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THE IRS WILL ACCEPT "SILENT" TAX RETURNS

The Affordable Care Act's (ACA) Individual Mandate requires that individuals maintain minimum essential health coverage or potentially be subject to a tax penalty, unless the individual qualifies for an exemption. The penalty is assessed by the Internal Revenue Service (IRS) at the time an individual files their individual tax returns. Specifically, taxpayers report in Line 61 of their Form 1040 whether or not they were enrolled in medical coverage, and this is the mechanism by which a penalty would/would not be assessed by the IRS against that individual.

Originally, the IRS anticipated automatically rejecting returns that did not provide coverage information in Line 61 (referred to as "silent" returns) starting this year. However, the IRS released a statement earlier this month explaining that it will continue to accept and process silent returns. This decision is in response to President Trump's January 20, 2017 Executive Order, which directed federal agencies to exercise their authority and discretion to "minimize the unwarranted economic and regulatory burdens of the [Affordable Care] Act."

Although the IRS's statement instructed taxpayers to file returns as they normally would, this decision may have broad implications for the future of the ACA. However, at this time, the IRS has left the issue open as to how "silent" returns will be treated by explaining that it is still currently reviewing the Executive Order to determine its implications.

No Action Required

No action is required at this time. Taxpayers may review the statement here and determine whether they will file silent returns, or complete Line 61 as instructed.

For IRS Statement, see:

https://www.irs.gov/tax-professionals/aca-information-center-for-tax-professionals

IRS RELEASES MEMORANDUM ON INCOME RECEIVED THROUGH FIXED INDEMNITY HEALTH PLANS

Background

Generally, under IRC Section 106(a), employer provided coverage under an accident or health plan (e.g., either funded through health insurance premiums, or through direct reimbursement by the employer for the healthcare expenses of an employee) are not considered income to the employee. However, an employee is required to claim as income any amounts that were paid to an employee if such plan does **not** take into account the actual cost of the health expenses incurred, but only pays the employee an amount of monies regardless of the cost of the care provided to that employee (e.g., certain fixed indemnity plans). Because these reimbursements are not paid pursuant to the actual cost of coverage, they are not considered true reimbursements for the personal injuries or sickness of an employee, unless an exception applies.

In addition, employees need not claim as income any salary reductions made to purchase health benefits, and such amounts are excluded from an employee's income so long as such payments are made pursuant to a qualified IRC Section 125 cafeteria plan that offers an employee a choice of two or more benefits and the employee has the choice of either electing cash or the purchase of benefits on a pre-tax basis.

IRS Memorandum

On January 20, 2017, the Office of Chief Counsel of the Internal Revenue Service (IRS) released a memorandum (the IRS memorandum) that discusses the taxability of payments made to an employee through a fixed indemnity plan. As a reminder, IRS memoranda are not binding, and cannot be used or cited as precedent. However, this IRS memorandum can be a helpful tool in discovering whether or not certain payments would/would not be considered taxable income to an individual in an IRS audit.

The IRS memorandum begins by posing two questions. These two questions are as follows:

1) Does an employer need to include in an employee's taxable earnings any payments made from an employer's fixed indemnity plan (under IRC Section 105)?
2) Does an employer need to include in an employee's taxable earnings any payments made from a fixed indemnity plan, if the employee paid such premiums through pre-tax salary reductions through an IRS Section 125 cafeteria plan?

The IRS memorandum goes through five hypothetical scenarios, discussing whether or not each fact scenario creates a situation where payments from a fixed indemnity plan are considered taxable income to the employee. To save time for the reader, the following is a summary of when fixed indemnity payments are/are not considered taxable income to the employee:

- If an employee pays for the premiums of a fixed indemnity plan with **after-tax** dollars, payments/reimbursements provided to an employee need **not** be considered taxable income to the employee.
- If an employer either pays the fixed indemnity plan premiums on behalf of the employee, or the employee pays the premiums on a **pre-tax** basis under a qualified IRC Section 125 cafeteria plan, then the amounts paid by the fixed indemnity plan to the employee **will be** included as taxable income to the employee.
- If an employee pays on a **pre-tax** basis for participation in a "wellness program" whereby the employee either receives fixed indemnity payments for completing activities (e.g., health risk assessment, health screenings, preventative care activities) within the "wellness program," or receives other kinds of fixed indemnity cash payments per pay period (e.g., percentage of salary payable for the pay period) for participation in a "wellness program, those payments **will be** treated as taxable income to the employee.

