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BENEFITS BULLETIN

Regulatory Updates

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2016 IS ALMOST HERE - READY TO REPORT?

The Affordable Care Act's (ACA's) reporting requirements are effective with the 2015 tax year, and the first reports are due to participants by the end of January 2016. The IRS recently released several documents related to these requirements.

Electronic Filing Test Package - A draft version of IRS Publication 5164 was issued in August. Plans filing 250 or more 1095-B forms must submit their reporting forms electronically. Publication 5164 outlines the steps administrators and/or software vendors (the entity that will do the electronic filing) must take to facilitate their submissions. The IRS calls their electronic filing system "AIR," which stands for Affordable Care Act Information Returns.

In brief, administrators need to:

1. Identify the "responsible official(s)" and "contacts." The responsible official is the person with authority to complete and submit 1094 and 1095 forms. Two additional contacts are also required.
2. Register with the IRS as an e-filer (if you are not already a registered e-filer). Select "Registration Services" on the IRS website to get started. You will be required to provide personal taxpayer data in order to authenticate your identity.
3. Apply for a Transmitter Control Code (TCC). There is a tutorial available.

The person who will be submitting the plan's 1094-B and 1095-B forms to the IRS should apply for a TCC as soon as possible.

4. Test. Participate in the testing process, which the IRS calls the ACA Assurance Test System (AATS). See Publication 5164 for more information.

You can download these and other IRS forms, along with tutorials and webinars, at the IRS website.

Substitute Forms - A draft version of IRS Publication 5223 was also issued in August detailing the requirements for substitute paper 1094 and 1095 forms. The requirements are extremely detailed—they dictate the type of paper used, the margins, font, type of ink, etc.

No other substitutes will be accepted. Plan administrators should contact their software vendors to make sure their vendors can create forms acceptable to the IRS. Monetary penalties apply to plans and employers that do not comply with the stated requirements, or use forms that have not been pre-approved by the IRS.

Who Should Get 1095-B Forms - Plans should include the following categories of participants when reporting to the IRS, and these same individuals should receive individual 1095-B forms before January 31, 2016:

- Any person (employee) who was covered, or offered coverage, for at least one month in 2015;
- Retirees who are not covered under the plan's supplement to Medicare benefit plan (plans do not have to report on coverage that supplements an already qualifying health plan, i.e., Medicare); and
- COBRA beneficiaries.

One 1095-B form is needed for each "responsible individual" (the employee, retiree, surviving spouse, or COBRA beneficiary). Dependents of that individual should not be issued separate 1095's.

Only employer-sponsored health plans providing minimum essential coverage (MEC) are subject to the reporting requirements. Stand-alone dental, vision and/or disability plans are exempt.

REGULATORY PROCESS BEGINS FOR THE CADILLAC TAX

Two Recent IRS Notices - Despite the significant bipartisan support to repeal it, the Excise Tax on High Cost Employer-Sponsored Health Coverage, popularly known as the "Cadillac tax," is still scheduled to go into effect in 2018. The IRS has now begun the clarification and regulation process by releasing two notices requesting comments on a number of issues.

One particular concern is how to calculate the "cost" of account-based benefit plans, e.g., HRA's and FSA's. The Cadillac tax must be calculated on a month-to-month basis, and this creates a problem for account-based benefits which are usually fully funded at the start of a plan year. The IRS is proposing that one-twelfth (1/12) of the person's HRA benefit be allocated toward each calendar month. In the case of an FSA, the amount allocated each month would be the greater of the amount actually withheld from the employee's salary that month or the amount reimbursed in that month.

The IRS is also considering:

- Options in lieu of COBRA calculation methods to determine costs;
- How to establish age and gender adjustments. (The Cadillac tax thresholds are subject to certain upward adjustments if the participant population is older or contains more females than the baseline determined by the IRS.); and
- How to deal with rollovers in FSA plans. (The IRS is proposing to ignore them for the purpose of the Cadillac tax).

All Plans Will Eventually Pay - For its first year, 2018, the Cadillac tax applies to plans that provide benefits in excess of $10,200 for employee-only or $27,500 for family coverage. Multiemployer plans can use the family threshold for all participants.

