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2016: Fourth Quarter

Compliance Digest

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This document is designed to highlight various employee benefit matters of general interest to our readers. It is not intended to interpret laws or regulations, or to address specific client situations. You should not act or rely on any information contained herein without seeking the advice of an attorney or tax professional.

2016 Transitional Reinsurance Fee Form Now Available

Published: October 14, 2016

By November 15, 2016, employers with self-insured medical plans must report annual enrollment counts to Health and Human Services ("HHS") in order to pay the 2016 Transitional Reinsurance Fee. Now in its final year, the fee for 2016 is $27 per covered life per year. Payment is due by January 17, 2017 (and November 15, 2017 if paying in two-installments).

The 2016 Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form is now available at https://www.pay.gov/public/form/start/77704988. If you go directly to www.pay.gov, search for "2016 ACA Transitional Reinsurance" to access the 2016 Form.

For further information, you can visit the CMS/CCIIO's 2016 Benefit Year Form announcement page for important links, training modules, reference materials, and aids. For a more detailed overview, click here:

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/2016-Benefit-Year-Page.html.

Final 2016 Forms 1094-C and 1095-C Available

Published: October 25, 2016

The Internal Revenue Service ("IRS") recently released final versions of the 2016 Forms 1094-C and 1095-C and associated instructions. These forms will be used in early 2017 by Applicable Large Employers ("ALEs") to report whether the ALE offered (or did not offer) a full-time employee ("FTE") health insurance coverage during the calendar year. Additionally, for ALEs with self-insured plans, these Forms reflect coverage provided under a self-insured group health plan to individuals (FTEs and non-FTEs) during calendar year 2016. Generally, the forms and instructions are substantially similar to their draft versions and the 2015 forms, with the exception of two new reporting codes, removal of certain transition relief that is no longer available and additional clarifications contained in the instructions.

Notable changes are summarized below.

The Forms

Form 1095-C Clarifications and Changes

- **New codes.** Codes 1J and 1K have been added for use on Line 14 to report a "conditional offer of spousal coverage." A conditional offer is an offer of coverage that is subject to one or more reasonable, objective conditions (for example, an offer to cover an employee's spouse only if the spouse is not eligible for coverage by a group health plan sponsored by another employer). Employers that have a spousal carve-out arrangement will need to be aware of these two new codes (specifically, 1K).
  - **1J:** MEC providing minimum value ("MV") offered to employee and at least MEC conditionally offered to spouse; MEC not offered to dependent(s).
  - **1K:** MEC providing MV offered to employee; at least MEC offered to dependents; and at least MEC conditionally offered to spouse.

- **Codes that are no longer applicable.** Codes 1I and 2I, used on the 2015 Form 1095-C in Lines 14 and 16 respectively, are no longer applicable and have been reserved. These Codes should not be used on the 2016 filings.

- **Qualifying Offer Method (Code 1A).** A "Qualifying Offer" means an offer of MEC providing MV to one or more FTEs for all calendar months during the calendar year for which the employee was an FTE, where the employee contribution for each month does not exceed (for 2016) 9.66% ($95.63) of the mainland single federal poverty line, provided the offer of coverage includes an offer of MEC to the employee's spouse and children. If this is the case, the employer may use Code 1A in Line 14 and leave Lines 15 and 16 blank. A corresponding Box "A" in Line 22 of Form 1094-C must also be checked. ALEs qualifying for this relief are not required to use Code 1A.

- **Line 15 of Form 1095-C.** Only complete if using Code 1B, 1C, 1D, 1E, 1J, or 1K on Line 14. If any other code is on Line 14 (e.g., 1A, 1F, 1G, or 1H), leave Line 15 blank.

- **"Do not attach to your tax return. Keep for your records."** Language has been added to the top of Form 1095-C reminding recipients to keep this statement for recordkeeping purposes. A copy should not be submitted with an individual's annual tax filing.

Transitional Relief – Form 1094-C, Line 22

- For the 2016 calendar year, the transition relief described below is applicable only if an ALE offers coverage under a health plan with a non-calendar plan year, and only for calendar months in 2016 that fall within the 2015 plan year.

- Check Box "C" if the ALE is eligible for the following relief for one or more months of the 2016 calendar year:
  - ALE employed fewer than 100 FTEs (50-99 Transition Relief), or
  - For employers with 100 or more FTEs, qualified for relief on the "A" penalty (applicable when there was an offer of coverage to at least 70% of FTEs as opposed to 95%).