Therefore, employers should be cautious in providing any kind of pre-tax payment for fixed indemnity plans, including those fixed indemnity plans that may be a part of a wellness program.

IRS Releases Memorandum on Income Received through Fixed Indemnity Health Plans (Continued)

Action Required

If an employer is currently allowing employees to pay for a fixed indemnity plan on a pre-tax basis (either as part of a health plan or a wellness program), or an employer is paying for a fixed indemnity plan on behalf of employees (either as part of a health plan or a wellness program), the employer should be aware that monies paid out from that fixed indemnity policy may be considered taxable income to the employee.

For the complete details, see the IRS Memorandum here:

https://www.irs.gov/pub/irs-wd/201703013.pdf

DEPARTMENT OF LABOR FEDERAL CIVIL PENALTIES ANNUAL INFLATION ADJUSTMENT FOR 2017

On July 1, 2016, the Department of Labor (DOL) published its interim rule which increases penalties for ERISA violations by implementing "catch-up" inflation adjustments. The increase will apply to penalties assessed after August 1, 2016, if the ERISA violation occurred after November 2, 2015. If the violation occurred on or prior to November 2, 2015, and the assessment was made on or before August 1, 2016, the penalty will be based on the pre-adjustment penalty amount. The agencies must annually adjust their civil penalty amounts for inflation.

The inflation adjustment is determined from October to October, and the penalty amount is adjusted for inflation and announced on the DOL's website no later than the following January 15. **Penalties, therefore, were adjusted as of January 15, 2017,** meaning that an increased penalty applies after January 13, 2017. Below is a chart comparing the penalties assessed prior to January 13, 2017, and penalties that are assessed after that date.

Violation	Rate for Penalties Assessed Between August 1, 2016 and January 13, 2017	Increased Rate for Penalties Assessed After January 13, 2017
Failure to furnish reports (i.e., statement of benefits) to former retirement plan participants and beneficiaries or failure to maintain records for a retirement plan.	$28/employee	$28/employee
Failure or refusal to file annual report (Form 5500).	$2,063/day per plan	$2,097/day per plan
Failure of Multiple Employer Welfare Arrangement (MEWA) to file required report (M-1).	$1,502/day	$1,527/day
Failure to furnish employee benefit plan documents to DOL upon request (including plan and trust documents and summary plan description).	$147/day (but no greater than $1,472 per request)	$149/day (but no greater than $1,496 per request)

Department of Labor Federal Civil Penalties Annual Inflation Adjustment for 2017 (Continued)

Failure by employer to inform employees of Medicaid/CHIP coverage opportunities.	$110/day/employee	$112/day/employee
Failure of group health plan's plan administrator to provide state with timely coverage coordination disclosure form from Medicaid/CHIP eligible individuals.	$110/day/participant or beneficiary	$112/day/participant or beneficiary
Genetic Information Nondisclosure Act (GINA) violation by group health plan sponsor/health insurance issuer.	$110/day/participant or beneficiary (if not corrected before notice of violation is received – subject to minimum of $2,745/day/participant or beneficiary for *de minimis* violations or $16,473/day/participant or beneficiary for violations that are not *de minimis*; maximum of $549,095 for unintentional failures)	$112/day/participant or beneficiary (if not corrected before notice of violation is received – subject to minimum of $2,790/day/participant or beneficiary for *de minimis* violations or $16,742/day/participant or beneficiary for violations that are not *de minimis*; maximum of $558,078 for unintentional failures)
Failure to provide Summary of Benefits Coverage to participant or beneficiary of group health plan.	$1,087/failure	$1,105/failure

No Action Required

Employers/Insurers should be aware of the increase in penalties for ERISA violations in 2017.

