ICMS
EMPLOYEE BENEFITS

January 11th, 2017 - In This Issue:

COMPLIANCE RECAP

December was a relatively busy month for new laws and administrative rulemaking in the employee benefits world. President Obama signed the 21st Century Cures Act into law. The IRS issued a reporting deadline reminder, two information reporting summaries, and Q&As on information reporting. A U.S. District Court issued a nationwide preliminary injunction regarding a portion of the Section 1557 regulations. The Centers for Medicare & Medicaid Services issued FAQs on broker compensation and discriminatory marketing practices. The Departments of Labor, Health and Human Services, and the Treasury issued FAQs on HIPAA special enrollment, women's preventive services, and qualifying small employer health reimbursement arrangements. The Equal Employment Opportunity Commission issued an informal discussion letter regarding wellness programs under the ADA and GINA. The IRS issued final regulations about the premium tax credit and deferred finalizing the opt-out arrangement proposed rules to a later time.

UBA Updates

UBA released three new advisors in December:

- 21st Century Cures Act
- Qualifying Small Employer Health Reimbursement Accounts
- FAQ on HIPAA Special Enrollment; QSE HSAs Released

UBA also updated existing guidance:

- Cafeteria Plans: Qualifying Events and Changing Employee Elections(previously called Cafeteria Plans: Change in Status and Changing Employee Elections)
- HRAs, HSAs, and HFSAs under the ACA

21st Century Cures Act

On December 13, 2016, President Obama signed the 21st Century Cures Act into law. Of the Act's many components, employers should be aware of the impact the Act will have on the Mental Health Parity and Addiction Equity Act, as well as provisions that will affect the way certain small employers can use health reimbursement arrangements to reimburse individual premiums. There will also be new guidance for permitted uses and disclosures of protected health information under the Health Insurance Portability and Accountability Act (HIPAA).

Read more about the Act.

IRS Reminder and Summaries

In December 2016, the IRS issued a reminder about its extension of the 2017 due date for employers and coverage providers to furnish information statements to individuals. The due dates to file those returns with the IRS are not extended. This IRS chart describes the upcoming deadlines. The IRS also issued two summaries: Information Reporting by Providers of Minimum Essential Coverage and Information Reporting by Applicable Large Employers.

IRS Q&As about Information Reporting by Employers on Form 1094-C and Form 1095-C

In December 2016, the IRS updated its longstanding Questions and Answers about Information Reporting by Employers on Form 1094-C and Form 1095-C that provides information about

- Basics of Employer Reporting
- Reporting Offers of Coverage and other Enrollment Information
- Reporting for Governmental Units
- Reporting Offers of COBRA Continuation Coverage and Post-Employment Coverage
- Reporting Coverage under Health Reimbursement Arrangements

The Q&A describes when and how an employer reports its offers of coverage and provides examples to illustrate the codes that employers should use. The updated Q&A provides information on COBRA reporting that had been left pending in earlier versions of the Q&A for the past year.

U.S. District Court Issues Nationwide Preliminary Injunction - No Impact on Benefit Plan Requirements

On December 31, 2016, the U.S. District Court for the Northern District of Texas granted a preliminary injunction sought by several states and private health care providers. The court issued a nationwide injunction that prevents the U.S. Department of Health and Human Services (HHS) and HHS' Secretary from enforcing the Patient Protection and Affordable Care Act's Section 1557 regulations that prohibit discrimination based on gender identity or pregnancy termination.

Practically speaking, until this litigation is resolved, healthcare providers and states will not face enforcement by HHS if they do not comply with the regulations that prohibit discrimination based on gender identity or pregnancy termination.

Healthcare providers and states should continue to comply with all other provisions of the Section 1557 regulations. This would include compliance with any portion of the Section 1557 regulations that impact employee benefit plans. On January 3, 2017, HHS released the following statement: "HHS's Office for Civil Rights will continue to enforce the law - including its important protections against discrimination on the basis of race, color, national origin, age, or disability and its provisions aimed at enhancing language assistance for people with limited English proficiency, as well as other sex discrimination provisions - to the full extent consistent with the Court's order."

CMS Frequently Asked Questions on Agent/Broker Compensation and Discriminatory Marketing Practices

In December 2016, the Centers for Medicare & Medicaid Services (CMS) issued a Q&A to address issuers' attempts to discourage insurance offers to higher risk individuals by reducing or eliminating commissions to brokers for sales to higher risk individuals.

Federal regulations prohibit marketing practices that discourage higher risk individuals' health insurance coverage enrollment, both inside and outside of the Marketplaces. In its Q&A, CMS concludes that a commission arrangement or other agent/broker compensation that is structured to discourage agents and brokers from marketing to and enrolling consumers with significant health needs constitutes a discriminatory market practice prohibited by federal regulations.

CMS provides the following example. If an issuer pays agents or brokers less through all forms of compensation for higher metal level plans (such as platinum and gold level plans), which are associated with higher utilization, than the issuer pays for lower metal level plans (such as bronze and silver level plans), then the payment arrangement is a failure to comply with the federal guaranteed availability provisions and qualified health plan marketing standards.