The Instructions

Aggregated ALE Groups

The instructions include an expanded discussion regarding instructions for filings made by ALE members that are part of an aggregated ALE group (i.e., controlled group or affiliated service group).

- There is no aggregated reporting or authoritative transmittal for all members of an aggregated ALE group (controlled group). Each ALE member must file its own Forms 1094-C and 1095-C under its own separate EIN, even if the ALE member is part of an aggregated ALE group.

- Only one Form 1094-C may be the authoritative transmittal for an ALE.

Electronic Filing

- Generally, if an employer must file at least 250 information returns, the employer must file electronically. The 250-or-more filing requirement applies separately to each type of form and separately for original and corrected forms. If you were required to file your forms electronically because you filed more than 250 forms and you have 150 corrected Forms 1095-C to file, you may file the corrected returns on paper.

Failure to file a correct information return.	**$260**/each return for which a failure occurs (maximum penalty for all failures during the calendar year cannot exceed $3,193,000).
Failure to provide a correct payee statement.	**$260**/each return for which a failure occurs (maximum penalty for all failures during the calendar year cannot exceed $3,193,000).
Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and to furnish the required statements.	
Waiver of penalties. Penalties may be waived if the failure was due to reasonable cause and not willful neglect.	

COBRA Coverage

An offer of COBRA coverage is reported differently depending on whether or not the offer is made due to an employee's termination of employment.

- If an employee is terminated, then the COBRA offer is reported as no offer of coverage using Code 1H on Line 14 and Code 2A on Line 16 with Line 15 blank.

- If there is an offer of COBRA coverage made to an employee who remains employed by the ALE (e.g., an offer of COBRA coverage due to a loss of group health plan coverage because of a reduction in hours), then the COBRA offer is reported using the appropriate code to indicate the offer of coverage to all eligible individuals. For example, use Code 1E if coverage is offered to employee, spouse, and dependents or Code 1B if coverage is offered to employee only.

Example

During the applicable open enrollment period for its health plan, Employer makes an offer of MEC providing MV to Employee and to Employee's spouse and dependents. Employee elects to enroll in employee-only coverage starting January 1. On June 1, Employee experiences a reduction in hours that results in loss of eligibility for coverage under the plan. As of June 1, Employer terminates Employee's existing coverage and makes an offer of COBRA continuation coverage to Employee, but does not make an offer to Employee's spouse and dependents.
Employer should enter Code 1E (MEC providing MV offered to employee and at least MEC offered to dependent(s) and spouse) on Line 14 for months January – May, and should enter Code 1B (MEC providing MV offered to employee only) on Line 14 for months June – December.

Counting FTEs for the ALE

Column (b) in Section III of Form 1094-C requests the number of FTEs for each month of the calendar year.

- **Monthly measurement method.** Employee should be counted as an FTE for a month if the employee satisfied the FTE definition under the monthly measurement method (as applicable) on any day of the month.

- **Look-back measurement method.** If the employee is identified as an FTE during the measurement period, then the employee is considered an FTE for each month of the stability period so long as the employee remains employed by the employer.

Be sure to use the definition under the employer mandate for an FTE (determined under one of the two applicable measurement methods) and not any other definition.

Example

Employer uses the look-back measurement method to determine the full-time status of its employees.
Employee, who is not in a Limited Non-Assessment Period, averaged over 130 hours of service per month during the measurement period that corresponds with the stability period starting January 1, 2016, and ending December 31, 2016. Employee terminates employment with Employer on February 15, 2016. Employer must include Employee in the number of FTEs reported in column (b) for January and February.

Post-Employment (non-COBRA) Coverage

An offer of post-employment coverage to a former employee upon termination of employment (i.e., a retiree) should not be reported as an offer of coverage on Line 14. Use Codes 1H in Line 14 and 2A in Line 16 if the ALE is required to file Form 1095-C for the former employee (for example, the employee was an FTE for part of the calendar year in which the termination of employment occurred).

Employee Required Contribution

The Employee Required Contribution is the employee's share of the monthly cost for the lowest-cost self-only MEC providing MV that is offered to the employee by the ALE.

To determine the amount of the employee's share of the monthly cost, the ALE may divide the total cost to the employee for the plan year by the number of months in the plan year. This monthly amount of the employee's share of the cost would then be reported for any months of that plan year that fall within the 2016 calendar year.