For more details, see the Interim Final rules:

https://www.federalregister.gov/documents/2016/07/01/2016-15378/department-of-labor-federal-civil-penalties-inflation-adjustment-act-catch-up-adjustments

U.S. Department of Labor fact sheet:

https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/fs-interim-final-rule-adjusting-erisa-civil-monetary-penalties-for-inflation.pdf

FAQs: https://www.dol.gov/sites/default/files/2016-inflation-faq.pdf

2017 inflationary adjustments: https://www.gpo.gov/fdsys/pkg/FR-2017-01-18/pdf/2017-00614.pdf

FOUR NEW DRAFT BILLS REFLECT GOP APPROACH TO HEALTH CARE REFORM

During a hearing titled "Patient Relief from Collapsing Health Markets" held on February 2, 2017, the Committee on Energy and Commerce considered four Republican-sponsored draft bills seeking to amend portions of the Patient Protection and Affordable Care Act (ACA) on a piecemeal basis. This article highlights the main components and potential implications of these bills.

State Age Rating Flexibility Act of 2017

Current health care reform regulations prevent insurance carriers in each state from charging older adults more than 3 times the premium rates they charge younger adults for the same coverage (referred to as an age rating ratio of 3:1), even though it may cost carriers four to five time more to cover older adults than younger adults. The age rating ratio sets a uniform standard to stabilize premium costs for older adults who purchase individual policies and small employers that employ and offer coverage to older adults.

Four New Draft Bills Reflect GOP Approach to Health Care Reform (Continued)

Introduced by U.S. Representative Larry Bucshon (R-IN), this bill seeks to amend the Public Health Service Act (PHSA) to change the age rating ratio for health insurance premium rates for older adults from 3:1 to 5:1. If the bill is approved, health insurance carriers could potentially charge a 60-year-old adult up to five times the premium charged to a 21-year-old for the same level of coverage. Supporters of the bill argue that the 3:1 ratio does not reflect the true cost of care, and imposes artificially high costs on younger, healthier individuals, while opponents argue it would result in high premium costs and/or reduced coverage for older Americans (especially those not yet Medicare-eligible).

Pre-existing Conditions Protection and Continuous Coverage Incentive Act of 2017

The pre-existing conditions exclusion, a key component of the ACA, prevents health insurance carriers from denying or limiting coverage to individuals with pre-existing health conditions in the individual and group markets. If the ACA were repealed in its entirety, millions of Americans could lose their health insurance, and many may be unable to find replacement coverage if insurers were allowed to deny, limit, or substantially increase the cost of coverage in light of an individual's pre-existing conditions.

This bill, introduced by Chairman Greg Walden (R-OR), would amend the PHSA to ensure that patients with pre-existing conditions could obtain health coverage through the individual and group markets if the ACA were repealed. Specifically, the bill prohibits health insurers from imposing any pre-existing condition exclusions or considering an individual's health status or genetic information when deciding whether to offer coverage.

Plan Verification and Fairness Act of 2017

Currently, individuals who lose coverage or experience certain life events can purchase insurance through the Exchange outside of open enrollment periods (i.e., during special enrollment periods). The Marketplace can require verified documentation for an individual to enroll in the Marketplace during a special enrollment period, but need not require such verification.

This bill, sponsored by Representative Marsha Blackburn (R-TN), would amend the ACA to require verification of an individual's eligibility to enroll in a qualified health plan offered through the Exchange during a special enrollment period, before coverage is effective. Until an individual's eligibility as a qualified individual is confirmed through an approved verification process, that individual would not be able to enroll in the Exchange. The approved verification process includes submitting documentation to the Secretary establishing that the individual is eligible to enroll during the special enrollment period.

In addition, the bill would require the Department of Health and Human Services to conduct a study to assess the number of individuals that tried to enroll in qualified health plans during special enrollment periods in 2016, the number of individuals not allowed to enroll (and the reasons why), and submit a report of its findings to Congress by June 1, 2018.

Health Coverage State Flexibility Act of 2017

Under the ACA, enrollees that are delinquent in paying their Exchange premiums receive a three-month grace period before their coverage is terminated. Therefore, an individual could potentially stop paying for Exchange coverage in October, but still have coverage throughout the year.