The thresholds for subsequent years are indexed to an inflation factor equal to the consumer price index plus 1 percent–an estimated 2%-3% overall. Health care costs, however, are expected to increase by 5.6% per year. Therefore, while 30% of plans will have to pay the tax in 2018 (unless they reduce their benefits), 60% will have to pay by 2022, only four years later.

BREATHING ROOM ON PROVIDER NON-DISCRIMINATION

An ACA FAQ issued on May 26, 2015 (Part XXVII) by the federal regulating Departments acknowledged that the requirement that plans not "discriminate with respect to participation under the plan or coverage against a health care provider who is acting within the scope of that provider's license or certification under applicable State law" is not, as they previously advised, "self-administering." After soliciting comments on the feasibility and cost of this provision in 2014 (at the behest of the Senate), the Departments revoked their prior guidance, and now state that they will take no enforcement action against any plan using a "good faith, reasonable interpretation of the statutory provision."

NEW SBC'S DELAYED

The final rules concerning the changes in the SBC template and instructions were issued in June 2015. The most significant change was the postponement of the effective date. The new template will now apply to plan years starting on

or after January 1, 2017. The original effective date was September 1, 2015.

UPDATE ON PREVENTIVE SERVICES

Non-grandfathered plans are required to cover certain in-network preventive services and supplies at 100%. ACA FAQ XXVI, issued May 11, 2015, clarified that:

- Plans must cover anesthesia services for routine screening colonoscopies.
- BRCA genetic testing and counseling has to be covered for any woman with a history of cancer (any type).
- Plans cannot exclude a particular form of female contraception. The FAQ identified 18 different methods of birth control that plans must cover, including emergency contraception (Plan B). Plans are, however, allowed to impose "reasonable medical management techniques," such as monetary incentives to use generics.
- Plans must provide sex-specific preventive services even to persons of the opposite sex if they are transgender or otherwise identify with the other sex.

EEOC PROPOSES RULES ON WELLNESS PROGRAMS

In April 2015 the Equal Employment Opportunity Commission (EEOC), the agency charged with administering the Americans with Disabilities Act (ADA), issued proposed rules regarding wellness programs. Wellness programs are also governed by HIPAA and the ACA (which amended HIPAA), and the entities regulating those statutes have also issued additional guidance.

The EEOC proposes that:

- A wellness program that requires a medical exam or asks "disability-related" questions must be voluntary.
- To be considered "voluntary," the incentive cannot exceed 30% of the cost of the coverage. (Under HIPAA rules, the 30% limit only applies to programs that require health risk assessments).
- A 50% incentive can be offered for tobacco-cessation programs, but only if the tobacco users are self-identified. If the tobacco usage is detected by a lab test or medical exam, the 30% limit would apply. (The HIPAA/ACA rules allow a 50% incentive regardless of how the tobacco usage is identified.)
- Participatory wellness programs must provide reasonable accommodations to persons with disabilities. For example, printed documents should be available in large print, or a sign language interpreter should be provided for the hearing impaired.

The EEOC's proposed rules differ in some details from the guidance issued by the other agencies. After the EEOC examines the comments it receives, it will issue final rules which will, it is hoped, explain how the new rules fit and coordinate with the rules issued by the other regulatory bodies.

MEDICAL MARIJUANA

Medical marijuana is legal in 23 states and the District of Columbia, and there are an estimated 1.1 million users in the U.S. Health plans, insured or otherwise, do not cover medical marijuana because it has not been granted FDA approval for any medical indication.

Advocates are working to change the FDA's stance, and the effort could be successful. Therefore, it would be prudent for health plans that do not wish to cover marijuana to consider adopting a specific Plan exclusion.

REMINDER - TRANSITIONAL REINSURANCE

Plans that are required to pay ACA's transitional reinsurance fees should register to pay by November 15, 2015. This is year 2 of 3 for the fees, and the amount due is $44 per covered person. Not all plans are required to pay the fees for the second and third years. COBRA participants are included, but Medicare-primary participants are excluded.

Plans that are self-insured and self-administered (meaning a TPA or insurer doesn't pay the claims) do not have to pay the reinsurance fee this year or next year.