ACA, HIPAA AND FEDERAL HEALTH BENEFIT MANDATES:

Practical Q&A

The Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other federal health benefit mandates (e.g., the Mental Health Parity Act, the Newborns and Mothers Health Protection Act, and the Women's Health and Cancer Rights Act) dramatically impact the administration of self-insured health plans. This monthly column provides practical answers to administration questions and current guidance on ACA, HIPAA and other federal benefit mandates.

Attorneys John R. Hickman, Ashley Gillihan, Carolyn Smith, and Dan Taylor provide the answers in this column. Mr. Hickman is partner in charge of the Health Benefits Practice with Alston & Bird, LLP, an Atlanta, New York, Los Angeles, Charlotte and Washington, D.C. law firm. Ashley Gillihan, Carolyn Smith and Dan Taylor are members of the Health Benefits Practice. Answers are provided as general guidance on the subjects covered in the question and are not provided as legal advice to the questioner's situation. Any legal issues should be reviewed by your legal counsel to apply the law to the particular facts of your situation. Readers are encouraged to send questions by E-MAIL to Mr. Hickman at john.hickman@alston.com.

2016 Health & Welfare Compliance Highlights: A Walk Down Memory Lane[1]

As we look forward to 2017, and the potential promise it holds for HSAs, FSAs, and consumer driven health care, it's all too easy to overlook the super-hot compliance summer of 2016 and the large number of compliance issues that piled up this year. While some of these obligations may melt away (like snow on the walkway) with a new Administration, others will continue during 2017. This article provides a quick reminder chart (and checklist) of the more significant obligations that should be addressed, barring an early regulatory thaw.

Issue	Very Brief Summary	Due Date
ACA Section 1557	• Any "health program or activity" that receives HHS "financial assistance". Generally, (1) an employer's plan that receives federal funds (e.g., RDS, EGWP); (2) insurers that receive HHS funds; (3) TPAs that receive HHS funds (e.g., insurers who are TPAs); and (4) employers that provide health services and receive funds from HHS (e.g., health care providers, like hospitals). • Prohibits discrimination based on gender (e.g., categorical exclusion of services related to gender transition). • Adds accessibility requirements for those with limited English proficiency and communications with individuals with disabilities • Requires grievance procedure • Posting notice of consumer civil rights. • Post taglines in top 15 non-English languages spoken in the state in significant publications, like claim denial letters, SBCs, and COBRA notices.	**October 16, 2016** – posting required notice and including taglines (e.g., in open enrollment materials). **January 1, 2017** – health plan designs must be in compliance
OFCCP gender identity rules	• Most federal contractors must ensure their plans do not discriminate based on gender, such as by including blanket limitations on services for transgender individuals	**August 15, 2016**, but OFCCP will consider good-faith progress to update plan
PCORI Fee Payment	• Payment on covered lives due each July 31 using Form 720 • Self-insured plans/insurers	**July 31, 2016** (and due again July 31, 2017)

Issue	Very Brief Summary	Due Date
Transitional Reinsurance Fee	• Fee to fund reinsurance payments to help stabilize ACA Marketplace premiums • 2016 is last year that it applies (with payments due in 2017)	**November 15, 2016** – submit enrollment count for current calendar year, and remit second portion payment for 2015 calendar year (if paying 2015 in two installments) **January 16, 2017** – remit first portion of payment (or entire payment) for 2016 calendar year. If making two payments, first payment is $21.60 per covered life. Entire payment is $27/covered life **November 15, 2017** – if entire payment not made in full, remit second portion for 2016 calendar year ($5.40 per covered life).
ADA Wellness Program Disclosure See our article in the prior edition of this column	• EEOC requires notice to employees eligible for wellness program, even if not enrolled in benefits. • Notice must be provided before the employee provides any information in connection with a wellness program.	Effective for **2017 plan year**. However, notice must be provided before employee provides any information that will be used for 2017 wellness program. Thus, **notice might need to be sent be before 2017 (e.g., during open enrollment).**
GINA Wellness Program Consent for Spouse See our article in the prior edition of this column	• EEOC requires written consent of spouse to participate in a wellness program. • Consent must be obtained before the spouse provides any information in connection with a wellness program.	Effective for **2017 plan year**. However, consent must be obtained before spouse provides any information that will be used for 2017 wellness program. Thus, **notice might need to be sent before 2017 (e.g., during open enrollment).**