Introduced by Representative Bill Flores (R-TX), this bill would amend the ACA to align the grace period requirement for the cancellation of an insurance policy based upon non-payment of premiums to match those provided for under State law prior to the ACA, or one month, for those states that previously did not impose a grace period.

Any bills enacted would take effect for plan years beginning on or after January 1, 2018.

No Action Required

Interested employers and individuals may want to be aware of these draft bills, which reflect the GOP's current approach and priorities regarding health care reform.

Interested parties can review the text of the bills here:

http://docs.house.gov/Committee/Calendar/ByEvent.aspx?EventID=105506

IRS PROPOSES REVISIONS TO DEFINITION OF DEPENDENT

On January 19, 2017, the Internal Revenue Service (IRS) issued Proposed Rules revising its definition of "dependent" so as to align the definition under Internal Revenue Code (the Code) Section 152, with the Working Families Tax Relief Act of 2004 (WFTRA) and related acts. Generally, the Code Section 152 allows an individual taxpayer to claim exemptions for a dependent. The WFTRA and related acts amended Section 152 so a taxpayer could only claim a qualifying child or qualifying relative as a dependent. The Proposed Rules apply to employers that offer health care coverage to their employees' **qualified** dependents **(this definition applies to dependents who are not spouses or children under age 27)**, and/or dependent care assistance programs because these tax benefits are limited to individuals who qualify as **a qualified dependent** under Section 152. This article highlights the key changes in the Proposed Rules.

Qualifying Child and Qualifying Relative Defined

Under the Proposed Rules, a qualifying child is defined as an individual who:

- Bears a certain relationship with the taxpayer (qualifying child relationship test)
- Has the same principal place of abode (i.e., residence) as the taxpayer for more than half the tax year (residency test)
- Is younger than the taxpayer and is under age 19, or age 24 if a full-time student, or any age if disabled (age test) **(new requirement)**
- Does not provide more than half of his or her own support (qualifying child support test) ; and
- Does not file a joint return with a spouse, except to claim a refund of estimated or withheld taxes (joint return test) **(revised requirement)**

A qualifying relative is defined as an individual who:

- Bears a certain relationship with the taxpayer (qualifying relative relationship test)
- Has gross income less than the federal exemption amount (gross income test)
- Receives more than half of his or her own support from the taxpayer (qualifying relative support test); and
- Is not the qualifying child of another taxpayer (not a qualifying child test)

Clarification of Adopted Children and Foster Children under the Relationship Test

Adopted Children

A qualifying child must have a relationship with the taxpayer, as a child, brother, sister, stepbrother or stepsister, or descendant of any of these individuals. The previous rule considered an adopted child to be the individual or taxpayer's child, and generally defined an adopted child as a child placed with an individual by an authorized placement agency.

The Proposed Rules removed the reference to an authorized placement agency, and clarified that any child legally adopted by a person, or placed with a person for legal adoption, is treated as that person's child (e.g., a child may be legally placed for adoption by the child's parents).

In addition, the Proposed Rules clarified that an adopted child who is a U.S. national may be a qualifying child.

Foster Children

The Proposed Rules clarify that a child under the qualifying child relationship test can include a foster child, generally defined as a child placed with the taxpayer by an authorized placement agency (including an Indian Tribal Government) or by a judgment, decree, or other court order.

Clarification of Student under the Age Test

The age test requires a qualifying child to be younger than the taxpayer, and under age 19, or age 24 if a full-time student (or any age if permanently and totally disabled). The Proposed Rules clarify that a student is an individual who is a full-time student at an educational institution for at least part of each month for 5 months during the tax year. Individuals in on-farm training programs may also qualify as students.

Clarification on Principal Place of Abode under the Residency Test

The residency test requires a qualifying child to have the same principal place of abode as the taxpayer for more than half the year. A qualifying relative may be an individual who has the same principal place of abode as the taxpayer and is a member of the taxpayer's

IRS Proposes Revisions to Definition of Dependent (Continued)

household. The Proposed Rules define principal place of abode as a main home, residence, or dwelling, and clarifies that it does not need to be the same physical location throughout the year, and may include temporary lodgings (e.g., a homeless shelter).