Self-Funded Plans

The instructions provide the following clarifications:

- Complete Part III of Form 1095-C ONLY if the ALE offers employer-sponsored self-insured health coverage in which the employee or other individual enrolled.

- If the ALE offers both insured and self-insured coverage, complete Part III only for employees who enroll in the self-insured coverage.

- Part III must be completed by the ALE offering self-insured health coverage for any individual who was an employee for one or more calendar months of the year, whether full-time or not, and who enrolled in the coverage.
  - The employee should be listed on Line 17 and any other family members who enrolled in the coverage offered to the employee should be listed on subsequent lines.

- Part III may be completed by the ALE offering self-insured health coverage for any other individual who enrolled in the coverage under the plan for one or more calendar months of the year but was not an employee for any calendar month of the year, such as a retired employee who retired in a previous year, a terminated employee receiving COBRA continuation coverage (or any other form of post-employment coverage) who terminated employment during a previous year, and a non-employee COBRA beneficiary (but not including an individual who obtained coverage through the employee's enrollment, such as a spouse or dependent obtaining coverage when an employee elects COBRA continuation coverage that is family coverage).
  - If using Form 1095-C for this purpose, use 1G in the "all 12 months" box or the box for each month of the calendar year.
  - If Form 1095-C is not used, the ALE must use Forms 1094-B and 1095-B.

Reporting Offers of Coverage under a Multiemployer Plan

For reporting offers of coverage for 2016, an ALE relying on the multiemployer interim guidance should enter Code 1H on Line 14 for any month for which the ALE enters 2E on Line 16.

- For reporting for 2016, Code 1H may be entered without regard to whether the employee was eligible to enroll or enrolled in coverage under the multiemployer plan.

- For reporting for 2017 and future years, ALE relying on the multiemployer arrangement interim guidance may be required to report offers of coverage made through a multiemployer plan in a different manner.

Other Clarifications

- Code 1G (used on Form 1095-C in Line 14) applies for the entire year or not at all. According to the instructions, there would not be an instance where 1G would be used with another Line 14 Code during the year.

- The "affordability" safe harbors for 2016 are based on 9.66%.

- Do not use an affordability safe harbor Code (e.g., 2F, 2G or 2H) if the ALE did not offer MEC to at least 95% of FTEs and their dependents (e.g., if NO is checked on Form 1094-C, Part III, column (a)).

- An FTE that experiences a break in service where no hours of service were credited should be reported as an employee only if the individual remained an employee during the break in service.

- A plan does not provide MV if it fails to offer substantial coverage of inpatient hospitalization and physician services.

Additional Information

Additional information on this employer reporting may be found here:

https://www.irs.gov/affordable-care-act/employers/questions-and-answers-about-information-reporting-by-employers-on-form-1094-c-and-form-1095-c

The 2016 instructions may be found here:

https://www.irs.gov/pub/irs-pdf/i109495c.pdf

The final Forms 1094-C and 1095-C can be found here:

https://www.irs.gov/pub/irs-pdf/f1094c.pdf

https://www.irs.gov/pub/irs-pdf/f1095c.pdf

The 2016 Forms 1094-B and 1095-B and Instructions have been released and are available here, https://www.irs.gov/pub/irs-pdf/i109495b.pdf. They are not addressed in this summary.

2017 Cost of Living Adjustments

Published: November 1, 2016

On October 25 and 27, 2016, the IRS released cost of living adjustments for 2017 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans

For plan years beginning in 2017, the dollar limitation under Section 125 for voluntary employee salary reductions for contributions to health flexible spending arrangements increases to **$2,600.**

The Affordable Care Act (ACA) amended Section 125 to place a $2,500 limitation under Section 125(i) on voluntary employee salary reductions for contributions to health flexible spending arrangements, subject to inflation for plan years beginning after December 31, 2013.

Qualified Transportation Fringe Benefits

For calendar year 2017, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Section 132(f)(2)(B)) is **$255.**

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Requirement To Maintain Minimum Essential Coverage

For calendar year 2017, the applicable dollar amount used to determine the penalty under Section 5000A(c), for failure to maintain minimum essential coverage is **$695.**

This is also referred to as the individual mandate under the ACA. Any assessed penalty tax is the greater of $695 or 2.5% of modified adjusted gross income in excess of the filing threshold and capped at the average premium amount for bronze coverage available on the health insurance exchange. The penalty is collected from an individual's tax refund due after filing their personal income tax return with the IRS.

