FYI® In-Depth
For Your Information®

Volume 39 | Issue 143 | November 22, 2016

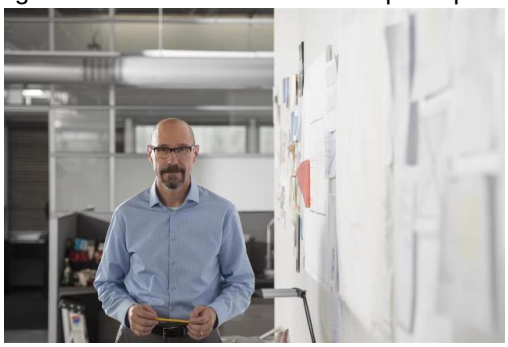
2017 Planning for Health and Welfare Benefit Plan Operations

As 2016 comes to a close, it's time to consider compliance issues for 2017. We have several resources that can help you stay on top of deadlines. The calendar below presents a schedule of activities that address important upcoming deadlines and the Complyendar, a customized calendar, can be used to help you track and anticipate compliance events. Additionally, our Reporting and Disclosure Guide identifies and addresses other activities that are event-based and participant specific. Below we highlight some issues you'll want to consider in the coming year.

In this issue: Post-Election – Stay the Course | ACA Reporting | Wellness Programs | Transitional Reinsurance Fee | PCORI Fee | Summary of Benefits and Coverage | Preventive Care | Transgender Health Coverage | Mental Health Parity | Out-of-Pocket Maximums | 2017 Benefit Limits | In Closing | Calendar of Health and Welfare Benefit Plan Compliance Tasks

Post-Election – Stay the Course

With Donald Trump elected to be our 45th president and the Republican party holding the majority of seats in both the Senate and the House of Representatives**,** we know that in 2017 legislation will be introduced and perhaps enacted to reflect the Republican party's agenda. For employer-sponsored benefits and policies, this could mean efforts to roll back many laws enacted and regulations implemented during the last eight years. Specifically, there will likely be efforts to change aspects of the Affordable Care Act (ACA), such as the 40% excise tax on "high cost" health care plans.



In the meantime, employers should prepare to communicate with employees who may be concerned about whether their employee benefits will change. Employees may wonder, for example, if their health benefits could be modified to eliminate coverage for adult children or to impose new annual or lifetime limits. Although legislative and/or regulatory changes are expected under the new administration, it is unclear what those changes will be. Employers should continue to comply with all rules that are currently in place. Employers should also prepare to re-visit their employee benefits strategies as changes in laws and regulations become clearer.

Volume 39 | Issue 143 | November 22, 2016

ACA Reporting

Employers are now familiar with the ACA information reporting obligation that applies to employers with 50 or more full-time (or full-time equivalent) employees. The IRS will use the reported information to enforce the individual and employer shared responsibility requirements, and to administer the low-income subsidies provided to eligible individuals who purchase coverage in the marketplace. (See our April 17, 2014 *FYI In-Depth*.) The IRS has issued forms and instructions for 2016 reporting and it extended (by 30 days) the deadline for furnishing the forms to employees to March 2, 2017. However, the deadline for filing the forms with the IRS has not been extended, and remains March 31, 2017 for electronic submissions (February 28, 2017, for paper filings). (See our November 21, 2016 *FYI Alert*). With this in mind, employers should gather the information and service provider support needed for this filing.

Wellness Programs

Employers and plan sponsors should ensure their wellness programs align with 2016 regulations issued under the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). Generally, a wellness program that provides an incentive in exchange for responding to disability-related inquiries, having a medical examination, or asking a spouse to provide information about his or her manifestation of disease or disorder complies with the ADA and/or GINA if it is reasonably designed, voluntary, authorized by the spouse, maintains confidentiality, and limits the amount of the incentive. (See our June 17, 2016 *FYI In-Depth*.) Both regulations require notices to inform employees; the ADA notice is new for 2017. The Equal Employment Opportunity Commission (EEOC) has also provided informal guidance addressing how these rules apply in the context of specific wellness program designs. 2017 is the ideal time for employers to review their wellness programs with trusted advisors and legal counsel in light of all wellness regulations and guidance. Plan sponsors should consider whether design changes are needed.

Transitional Reinsurance Fee

2016 is the last year for insurers and self-insured group health plan sponsors to make payments to the transitional reinsurance program, with payments due in 2017. With the goal of stabilizing premiums in the individual insurance market, the program collects contributions from insurers and plan sponsors for the 2014, 2015 and 2016 calendar years. For 2016, enrollment counts were due to CMS by November 15, 2016. Plan sponsors may pay the amount in one payment by January 17, 2017, or make two payments, the first of which is due by January 17, 2017, and the second by November 15, 2017. (See our October 13, 2016 *For Your Information*.)