A dependent is deemed to reside in the taxpayer's principal place of abode even during a temporary absence by either person. A person is temporarily absent if, but for the specific reason, that person would have resided at the place of abode, and it is reasonable to assume that the person will return to the place of abode. Nonpermanent absences related to illness, education, business, vacation, military service, or custody agreement may be treated as temporary absences.

Clarification of Support Test

Generally, an individual's support is determined by comparing the amount of support provided by the individual (under the qualifying child support test) or by the taxpayer (under the qualifying relative support test) with the total amount of the individual's support from all sources (e.g., from the individual's own income or other parties). Government payments (e.g., Temporary Assistance for Needy Families, food stamps) are considered support from a third party (not the taxpayer or dependent).

The Proposed Rules also explain that the amount of support is the cost to furnish the item of support. For items of support furnished as property or a benefit, the amount of support is the fair market value of the item furnished (e.g., fair market value of lodging provided). Support includes food, shelter, clothing, medical care (including medical insurance premiums), education, but does not include taxes, life insurance premiums, or scholarships received by a taxpayer's child who is a student.

"Tiebreaker" Rules When More than One Taxpayer May Claim an Individual as a Dependent Child

Tiebreaker rules apply if two or more taxpayers may claim an individual as a qualifying child. Unless an exception applies, two or more taxpayers cannot claim the same individual as a qualifying child, and if they do so, tiebreaker rules apply to determine which taxpayer can claim the individual. If more than one eligible parent claims the individual as a dependent, and they do not file a joint return, then the individual is treated as the qualifying child of the parent that the individual lived with for the longest time during the tax year. If the individual lived with both parents for the same time during the tax year, then the parent with the highest adjusted gross income (AGI) can claim the individual as a dependent. If only one taxpayer is an eligible parent, then that taxpayer can claim the child as a dependent. If no eligible parent claims the child as a dependent, then another taxpayer may claim the child as a dependent if this taxpayer's AGI is higher than any eligible parent's AGI.

If no eligible parent claims an individual as a qualifying child, and two or more non-parent taxpayers are eligible to claim the individual as a qualifying child and each has an AGI higher than any eligible parent, then the taxpayer with the highest AGI may claim the individual as a qualifying child.

Finally, the Proposed Rules provide an exception to the rule that only one taxpayer may claim a child as a qualifying child. Under a special rule, a noncustodial parent may claim an individual as a qualifying child or qualifying relative for the dependency exemption and child tax credit, and another taxpayer may claim the child for other benefits if certain exceptions are met.

Effective Date

The Proposed Regulations will be effective the first taxable year following the publication of the final regulations. However, taxpayers may rely on the Proposed Regulations pending the issuance and publication of the Final Regulations for any open taxable year.

Action Required

Although these regulations have yet to be finalized, the IRS has stated that taxpayers may rely on the Proposed Rules for any open taxable year, indicating employers and taxpayers may use the revised definition immediately, or wait until the final regulations are published. Employers and taxpayers may want to familiarize themselves with these Proposed Rules in case the revised definition is more advantageous to them from a tax perspective.

For the text of Proposed Regulations, see:

https://www.gpo.gov/fdsys/pkg/FR-2017-01-19/pdf/2017-01056.pdf

MAXIMUM WEEKLY BENEFIT INCREASES FOR CALIFORNIA AND SAN FRANCISCO PAID PARENTAL AND FAMILY LEAVE

Background

The San Francisco Paid Parental Leave Ordinance (San Francisco Ordinance) took effect on January 1, 2017, requiring San Francisco covered employers with 50 or more employees to provide paid parental leave to employees to bond with a newborn child, a newly adopted child, or a new foster child. The San Francisco Ordinance will become effective for employers with 35 or more employees on July 1, 2017, and employers with 20 or more employees on January 1, 2018. Under the San Francisco Ordinance, covered employers are required to pay covered employees 45% of their wages while on parental leave, supplementing the 55% wage replacement that employees on family leave receive under California's Paid Family Leave (California PFL). An article detailing the San Francisco Ordinance requirements was included in our April 2016 Legislative Compliance Monthly.

