UBA ComplianceAdvisor

Compliance Recap

October 2016

October was a busy month for administrative rulemaking in the employee benefits world.

The Internal Revenue Service (IRS) released final instructions for Forms 1094-C and 1095-C, guidance on the taxability of health care sharing ministry employer contributions, and health care information reporting tips. The Department of Health and Human Services (HHS) released guidance on HIPAA and cloud computing. The Department of Labor (DOL) issued final regulations governing employee retaliation and whistleblower protection. The Centers for Medicare and Medicaid Services (CMS) issued guidance on off-Marketplace enrollment periods for stand-alone dental plans. The IRS, DOL, and HHS released notice of enforcement relief extension for higher education institutions, FAQs about preventive services coverage and mental health and substance use disorder parity implementation, and final regulations regarding short-term, limited-duration insurance, excepted benefits, and lifetime and annual limits.

UBA Updates

UBA released five new advisors in October:

- Final Regulations Regarding Short-Term, Limited-Duration Insurance, Excepted Benefits, and Lifetime/Annual Limits
- Enforcement Relief Extension for Higher Education Institutions Offering Student Premium Reduction Arrangements
- Health Savings Accounts: What You Need to Know
- IRS Releases 2016 Forms and Instructions for 6055 and 6056 Reporting
- Final Summary of Benefits and Coverage Template and Updates

UBA updated existing guidance:

- Highlights of the SHOP Exchange
- Frequently Asked Questions about the Transitional Reinsurance Fee
- Instructions for Completing the Transitional Reinsurance Fee Filing

IRS Releases Health and Welfare Plan Inflation-Adjusted Limits for 2017

The IRS recently released its Rev. Proc. 2016-55, including these health and welfare plan inflation-adjusted limits for 2017:

- **Requirement to Maintain Minimum Essential Coverage.** For calendar year 2017, the applicable dollar amount used to determine the penalty for failure to maintain minimum essential coverage is $695.
- **Employee Health Insurance Expense of Small Employers.** For taxable years beginning in 2017, the dollar amount is $26,200. This amount is used for limiting the small employer health insurance credit and for determining who is an eligible small employer for purposes of the credit.
- **Cafeteria Plans.** For the taxable years beginning in 2017, the annual dollar limitation on voluntary employee salary reductions for contributions to health flexible spending arrangements is $2,600.
- **Medical Savings Accounts.**
    - Self-only coverage. For taxable years beginning in 2017, the term "high deductible health plan" means, for self-only coverage, a health plan that has an annual deductible that is not less than $2,250 and not more than $3,350, and under which the annual out-of-pocket expenses required to be paid (other than for premiums) for covered benefits do not exceed $4,500.
    - Family coverage. For taxable years beginning in 2017, the term "high deductible health plan" means, for family coverage, a health plan that has an annual deductible that is not less than $4,500 and not more than $6,750, and under which the annual out-of-pocket expenses required to be paid (other than for premiums) for covered benefits do not exceed $8,250.

Final Instructions for Forms 1094-C and 1095-C

The IRS recently released the 2016 Forms and Instructions for 6055 and 6056 reporting. Under the Patient Protection and Affordable Care Act (ACA), individuals are required to have health insurance, while applicable large employers are required to offer health benefits to their full-time employees. In order for the IRS to verify that individuals and employers have met their requirements under the ACA, employers with 50 or more full-time or full-time equivalent employees and insurers are required to report on the health coverage they offer. UBA released an Advisor that describes the final instructions for using Forms 1094-B, 1095-B, 1094-C, and 1095-C.

HIPAA Privacy Notice Deadline

HIPAA requires health plans to distribute:

- a notice of privacy practices (NPP) to all newly eligible participants in the health plan,
- a new NPP within 60 days of a material change to the notice, and
- a notice of NPP availability to all participants once every three years.

In most cases, the insurer is likely handling notice distribution if the plan is fully-insured; the plan sponsor is generally responsible for notice distribution if the health plan is self-funded.

Under the HITECH regulations, effective September 23, 2013, all plans were required to revise their NPPs by September 23, 2013. This means that many employers, who have opted not to provide the notice annually, are likely due to provide the notice again in 2016.

For a health plan that posts its notice on its website, the revised notice (or information about the material changes and how to get a copy) had to be sent to participants in the health plan's next annual mailing after September 23, 2013, the effective date of the revisions.

For a health plan without a website, the health plan had to distribute the revised notice (or information about the material change and how to get a copy) to participants within 60 days of the effective date of the material change.