Highly Compensated

The compensation threshold for a highly compensated individual or participant (as defined by Code Section 414(q)(1)(B) for purposes of Section 125 nondiscrimination testing) again remains unchanged at **$120,000** for 2017.

Under the cafeteria plan rules, the term highly compensated means any individual or participant who for the preceding plan year (or the current plan year in the case of the first year of employment) had compensation in excess of the compensation amount as specified in Code Section 414(q)(1)(B).

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2017 increases to **$175,000.**

For purposes of cafeteria plan nondiscrimination testing, a key employee is a participant who is a key employee within the meaning of Code Section 416(i)(1) at any time during the preceding plan year.

Non-Grandfathered Plan Cost-Sharing Limits

The 2017 maximum annual out-of-pocket limits for all non-grandfathered plans are **$7,150** for individual coverage and **$14,300** for family coverage.

These limits generally apply with respect to any essential health benefits (EHBs) offered under the group health plan. The final regulations established that starting in the 2016 plan year, the self-only annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in other than self-only coverage, including in a family HDHP.

Health Savings Accounts

As announced in May 2016, the inflation adjustments for health savings accounts (HSAs) for 2017 were provided by the IRS in Rev. Proc. 2016-28.

Annual Contribution Limitation.

For calendar year 2017, the limitation on deductions for an individual with **self-only coverage** under a high deductible health plan is **$3,400.** For calendar year 2017, the limitation on deductions for an individual with **family coverage** under a high deductible health plan is **$6,750.**

High Deductible Health Plan.

For calendar year 2017, a "high deductible health plan" is defined as a health plan with an **annual deductible that is not less than $1,300 for self-only coverage** or **$2,600 for family coverage,** and the annual out-of-pocket expenses (deductibles, co-payments, and other amounts, but not premiums) **do not exceed $6,550 for self-only coverage** or **$13,100 for family coverage.**

Non-calendar year plans: In cases where the HDHP renewal date is after the beginning of the calendar year, any required changes to the annual deductible or out-of-pocket maximum may be implemented as of the next renewal date.

Catch-Up Contribution.

Individuals who are age 55 or older and covered by a qualified high deductible health plan may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined in Code 223(b)(3)(B), is $1,000 for 2009 and thereafter.

Relief Extended for Premium Reimbursement Programs for Student Employees

Published: November 2, 2016

On October 21, 2016, the Departments of Labor, the Treasury and Health and Human Services (collectively, the "Departments") issued FAQ 33, providing an indefinite extension of the enforcement relief available to colleges and universities for certain premium reduction arrangements offered in connection with student health plans. In February 2016, the Departments had announced a one-year non-enforcement period in the event a premium reduction arrangement is an impermissible Employer Payment Plan ("EPP"). This relief was limited to a plan or policy year that begins before January 1, 2017.

The Departments will not assert that a premium reduction arrangement offered by an institution of higher education fails to comply with the Affordable Care Act ("ACA") prohibition on annual dollar limits and preventive care mandate. Colleges and universities that offer students working for the school premium reduction programs, which may pay for some, or all, of the costs of individual student health insurance coverage (insured or self-insured) may continue to offer such program until (and unless) there is further guidance.

Following is a more detailed summary of the issue.

The Issue

Student health insurance is a type of individual health coverage that is generally offered to students and their dependents by an institution of higher learning (e.g., college or university). This coverage can be insured or self-insured.

Some students, typically graduate students, receive reduced cost (or no cost) student health insurance coverage as part of their student packages. In many cases, these students are performing services for the school (such as teaching or research) in connection with those packages. For these students, the bill they receive from the school for their health insurance coverage may take into account the premium reduction.

Generally, employers are prohibited from paying for (or reimbursing) an employee's individual health insurance policy. As student health insurance is considered to be individual coverage, there is concern that these premium

reduction arrangements, in some circumstances, might be considered employer-sponsored group health plan coverage and, as a result, might be viewed as prohibited EPPs.

In many cases when the college or university offers a premium reduction arrangement to its students, the payment will not constitute an EPP (i.e., where the student is not an employee of the college or university).

However, in cases where the student is an employee of the school, such an arrangement may constitute an impermissible EPP. For example, if a university pays for a student-employee's student health insurance coverage as part of the student's employment as a research assistant for the university; this may be an impermissible EPP.