PCORI Fee

Plan sponsors of self-insured group health plans will pay the Patient-Centered Outcomes Research Institute (PCORI) fee again in 2017. The fee, which helps to fund patient-centered outcomes research, applies to plan years ending after September 30, 2012, and before October 1, 2019, and is based on the average number of lives covered under the plan. The fee used to calculate the payment amount for plan years that end on or after October 1, 2016, and before October 1, 2017 (including 2016 calendar year plans), is $2.26. (See our November 8, 2016

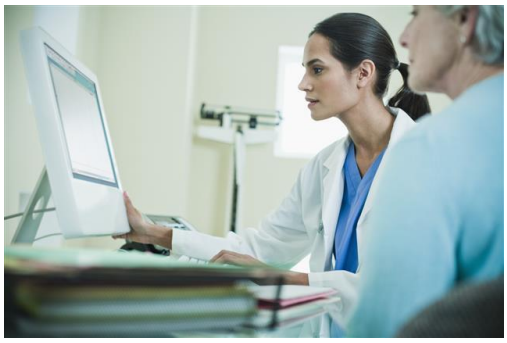
For Your Information.) Plan sponsors must pay the PCORI fee by July 31 of the calendar year immediately following the last day of that plan year.

Summary of Benefits and Coverage

The ACA requires group health plans to provide a Summary of Benefits and Coverage (SBC) to participants and beneficiaries to help them compare coverage options and understand their health benefits. Earlier this year, the departments released a final SBC template, instructions, glossary and other materials. Health plans and issuers should use the final SBC template starting with the first open enrollment period that begins on or after April 1, 2017. (See our April 21, 2016 *For Your Information*.)

Preventive Care

Non-grandfathered group health plans must cover preventive care without cost-sharing. The list of recommendations and guidelines that make up the required preventive services changes over time. As noted in the final regulations (see our August 7, 2015 *For Your Information*), when a new recommendation or guideline is added, a plan must cover it beginning with the first plan year that starts on or after the date that is one year after the recommendation or guideline goes into effect. For example, if a new preventive service coverage recommendation is adopted on August 1, 2016, a calendar year plan must begin covering this service on January 1, 2018. Plan sponsors should review the list of preventive services recommendations and guidelines to ensure their plans include the current required services for 2017.



> **Example**. In October 2016, the US Preventive Services Task Force made a final statement recommending interventions to support breastfeeding, citing the efficacy of increasing the rate and duration of the practice. This final recommendation is effective for calendar year plans beginning January 1, 2018. Previously, the departments issued FAQs discussing related health plan (including employer-sponsored group health plan) requirements. (See our December 15, 2015 *For Your Information*.) Among other things, the FAQs provide that a plan must cover in-network lactation counseling or an out-of-network provider without cost-sharing and support services and equipment for the duration of breast-feeding. Employers and plan sponsors should check plan design to ensure such coverage is properly supported under the plan. (Also, note our April 3, 2014 *FYI In-Depth* for FLSA requirements around break time and a place for nursing mothers to express milk.)

Transgender Health Coverage

ACA Section 1557 prohibits covered entities from discriminating in their health programs and activities on the basis of race, color, national origin, sex, age or disability. Covered entities include those operating health programs that receive financial assistance from the Department of Health & Human Services (HHS) — such as a hospital that accepts Medicare Part A payments or an issuer offering coverage in the marketplace. HHS final regulations clarify that although an issuer receiving federal financial assistance through participation in a marketplace must comply with

the regulations even when it is acting as a TPA for a self-funded plan, the rules do not apply to the employer sponsoring the group health plan, unless the employer is itself a covered entity. (See our May 17, 2016 *FYI Alert*.) However, HHS has stated that where a non-covered entity employer is responsible for alleged discrimination, it will refer the matter to the EEOC, which broadly interprets sex discrimination to include discrimination based on sexual orientation, transgender status and gender stereotyping. Federal courts nationwide are considering challenges to denials of coverage for transgender health services brought under both Section 1557 and Title VII. With this in mind, employers with group health plans that either limit coverage of or don't cover such services should work with legal counsel to assess their potential exposure under these laws. (See our September 7, 2016 *For Your Information*.)

Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans that offer mental health and substance use disorder benefits to cover those benefits on terms that are no more restrictive than those for medical and surgical benefits. (See our January 14, 2014 *For Your Information*.)