Because HIPAA requires health plans to provide notice of NPP availability to all participants once every three years, if a health plan has not already send its notice of NPP availability this year, then it should do so within the three-year deadline of when it complied with the final regulations in 2013.

HHS Issues Guidance on HIPAA and Cloud Computing

HHS provided guidance that cloud services providers (CSP) are business associates under HIPAA when a covered entity engages a CSP's services to create, receive, maintain, or transmit electronic protected health information (ePHI).

Further, when a business associate subcontracts with a CSP to create, receive, maintain, or transmit ePHI on its behalf, the CSP subcontractor itself is a business associate.

HHS explains that this business associate relationship exists even if the CSP processes or stores only encrypted ePHI and lacks an encryption key for the data. According to HHS, lacking an encryption key does not exempt a CSP from business associate status and obligations under the HIPAA Rules. Practically speaking, the covered entity (or business associate) and the CSP must enter into a HIPAA-compliant business associate agreement (BAA), and the CSP is both contractually liable for meeting the terms of the BAA and directly liable for compliance with the HIPAA rules' applicable requirements.

DOL OSHA Final Regulation Regarding Employee Retaliation and Whistleblower Protection

On October 13, 2016, the Department of Labor's Occupational Safety and Health Administration (OSHA) issued final regulations governing employee retaliation and whistleblower protection under the Fair Labor Standards Act (FLSA) Section 18C, which was added under health care reform.

Section 18C protects employees who may have been subject to retaliation for receiving premium tax credits for coverage purchased on an Exchange, of for reporting potential violations of key health care reform requirements (such as the prohibition on rescission or provision of preventive services without cost-sharing). This type of FLSA compliance must be filed within 180 days of the time when the alleged violation occurs. OSHA's website has an online complaint form, although no particular form is required and a complaint may be oral or in writing.

Read about the final regulations.

IRS Information Letter 2016-0051 Regarding Taxability of Employer Contributions to Health Care Sharing Ministry

The IRS answered the question of whether an employer can contribute to the premiums of employees who decline employer group health plan coverage and instead participate in a health care sharing ministry (HCSM).

Per the IRS, because participation in an HCSM is not employer-provided coverage under an accident or health plan, the law does not exclude employer payment for the cost of employee participation from the employee's gross income. Instead, the law considers it as taxable income and wages to the employee.

CMS FAQ on Off-Marketplace Enrollment Periods for Stand-Alone Dental Plans

CMS recently released an FAQ stating that Exchange-certified stand-alone dental plans offered off-Exchange may accept enrollments outside the Exchange enrollment periods.

Enforcement Relief Extension for Higher Education Institutions Offering Student Premium Reduction Arrangements

On October 21, 2016, the Department of Labor, Department of Health and Human Services, and Department of the Treasury released an FAQ to extend enforcement relief for higher education institutions offering premium reduction arrangements to their students. Pending further guidance, the Departments will not assert that a premium reduction arrangement fails to satisfy the annual dollar limits prohibition and preventive services requirement if the arrangement is offered in connection with other student health coverage (insured or self-insured). UBA released an Advisor regarding the agencies' enforcement relief

extension.

IRS Health Care Tax Tip

On October 26, 2016, the IRS released its Health Care Tax Tip 2016-75 that provides seven reporting tips.

1. The health care law requires applicable large employers (ALEs) to report information about health insurance coverage offered to its full-time employees and their dependents as well as to the IRS.
2. ALEs must report information about themselves, the coverage they offered - if any - and the individuals covered under the policy.
3. ALEs are required to furnish a statement to each full-time employee that includes the same information provided to the IRS by January 31, 2017.
4. ALEs that file 250 or more information returns during the calendar year must file the returns electronically.
5. ALEs must file Form 1095-C Employer-Provided Health Insurance Offer and Coverage with the IRS annually, no later than February 28, 2017, or March 31, 2017, if filed electronically. Forms 1095-C are filed accompanied by the transmittal form, Form 1094-C.
6. Self-insured employers that are applicable large employers, and therefore are also subject to the information reporting requirements for offers of employer-sponsored health insurance coverage, must combine reporting under both provisions by filing a single information return, Form 1095-C, and transmittal, Form 1094-C.
7. The ACA Assurance Testing System opens November 7, 2016, for tax year 2016 testing. Software developers - including employers and issuers who passed AATS for tax year 2015 - will not have to retest for tax year 2016; the Tax Year Software Packages will be moved into Production status. New participants need to comply with test requirements for tax year 2016.

FAQs About Preventive Services Coverage and Mental Health and Substance Use Disorder Parity Implementation

On October 27, 2016, the Treasury, DOL, and HHS (collectively, the Departments) issued "FAQs About Affordable Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation."