Employer Action

No specific action items at this time. Educational organizations that employ student employees should continue to monitor guidance in this area.

Updates Regarding the NJ Small Employer Health Benefits Program

Published: November 7, 2016

The New Jersey Small Employer Health Board recently met and re-adopted the NJ small group regulations (which sunset every 7 years), with certain changes and/or clarifications. These regulations will be effective for new and renewal business as of January 1, 2017. Briefly, the re-adopted regulations:

Remove the state definition of a small employer and require use of the federal small employer definition.

Clarify that an employer must have at least one common law employee enrolled to qualify as a group.

Clarify that a C corporation owner is not a common law employee.

Below you will find additional information about the significant changes and clarifications in the regulations.

Small Employer Defined

The "A" definition (the state definition) of a small employer has been eliminated. Beginning January 1, 2017, we will only see the federal definition which was the "B" definition. Under the federal definition, a small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. As a result of using the "B" definition, part-time employees will be included in the count for defining the group as small or large, which may result in some small groups now being considered to be large groups.

A new annual certification form will be issued taking into account the new definition. Insurance carriers are required to resend the new approved NJ annual certification form to everyone that may have received the old form. In the event an employer already completed the old certification form for a January or February renewal and utilized the "A" definition of small employer, they must complete the new certification form which only allows the federal definition.

Insurance carriers will be given until April 1, 2017 to provide new policy forms with all the new re-adoption changes for all new and renewal business. In the interim, the carriers are allowed to issue a Compliance and Variability Rider to new policyholders.

The employer application has also been updated as follows:

Question 14 (Waiting period) may have been changed by some of the carriers. They may now include check boxes (Ex .The ☐ 1st or ☐ 15th of the month following the waiting period of ☐ 0 Days ☐ 30 Days ☐ 60 Days ☐ exactly 90 Days). They might separate New or Rehire Employees.

Question 16 – What percentage of the total premium will the employer pay?

The final NJ annual certification forms and employer application are posted at:

www.state.nj.us/dobi/division_insurance/ihcseh/index.html

Who is an Employee?

For purposes of small employers in New Jersey, "employee" means a common law employee of the policyholder. An individual and his or her legal spouse when the business is owned by the individual or by the individual and his or her legal spouse, partners in a partnership, two percent shareholders in a Subchapter S corporation, sole proprietors and independent contractors are not employees of the Policyholder.

An employer must have one common law employee covered to have a Small Employer plan.

Other Changes

Small Group – out of network reimbursements

The PHCS database is used for out of network reimbursements and hasn't been updated since 2010. Recognizing this, the Board has stated that, effective for new business and renewals beginning January 1, 2017, carriers are permitted to use other databases (such as Fair Health and Medicare) to determine reimbursements.

The Board requires transparency and consumers must be able to find the allowed charged information. By allowing carrier to choose the reimbursement method, it is likely that this will result in potentially higher balance billing to consumers, especially with regard to specialists.

SEH Program Buyer's Guide

The New Jersey DOBI website has been updated with 2017 rates and a preliminary 2017 version of the Buyer's Guide. See:

http://www.state.nj.us/dobi/division_insurance/ihcseh/shop_seh.htm

and

http://www.state.nj.us/dobi/division_insurance/ihcseh/whichindividualplanbest/whichplan.html

For more information, see Advisory Bulletin 16-SEH-02 with the Compliance and Variability Rider at:

http://www.nj.gov/dobi/division_insurance/ihcseh/bulletins/seh16_02.pdf

Also, see the proposal and adoption at:

http://www.state.nj.us/dobi/division_insurance/ihcseh/sehrulesadoptions.htm

http://www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html

Election Results and the ACA:

Preliminary Thoughts

Published: November 10, 2016

With the outcome of the 2016 elections now official, the Republicans will hold the majority in both chambers of Congress and control of the White House beginning in 2017. Since President-elect Trump ran on a platform of "Replace and Repeal" of the Affordable Care Act (ACA), we anticipate that acting on this campaign promise will be one of the top priorities of the new Trump administration. We anticipate there will be significant disruption for individuals, employers, brokers and carriers across the country.

