the purpose of keeping them below the ACA's "full-time employee" threshold.

On Feb. 9, 2016, the court rejected Dave & Busters' motion to dismiss the case. This is the first case of its kind, and will set a precedent for other employers who are considering or have implemented similar strategies regarding their employees' work hours as a result of the ACA.

*Source: Zywave*

## *Affordability Contribution Increased for 2017*

The Internal Revenue Service (IRS) has increased the required contribution percentages in 2017 for purposes of determining the affordability of an employer's plan under the Affordable Care Act (ACA).

For plan years beginning in 2017, employer-sponsored coverage will be considered affordable if the employee's required contribution for self-only coverage does not exceed:

- **9.69 percent** of the employee's household income for the year, for purposes of both the pay or play rules and premium tax credit eligibility; and
- **8.16 percent** of the employee's household income for the year, for purposes of an exemption from the individual mandate.

**ALEs using an affordability safe harbor may rely on the adjusted affordability contribution percentages for 2015 and future years.**

## *ARE YOU AWARE?*

CMS uses a Data Match program to help identify Medicare beneficiaries who are employed (or whose spouses are employed) and who may therefore be covered by a group health plan that should pay primary to Medicare. Under this program, the Social Security Administration (SSA) provides the IRS with a list of the Social Security numbers of Medicare beneficiaries. The IRS then matches the list against beneficiary income tax return data and sends the results to CMS for further analysis. For example, if tax records show that a Medicare beneficiary received payments from an employer during the prior year; CMS may contact the employer to determine whether the beneficiary was covered by the employer's group health plan.

Employers that are contacted must complete a questionnaire that requests information about the employer's group health plans and the individuals identified by CMS. This information is used to identify the primary and secondary payers for a Medicare beneficiary's medical services and to determine whether Medicare may have mistakenly paid claims on behalf of the beneficiary. The questionnaire asks,

among other things, whether each named individual worked during a specified time period and, if so, whether he or she had employer-sponsored group health coverage. The IRS/SSA/CMS Data Match Questionnaire also asks for a list of the group health plans under which such individuals have or had coverage during the specified time period.

Employers must complete the Data Match Questionnaire **within 30 days**, unless an extension has been requested and approved. Employers that fail to comply with CMS's request for information can be subject to adverse consequences, including the following:

- civil monetary penalties of $1,000 for each person for whom the employer has neither responded to nor has provided incomplete information;
- subpoenas of business records and members of the organization; and
- an investigation of the employer's group health plan for a determination of nonconformance, which may result in a referral to the IRS for imposition of an excise tax on the employer.

A detailed instruction booklet with sample filled-in responses, found HERE, can assist employers in completing the Data Match Questionnaire.  Employers that receive a questionnaire will want to consult the instructions and to follow them carefully. For example, the instructions indicate that if multiple options are available under a plan (e.g., fee-for-service, HMO, etc.), then each option should be listed as a separate group health plan. The instructions also direct employers not to list dental plans or special-purpose indemnity benefit plans (e.g., cancer plans). In addition, information is provided regarding how to request an extension of time in which to complete the questionnaire and how to submit the completed questionnaire electronically.

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