In their FAQs, the Departments seek public comment by January 3, 2017, on tobacco cessation coverage. The Departments intend to clarify the items and services that must be provided without cost sharing to comply with the United States Preventative Services Task Force's updated tobacco cessation interventions recommendation applicable to plan years or policy years beginning on or after September 22, 2016.

In their FAQs, the Departments also seek public comment by January 3, 2017, on potential model forms that could be used by participants and their representatives to request information on various nonquantitative treatment limitations (NQTLs). The Departments also seek public comment on the disclosure process in connection with mental health / substance use disorder (MH/SUD) benefits and on steps that could improve state market conduct examinations or federal oversight of compliance by plans and issuers, or both.

Their FAQs also answered questions about receiving help in obtaining documents and interpreting documents related to MH/SUD benefit denial. Participants may use the Parity Consumer Web Portal to connect to an agency for help.

Further, their FAQs discussed the data that a plan or issuer can use to conduct its analyses. Under the Departments' regulations pursuant to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), group health plans and issuers must use a "reasonable method" for the MHPAEA's substantially all and predominant analyses, which includes using reasonable data to produce reasonable projections.

Group health plans and issuers should not use claims data from an issuer's or third party administrator's entire book of business in an unreasonable manner to calculate the amount of a particular group health

plan's or issuer's payments under MHPAEA. The Departments clarify that, for large group market and self-insured group health plans, a group health plan or issuer must consider group health plan-level claims data to perform the substantially all and predominant analyses and must rely on such data if it is credible to perform the required projections.

The FAQs state that the MHPAEA regulations do not permit a plan or issuer to apply stricter NQTLs to all benefits for mental health conditions in a classification than those applied to all medical/surgical benefits in the same classification. Further, the Departments' regulations require that a plan or insurance issuer may not impose an NQTL with respect to MH/SUD benefits in a benefit classification unless, under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL are comparable and applied no more stringently with respect to MH/SUD benefits than with respect to medical/surgical benefits in the same classification.

Final Regulations Regarding Short-Term Limited Duration Insurance, Excepted Benefits, and Lifetime / Annual Limits

On October 31, 2016, the Department of the Treasury, Department of Labor (DOL), and Department of Health and Human Services (HHS) (collectively, the Departments) issued final regulations regarding the definition of short-term, limited-duration insurance, standards for travel insurance and supplemental health insurance coverage to be considered excepted benefits, and an amendment relating to the prohibition on lifetime and annual dollar limits.

Read about the final regulations.

Question of the Month

Q. An employer has a United States division with fewer than 20 employees; the parent company is located in a foreign county. Can the United States division's employee count be separated from the parent company for COBRA eligibility determination?

A. The USA division cannot be treated separately from its parent company for the purpose of employee count for COBRA eligibility determination. However, be aware that if the employer has immunity under the Foreign Sovereign Immunities Act, then COBRA would not apply. The employer's attorney must determine if this immunity applies.

Most employers are obligated to follow COBRA's rules if they provide group health plans. There is also an exemption for small employers who normally employed fewer than 20 employees on a typical business day in the year preceding the year for which exemption is sought. The typical business day standard is satisfied only if the employer had fewer than 20 employees on at least 50 percent of its typical business days during the preceding calendar year.

COBRA does not address the situation of a domestic subsidiary of a foreign corporation. To resolve the issue, the courts have determined that COBRA does not apply at all to any employer that is immune from jurisdiction pursuant to the Foreign Sovereign Immunities Act (FSIA) because it is a foreign state or instrumentality of that state.

In a Ninth Circuit case, employees sued a British Columbia processing plant and its parent corporation for violating COBRA. The court determined that the parent corporation was an agent of the Alberta province and thus immune from jurisdiction so COBRA did not apply to the parent corporation. However, the court found that the British Columbia processing plan did not fall within FSIA and that the processing plan was subject to COBRA.

In a separate case, a corporation located in Puerto Rico claimed that it was an exempt small employer. It employed 27 people; the corporation argued that, under Puerto Rico law, the employer's 2 owners and 7 relatives should not be counted as employees. The court disagreed and applied COBRA's definition of employee. The court held that the corporation was subject to the COBRA continuation coverage requirements.

Further, under controlled group rules, foreign corporations are not excluded from membership in a controlled group of corporations. Controlled group analysis is complex so the employer should consult with its attorney to determine whether the group is a controlled group.

11/3/2016

The UBA Compliance Advisors help you to stay up to date on regulatory changes to help simplify your job and mitigate compliance risk.