Republicans will likely need to use the process of Budget Reconciliation to pass legislation through the Senate, given the party did not secure enough seats to control a filibuster-proof supermajority. In other words, the legislation can pass in the Senate with a simple majority vote and not a super majority (which requires 60 votes). Reconciliation can be used to take away some, but not all, of the ACA. It is anticipated that certain provisions of the ACA would be targeted such as Medicaid expansion, the availability of subsidies and premium tax credits in the Marketplace, and the employer and individual mandate. It cannot be used to remove non-budgetary provisions (for example, insurance mandates like "to age 26"). In addition, it is conceivable that a Trump administration may simply direct various federal agencies (such as the Department of Labor) to not enforce certain ACA provisions.

The Republicans have not laid out a specific plan on what will replace the ACA. Generally, the party has supported the existing employer-based system (with some party members calling for limits on the tax exclusion). Based on published white papers on the President-elect Trump's website, other aspects of a healthcare overhaul plan may include:

- Tax credits for purchasing individual health insurance;
- Expansion of Health Savings Accounts and High Deductible Health Plans;
- Continuation of the prohibition on pre-existing condition exclusions from health insurance;
- High risk pools;
- Interstate sales of insurance; and
- Medical malpractice reform.

The process to repeal and replace the ACA will take time and nothing will happen between now and the New Year. Open enrollment is currently underway in the Marketplaces across the country and it is expected that individual policies (and subsidies for lower and middle-income individuals) will be available to enrollees as of January 1, 2017. What is unknown is whether the Trump administration and subsequent legislation will affect the Marketplace and subsidies in mid-2017 or instead phase out this coverage after the 2017 calendar year.

Right now it is too early to tell how all of this will play out. However, for employers preparing for their 2017 plan year renewals, nothing has changed. Employers should be prepared to comply with the various requirements including:

- The employer mandate (for applicable large employers);
- Form 1094-C and 1095-C reporting for Calendar Year 2016;
- Any ACA taxes and fees for self-funded plans to pay directly (such as reinsurance fees); and
- Plan design changes applicable to plan years that begin on or after January 1, 2017.

In addition, all other federal law mandates impacting employer health and welfare plans such as ERISA, HIPAA, COBRA, Code Section 125, the Mental Health Parity and Addiction Equity Act, and the Service Contract Act / Davis Bacon and Related Acts are still good law. There has been no indication that these non-ACA laws are targeted for repeal or replacement.

We are carefully following these political developments and will keep you updated on next steps.

Extension of Deadline for 2016 Forms 1095-C

Published: November 21, 2016

On November 18, 2016, the IRS issued Notice 2016-70 which provides a limited extension of time for employers to provide 2016 Forms 1095-C to individuals. It also extends good-faith transition relief from certain penalties for the 2016 reporting year.

Q1: What Was Extended?

2016 Forms 1095-C statements must be furnished to individuals by March 2, 2017 (rather than January 31, 2017).

This extension of time also applies to carriers providing Forms 1095-B to individuals in insured plans.

Q2: Were The Deadlines For Reporting To The IRS Extended?

No.

The 2016 Form 1094-C and all supporting Forms 1095-C (collectively, “the return”) is due to the IRS by March 31, 2017 if filing electronically (or February 28, 2017 if filing by paper). These deadlines **were not extended** as part of the relief announced in Notice 2016-70. Per the Notice, the government determined there was no similar need for additional time for employers to file these Forms with the IRS.

As a reminder, employers that file at least 250 Forms 1095-C must file electronically. The IRS encourages all filers to submit returns electronically.

Q3: Is There Penalty Relief?

Yes

Notice 2016-70 extends transition relief from penalties to reporting entities that have made good-faith efforts to comply with the information reporting requirements for the 2016 reporting year, both for furnishing the Form 1095-C to individuals and for filing with the IRS. Specifically, this relief applies to missing or inaccurate taxpayer identification numbers and dates of birth, as well as other information required on the return or statement.

No relief is available if the reporting entity does not make a good-faith effort to comply with the regulations or for a failure to file a return or furnish a statement by the applicable due dates.

This relief does not absolve an employer from correcting an incorrect Form if so instructed by the IRS.

Q4: What If The Submissions Are Late?

Employers that do not comply with these due dates are subject to penalties. However, employers should still furnish and file the forms and the IRS will take such furnishing and filing into consideration when determining whether to abate penalties.

Q5: What If Employees Do Not Have Forms 1095-C (Or Forms 1095-B From The Carrier) Before They File Their Tax Returns?