On December 23, 2016, the San Francisco Office of Labor Standards Enforcement (SFOLSE) issued final rules implementing the San Francisco Ordinance.[1] In addition, as of January 1, 2017, the California PFL weekly benefit maximum increased, which caused a corresponding increase in the San Francisco Ordinance's weekly benefit maximum.

Increases to the Maximum Weekly Benefit

If an employee is out on family leave to bond with a new child, California PFL provides 55% wage replacement for up to six (6) weeks. The San Francisco Ordinance requires that covered employers provide 45% wage replacement to supplement the amount paid under California PFL.

Previously, California PFL wage replacement limited the weekly benefit to $1,129. For any claim filed on or after January 1, 2017, however, the California PFL weekly benefit maximum is increased to $1,173. Because the San Francisco Ordinance supplements the compensation required by California PFL, the maximum weekly benefit for employees on parental leave under the San Francisco Ordinance has consequently increased from $924 to $960.

The California PFL and the San Francisco Ordinance fall under the category of leave administration, and therefore employers should seek advice from a labor and employment attorney should they have any questions about how the state and city leave laws interact, how the benefits are to be calculated, or any other of the Ordinance's requirements.

Action Required

San Francisco should ensure that they are in compliance with the Ordinance by the effective date applicable to their company size, and ensure that they comply with the increased wage replacement limits.

For complete details, see:

http://sfgov.org/olse/paid-parental-leave-ordinance

[1] We sent an email communication to B&B teams detailing the final rules implementing the San Francisco Ordinance, which included links to the San Francisco Office of Labor Standards Enforcement's website where employers can access the workplace poster, paid parental leave form, and supplemental compensation calendar.

ILLINOIS AMENDS EMPLOYEE SICK LEAVE ACT

On January 1, 2017, the Illinois Employer Sick Leave Act (the Act), Public Act 99-0841, went into effect. The Act generally requires that Illinois employers, **who choose to provide sick leave to employees**, revise their policies to allow employees to use up to half of their annual accrued sick time to care for family members. Specifically, the Act permits employees to use "personal sick leave benefits" to care for themselves or a family member due to an illness, injury, or medical appointment.

However, the Act provided little guidance on how it was to be applied, including, for example, whether the benefits required to be offered under the Act were paid or unpaid time off. In order to clarify the Act, Governor Bruce Rauner approved an amendment to the Act (the Amendment), which became effective on January 13, 2017. Highlights of the Amendment are discussed below.

Definition of "Personal Sick Leave Benefits"

The Act's definition of "personal sick leave benefits" broadly referred to as "time accrued" that the employee could use to care for himself/herself or a family member due to an illness, injury, or medical appointment. The Amendment clarifies that the benefits include any **paid or unpaid** time off provided through an employment benefit plan or paid time off policy (regardless of whether it is accrued or earned), excluding any plans for long term disability, short term disability, or insurance policies.

Definition of "Family Member"

Under the Act, an employee could use personal sick leave benefits to care for a "family member," which was originally defined as an employee's child, spouse, sibling, parent, mother/father-in-law, grandchild, grandparent, or stepparent. The Amendment adds stepchild and domestic partner to the definition of "family member."

The Amendment also clarifies that employees are able to use paid sick leave benefits for a family member on the same terms to which employees are able to use the benefits for themselves.

Verification of Employee Absence

The Amendment clarifies that an employer may request written verification from a healthcare professional that the employee's absence fell within the permitted reasons under the Act, if written verification is a requirement under the employer's policy.

Limit on Use of Sick Leave

The Act permits an employer to limit an employee's use of sick leave for the purpose of caring for a family member to half of their *accrued* sick leave in a year (i.e., the employee can use the sick leave he/she accrued in a 6 month period towards caring for a family member). The Amendment adds that an employer who offers employees sick leave based on years of service (as opposed to monthly or yearly accrual) may limit that employee's use of sick leave to care for a family member to half of the employee's *earned* sick leave.

Prohibition on Retaliation

The Act prohibits employers from retaliating against an employee for exercising his/her right to use sick leave as permitted by the Act.