Issue	Very Brief Summary	Due Date
2016 W-2	• Beginning with 2016 tax year, all employers must give W-2 and file W-2 with SSA by January 31, 2017, regardless of whether filing electronically or on paper. Before 2016 tax year, SSA filing deadline was after employee deadline, and varied for paper vs. electronic submissions.	**January 31, 2017**
Calendar Year 2016 ACA reporting	• Applies to: - Employers with 50 or more full-time or full-time equivalent employees in controlled group - Self-insured employers and MEC insurers regardless of number of covered lives • Forms 1095-B/1095-C must usually be provided to individuals by January 31, but IRS extended to March 2, 2017 in Notice 2016-70 • No extension to file Form 1094-B; 1094-C; 1095-B; or 1095-C with IRS	**February 28, 2017** – Forms 1094-B/1095-B/1094-C/1095-C (to IRS if paper filing) **March 2, 2017** – Forms 1095-B/1095-C (to individual) **March 31, 2017** - Forms 1094-B/1095-B/1094-C/1095-C (to IRS if electronic filing)
2017 maximum out-of-pocket limit	• For 2017, $7,150 self-only/$14,300 other than self-only • New FAQ for plans that use reference based pricing	**2017 plan year**
Integrated HRAs and dependent/family reimbursements	• HRAs can only reimburse expenses of dependent family members enrolled in integrated medical plan • IRS provided transition period through start of 2017 plan year for HRAs that reimbursed family members as of 12/16/2015	**2017 plan year**
Health Flex credit contributions and Affordability	• Flex credit contributions that might be cashed out or used for non-213(d) medical benefits ignored when determining if coverage is affordable under the ACA	**2017 plan year**
Opt-out payments	• Unconditional opt-outs (e.g., not tied to enrollment in another employer's medical coverage) must be added to cost when determining if coverage is affordable under ACA. [Transition rule for CB plans].	**2017 plan year**
Health FSA contributions and carryovers	• Update COBRA notices to describe how carryovers impacts premium and that amounts carried over will be available until used or COBRA ends. • Amend plan to limit maximum carryover period, if desired	**Now** – COBRA notice **Before cafeteria plan year** – amend to limit maximum carryover, if desired

Issue	Very Brief Summary	Due Date
Mental Health and Substance Use Disorder Benefits	• New FAQ • Cannot use issuer's entire book of business to determine compliance	**In effect**
Annual Notices	• Part D disclosure to CMS • Part D notice to participants/beneficiaries • Summary Annual Report (if applicable) • Summary of Benefits and Coverage (SBC) (New Template for enrollments after 4/1/17) • Summary of Material Modifications (SMM – not required if new SPD provided) • Notice of Right to Designate a Primary Care Provider (if applicable) • CHIPRA Notice (be sure to send to all employees, including employees who are not benefit eligible) • HIPAA Privacy Notice (notice of availability required every 3 years, but suggest providing notice of availability annually so that 3 year period doesn't need to be tracked) • Women's Health and Cancer Rights Act (WHCRA) • Notice of Right to Designate a Primary Care Provider (if applicable) • ACA grandfathered plan notice (if applicable)	**In effect**

2017 Limits

HSA Contribution Limit	$3,400 self-only/$6,750 other than self-only
HDHP minimum deductibles	$1,300 self-only/$2,600 other than self-only
HDHP maximum out-of-pocket	$6,550 self-only/$13,100 other than self-only
ACA maximum out-of-pocket	$7,150 self-only/$14,300 other than self-only
Health FSA contribution limit	$2,600
HCE for 414(q) and cafeteria plan testing purposes	$120,000
Key employee compensation for cafeteria plans	$175,000
Social Security Wage Base	$127,200
Medical Mileage rate	17 cents

References

1 Steven Mindy, a senior associate in our Washington DC office assisted with this article.