Some taxpayers may not receive their Form 1095-C (or 1095-B from the carrier) by the time they are ready to file their personal tax return for 2016. Taxpayers do not need to wait until they receive their Form 1095-C (or 1095-B) to file their annual tax return, and may rely on other information from their employer (or carrier) for purpose of filing individual taxes. Individuals need not send this information to the IRS when filing their returns but should keep it with their tax records.

Q6: Will The IRS Offer This Relief For 2017 Reporting?

According to the Notice, the IRS does not anticipate extending this transition relief, either with respect to the due date for furnishing the Form 1095-C to individuals and good-faith relief from certain penalties, to reporting in 2017.

Adjusted PCOR Fee for Fifth Filing Year Released

Published: November 22, 2016

The Internal Revenue Service (IRS) recently released Notice 2016-64, which provides the adjusted applicable dollar amount for the fifth filing of the PCOR fee. The adjusted dollar amount for plan years ending on or after October 1, 2016 and before October 1, 2017 is $2.26.

For self-insured plans and HRAs, the PCOR fee is due by July 31st of the calendar year following the end of the applicable plan year. The fee is paid using the 2nd quarter Form 720. The next payment and filing deadline is July 31, 2017.

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2015 – January 31, 2016	$2.17/covered life/year	July 31, 2017
March 1, 2015 – February 29, 2016	$2.17/covered life/year	July 31, 2017
April 1, 2015 – March 31, 2016	$2.17/covered life/year	July 31, 2017
May 1, 2015 – April 30, 2016	$2.17/covered life/year	July 31, 2017
June 1, 2015 – May 31, 2016	$2.17/covered life/year	July 31, 2017
July 1, 2015 – June 30, 2016	$2.17/covered life/year	July 31, 2017
August 1, 2015 – July 31, 2016	$2.17/covered life/year	July 31, 2017
September 1, 2015 – August 31, 2016	$2.17/covered life/year	July 31, 2017
October 1, 2015 – September 30, 2016	$2.17/covered life/year	July 31, 2017
November 1, 2015 – October 31, 2016	$2.26/covered life/year	July 31, 2017
December 1, 2015 – November 30, 2016	$2.26/covered life/year	July 31, 2017
January 1, 2016 – December 31, 2016	$2.26/covered life/year	July 31, 2017
February 1, 2016 – January 31, 2017	$2.26/covered life/year	July 31, 2018

March 1, 2016 – February 28, 2017	$2.26/covered life/year	July 31, 2018
April 1, 2016 – March 31, 2017	$2.26/covered life/year	July 31, 2018
May 1, 2016 – April 30, 2017	$2.26/covered life/year	July 31, 2018
June 1, 2016 – May 31, 2017	$2.26/covered life/year	July 31, 2018
July 1, 2016 – June 30, 2017	$2.26/covered life/year	July 31, 2018
August 1, 2016 – July 31, 2017	$2.26/covered life/year	July 31, 2018
September 1, 2016 – August 31, 2017	$2.26/covered life/year	July 31, 2018
October 1, 2016 – September 30, 2017	$2.26/covered life/year	July 31, 2018

For plan years that are less than 12 months long, look to the plan year ending date to determine the applicable fee and due date.

For more information, see IRS Notice 2016-64,

https://www.irs.gov/pub/irs-drop/n-16-64.pdf

Beware of Phishing Email Disguised as HIPAA Privacy Audit Letter

Published: December 13, 2016

The Office of Civil Rights ("OCR") of the Department of Health and Human Services ("HHS") has posted an alert warning employers and others of a fake communication involving the OCR audit program under HIPAA. The email falsifies HHS departmental letterhead and the signature of the OCR Director and directs individuals to a non-governmental website marketing the cybersecurity services of a firm that is not associated with HHS or OCR.

This phishing email originates from the email address OSOCRAudit@hhs-gov.us and directs individuals to a URL at http://www.hhs-gov.us. This is a subtle difference from the official email address for the real HIPAA audit program, OSOCRAudit@hhs.gov. Phishing is a scam typically carried out through unsolicited email and/or websites that pose as legitimate sites and lure unsuspecting victims to provide personal and financial information.

Employers should alert their employees of this issue and take note that official communications regarding the HIPAA audit program are sent to selected auditees from the email address OSOCRAudit@hhs.gov.

If you question any communication regarding a HIPAA audit, please contact OCR at: OSOCRAudit@hhs.gov.

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