Employees and Employers Exempt from the Act

The Amendment adds a new section to the Act, exempting the following individuals from the requirements of the Act:

- Employees of employers subject to Title II of the Railway Labor Act
- Employers or employees defined under the Federal Railroad Unemployment Insurance Act or the Federal Employers' Liability Act (or comparable laws); and
- Other employment that the Illinois Department of Labor exempts under future regulations implementing the Act.

The Amendment also states that the Act should not interfere with any collective bargaining agreement, nor should it affect any party's power to collectively bargain under an agreement.

Illinois Amends Employee Sick Leave Act (Continued)

Action Required

Illinois employers that offer sick leave should review their leave policies and ensure they comply with the requirements of the Amended Act.

For complete details, see the Amended Ordinance:

http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0921&GA=99

COMPLIANCE REMINDER: ONLINE CMS DISCLOSURE FORM DUE BY MARCH 1, 2017

Health plan sponsors are required to complete an **annual online disclosure form** in relation to their prescription drug coverage with the Centers for Medicare and Medicaid Services (CMS). This form details whether prescription drug coverage under the sponsor's health plan is "creditable" (meaning that the plan's prescription coverage is comparable to, or better than, Medicare Part D's prescription drug benefit), or is "non-creditable" (does not reimburse prescription coverage at the same level as Medicare Part D's prescription drug benefit). Plan sponsors must complete the disclosure within 60 days of the start of the plan year if any plan participants are receiving Medicare Part D prescription drug benefits. Therefore, for **calendar year** health plans, this online disclosure form is due to CMS by **March 1, 2017.**

A health plan is also required to report to CMS within 30 days if a prescription drug plan is terminated, or if there are any other changes in a plan's creditable coverage status.

Plans Exempt from the Filing Process

Employer health plans that do not offer prescription drug coverage to any Medicare-enrolled employees, dependents, or retirees at the start of the plan year are exempt from filing with CMS. In addition, employers who qualify for the Medicare Part D retiree drug subsidy are exempt from filing, but only in regard to those individuals for which they claimed the plan subsidy.

Annual Part D Notice

As a reminder, plan sponsors must annually issue a notice to their Medicare-enrolled employees, dependents, and retirees informing them whether the drug coverage under the sponsor's plan is "creditable" or "non-creditable". Notices must be provided:

- Prior to enrollment in the employer's plan
- Prior to annual Part D enrollment window (opens October 15th)
- Prior to an individual's initial enrollment period for Part D
- When a plan ceases prescription drug coverage, or drug coverage status changes (i.e., creditable to non-creditable)
- Upon Request

Compliance Reminder: Online CMS Disclosure Due by March 1, 2017 (Continued)

Action Required

Plan sponsors with calendar year health plans must complete the disclosure to CMS by **March 1, 2017.** Plan sponsors must go online to complete this filing before the due date. Plan sponsors should print a copy of the confirmation page for their records.

For instructions on how to file, see:

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

To complete the online disclosure to CMS form, see:

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

COMPLIANCE REMINDER: DEADLINES TO FILE AND FURNISH REPORTING FORMS ARE FAST APPROACHING

The Affordable Care Act (ACA) requires Applicable Large Employers (ALEs) to file Form 1094-C (Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns) and Form 1095-C (Employer-Provided Health Insurance Offer and Coverage), to report information regarding employer offers of health coverage to full-time employees, and enrollment of employees and family members in their health coverage (if the ALE is a self-funded plan).

Due Date for Filing Form 1094-C and Form 1095-C

Forms 1094-C and 1095-C may be filed in paper or electronic format. ALEs who are filing **250 or more** Form 1095-Cs must file returns **electronically**. Due dates for filing the 2016 Form 1094-C and Form 1095-C with the Internal Revenue Service (IRS) are as follows:

Paper Filings Due: **February 28, 2017**

Electronic Filings Due: **March 31, 2017**

Additionally, employers may request a 30-day extension to file Forms 1094-C and 1095-C by filing Form 8809 with the IRS. An employer must file Form 8809 on or before the filing deadline in order to receive the 30-day extension to file Forms 1094-C and 1095-C.