CMS will enforce this guidance for policy years beginning on January 1, 2018, in an individual or merged market, and plan years beginning after April 1, 2017, in a small group market in a state that permits quarterly rate updates. For non-grandfathered coverage offered with a plan or policy year beginning on or after such dates, issuer agent/broker compensation arrangements and accompanying marketing and distribution practices must comply with CMS' guidance, regardless of whether coverage is offered through or outside of the Marketplaces.

FAQs on HIPAA Special Enrollment; QSE HRAs Released

On December 20, 2016, the Department of Labor (DOL), Department of Health and Human Services (HHS), and the Department of the Treasury (collectively, the Departments) issued FAQs About Affordable Care Act Implementation Part 35. The FAQs cover a new HIPAA special enrollment period, an update on women's preventive services that must be covered, and clarifying information on qualifying small employer health reimbursement arrangements (QSE HRAs).

Read more about the FAQs.

EEOC Informal Discussion Letter

In December 2016, the Equal Employment Opportunity Commission (EEOC) released one informal discussion letter to address wellness programs under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). These letters are customarily released to the public within a few months of being provided to the initial addressee.

Read the EEOC Letter.

The letter confirmed that the ADA wellness rules apply only to wellness programs that require a medical exam or answers to disability-related questions, or both. The ADA wellness program rules does not apply if the same incentive can be earned with or without a medical exam or answering disability-related questions. Further, employers may offer incentives only to employees who enroll in the employer-sponsored group health plan and complete wellness activities; if the incentive is the same across all the employer's group health plans, then the employer must use the lowest-cost option to calculate the applicable incentive limit.

IRS Premium Tax Credit Regulation VI

On December 19, 2016, the IRS issued final regulations relating to the health insurance premium tax credit.
If an individual declines enrollment in affordable, minimum value employer-sponsored coverage for a year, and the individual is not given an opportunity to enroll in employer-sponsored coverage for one or more succeeding years, the individual is not disqualified from premium tax credits for the succeeding years. For purposes of the employer shared responsibility penalty, a large employer may be treated as not having offered coverage for those succeeding years.

On a separate issue, although the proposed rule addressed the effect of payments made available under opt-out arrangements on an employee's required contribution for purposes of premium tax credit eligibility and an exemption from the section 5000A individual shared responsibility provision, the final regulations do not finalize regulations on the effect of opt-out arrangements on an employee's requirement contribution.

Per the final regulations, the Treasury Department and the IRS continue to examine the issues raised by opt-out arrangements and expect to finalize regulations later. Until final regulations are applicable, individuals and employers can continue to rely on the proposed rule and the guidance provided in Notice 2015-87.

	Form W-2, Box 12, Code DD		
Coverage Type	**Report**	**Do Not Report**	**Optional**
Major medical	X		
Dental or vision plan not integrated into another medical or health plan			X
Dental or vision plan which gives the choice of declining or electing and paying an additional premium			X
Health flexible spending arrangement (FSA) funded solely by salary-reduction amounts		X	
Health FSA value for the plan year in excess of employee's cafeteria plan salary reductions for all qualified benefits	X		
Health reimbursement arrangement (HRA) contributions			X
Health savings account (HSA) contributions (employer or employee)		X	
Archer medical savings account (Archer MSA) contributiosn (employer or employee)		X	
Hospital indemnity or specified illness (insured or self-funded), paid on after-tax basis		X	
Hospital indemnity or specified illness (insured or self-funded), paid through salary reduction (pre-tax) or by employer	X		
Employee Assistance Plan (EAP) providing applicable employer-sponosred healthcare coverage	Required if employer charges a COBRA premium		Optional if employer does not charge a COBRA premium
On-site medical clinics providing applicable employer-sponsored healthcare coverage			
Wellness programs providing applicable employer-sponsored healthcare coverage			
Multi-employer plans			X
Domestic partner coverage included in gross income	X		
Governmental plans providing coverage primarily for members of the military and their families		X	
Federally recognized Indian tribal government plans and plans of tribally chartered corporations wholly owned by a federally recognized Indian tribal government		X	
Self-funded plans not subject to federal COBRA			X
Accident or disability income		X	
Long-term care		X	
Liability insurance		X	
Supplemental liability insurance		X	
Workers' compensation		X	
Automobile medical payment insurance		X	
Credit-only insurance		X	
Excess reimbursement to highly compensated individual, included in gross income		X	
Payment/reimbursement of health insurance premiums for 2% shareholder-employee, included in gross income		X	
Other Situations	Report	DoN ot Report	Optional
Employers required to file fewer than 250 Forms W-2 for the preceding calendar year (determined without application of any entity aggregation rules for related employers)			X
Forms W-2 furnished to employees who terminate before the end of a calendar year and request, in writing, a Form W-2 before the end of that year			X
Forms W-2 provided by third-party sick-pay provider to employees of other employers			X