Earlier this year, President Obama formed the White House Mental Health and Substance Use Disorder Parity Task Force (Task Force) with the goal of developing tools, guidelines, and mechanisms to help enforce the MHPAEA. In October, the Task Force released its final report, recommending various actions designed to ensure parity in coverage, as well as a consumer guide to disclosure rights. Also, throughout the year, the departments have issued FAQs on the MHPAEA. (See our May 19, 2016 *For Your Information*.) Plan sponsors, in conjunction with trusted advisors, should use the information provided by the Task Force and the departments to ensure their plans are in compliance with MHPAEA requirements. Mental health issues, perhaps uniquely, enjoy bipartisan support on Capitol Hill. It's possible that the benefits community will see an uptick in audit activity around mental health and substance abuse services and benefits. (See our November 14, 2016 *Legislate.*)

Out-of-Pocket Maximums

The 2017 annual ACA out-of-pocket (OOP) maximums on essential health benefits for non-grandfathered group health plans are $7,150 for self-only coverage and $14,300 for coverage other than self-only. Plan sponsors can still allocate a plan's OOP limit among different coverage categories so long as the combined amounts don't exceed the annual OOP limit. (See our March 14, 2016 *For Your Information*.)

2017 Benefit Limits

The IRS issued the 2017 limits for qualified transportation fringe benefits, adoption assistance programs, long-term care premiums, health flexible spending arrangements, health savings accounts, and medical savings accounts. (See our May 2, 2016 *For Your Information* and our October 25, 2016 *FYI Alert*.) Many of the limits have changed, including the limit for health flexible spending arrangements, which increased to $2,600 for 2017. Plan sponsors should review and consider whether to update their plan documents to reflect these 2016 limits.

In Closing

Planning ahead to identify tasks and set compliance goals for the coming year is an important first step for assuring smooth operations during the year. In addition to the significant items noted above, plan sponsors may want to perform an annual "checkup" (i.e., an audit of operational practices and fiduciary responsibilities) to address plan

compliance and design considerations. Plan sponsors may conduct their own review or contract with an independent party. Regardless of who performs the review, identifying problems and initiating corrections in advance of any official governmental audit is certainly the preferred course of action.

We have published companion pieces to this *FYI In-Depth* that cover year-end planning:

2017 Planning for ERISA Single-Employer Defined Benefit Plan Operations
2017 Planning for ERISA Single-Employer Defined Contribution Plan Operations
2017 Planning for Multiemployer Plan Operations
2017 Planning for Governmental Plan Operations

Calendar of Health and Welfare Benefit Plan Compliance Tasks[1]

Action Item	Due Date
January	
Reporting of value of health coverage on Form W-2	January 31, 2017*
February	
File ACA information reporting returns with IRS (for paper filing)	February 28, 2017*
March	
DOL Form M-1 (for MEWAs)	March 1, 2017*
Disclosure of creditable/noncreditable status of prescription drug coverage to CMS	March 1, 2017
Provide ACA information reporting returns to individuals	March 2, 2017*
Last day for flexible spending accounts with 2½ month grace periods	March 15, 2017
File ACA information reporting returns with IRS (for electronic filing)	March 31, 2017*

[1] Assumes calendar plan and sponsor tax year. Does not account for weekends, extended due dates other than for Forms 5500 and 990, short plan years, or new plans. The "weekend rule," which extends due dates falling on weekends to the following Monday, generally applies to filing deadlines and certain other acts under tax rules.

Volume 39 | Issue 143 | November 22, 2016

May	
Form 990 or Form 8868 if requesting extension	May 15, 2017
July	
Summary of Material Modifications for prior year amendments	July 29, 2017
Form 720 filing and payment of PCORI fee	July 31, 2017*
Form 5500 or file Form 5558 to request an extension	July 31, 2017
August	
Form 990 (if on extension) or Form 8868 if requesting additional extension	August 15, 2017
September	
Summary Annual Report (if no extension)	September 30, 2017
October	
Provide notice of creditable/noncreditable prescription drug coverage to participants	October 14, 2017*
Form 5500 filed if on extension	October 16, 2017
November	
Form 990 (if additional 3 month extension)	November 15, 2017
December	
Summary Annual Report (if on extension)	December 15, 2017
Deadline for correcting DCAP discrimination test failures	December 31, 2017

**Date does not vary regardless of plan year*

FYI® In-Depth

Volume 39 | Issue 143 | November 22, 2016

Authors
Kimberley Mitchell, JD
Sharon Cohen, JD

Produced by the Knowledge Resource Center of Xerox HR Consulting
The Knowledge Resource Center is responsible for national multi-practice compliance consulting, analysis and publications, government relations, research, surveys, training, and knowledge management. For more information, please contact your account executive or email fyi@xerox.com.

You are welcome to distribute *FYI*® publications in their entireties. To manage your subscriptions, or to sign up to receive our mailings, visit our Subscription Center.

This publication is for information only and does not constitute legal advice; consult with legal, tax and other advisors before applying this information to your specific situation.