Deadline for Furnishing Form 1095-C to Employees

An employer must furnish a completed Form 1095-C to full-time employees, regardless of whether an employee enrolls in or waives coverage. The deadline for employers to furnish Form 1095-C to employees was extended from January 31, 2017 to **March 2, 2017**. Any employer who has not begun the process of completing Form 1095-C for applicable employees should do so ***immediately***, if they hope to meet the deadline.

Since the IRS has extended the deadline to furnish Form 1095-C to employees from January 31, 2017 to March 2, 2017, the IRS has indicated that an additional 30-day extension will **not** be granted. Therefore, employers should plan to furnish Form 1095-C to employees by the deadline of March 2, 2017.

Compliance Reminder: Deadlines to File and furnish Reporting Forms Are Fast Approaching (Continued)

2016 ACA Reporting Requirements Unlikely to Change

While the future of the ACA remains uncertain, employers should not wait to complete and furnish Forms 1094-C and 1095-C pending action by President Donald Trump's administration. Any changes or repeal of the ACA will almost undoubtedly **not** impact 2016 reporting, and likely will not impact reporting for 2017.

Action Required

ALEs should ensure they have completed and filed Forms 1094-C and 1095-C by **February 28, 2017**, if filing paper copies, and by **March 31, 2017**, if filing electronically. ALEs should also ensure they furnish Form 1095-C to employees by **March 2, 2017**. Employers who have not yet begun the process of completing Form 1095-C should do so promptly.

For Form 1094-C and Instructions for Form 1094-C, see:

https://www.irs.gov/uac/about-form-1094-c

For Form 1095-C and Instructions for Form 1095-C, see:

https://www.irs.gov/uac/about-form-1095-c

For information on requesting an extension to file Forms 1094-C and 1095-C, see Form 8809:

https://www.irs.gov/pub/irs-pdf/f8809.pdf

QUESTION OF THE MONTH

How Does an Employer Comply with HIPAA's Privacy Rule When Reporting Health Plan Enrollment Information on Form 1095-C?

QUESTION: My company is an applicable large employer (ALE) with a self-insured health plan. What steps must we take under HIPAA's privacy rule when we report enrollment information for employees and dependents on Form 1095-C?

ANSWER: You should follow the HIPAA rules that apply to disclosures of protected health information (PHI) from a group health to the plan sponsor for plan administration purposes.

Code § 6055 requires providers of minimum essential coverage (MEC) to report the name, taxpayer identification number (TIN), and months of coverage for all individuals enrolled in the MEC. For a self-insured health plan, Code § 6055 regulations impose the reporting obligation on the employer sponsoring the plan. Where the employer is an ALE, the ALE satisfies the reporting obligation by reporting enrollment information on Part III of Form 1095-C.

The HIPAA privacy rule allows a group health plan to share PHI with the plan sponsor to the extent that the plan sponsor performs plan administration functions. Code § 6055 reporting is a plan administration function performed by the plan sponsor. Thus, HIPAA allows the group health plan to disclose enrollment information to the plan sponsor so that the plan sponsor may satisfy the Code § 6055 reporting obligation with respect to the plan.

A number of technical requirements must be satisfied before these disclosures may be made by the health plan to the plan sponsor. For example, group health plan documents must be amended to establish permitted and required uses and disclosures of PHI by the plan sponsor, and the plan sponsor must agree not to use or disclose PHI for employment-related actions or in connection with any other benefit or employee benefit plan of the plan sponsor. In addition, the plan sponsor must establish a firewall between those employees who will have access to PHI to perform plan administration functions and all other employees of the plan sponsor. If you hire a third party to file Form 1095-C on your behalf, you should consider whether the third party is a business associate of the plan and whether you need to enter into a business associate contract with the third party before you disclose enrollment information.

Apart from enrollment information under Code § 6055, Code § 6056 requires ALEs to report information about offers of coverage to full-time employees (and their dependents). This information is reported on Part II of Form 1095-C. Information about offers of coverage to your employees should be available from your employment records (rather than your health plan). Because information in employment records generally is not PHI, reporting this information should not implicate HIPAA's privacy rule.

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