Subject: 1) IRS Releases Draft 2017 Forms 1094/1095 Series; 2) Summary of Benefits and Coverage Reminder; 3) Return of the Annual Health Insurer Provider Fee; 4) Update on Preventive Services; 5) Reporting QSEHRA Reimbursements; and 6) HPID Requirement Remains Suspended

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As has been covered extensively in the press, Congress went on its summer recess without repealing, replacing or modifying the Affordable Care Act. What this means for employers is that it is "business as usual", including all reporting obligations, as more fully described below.

So where does health care reform stand at this point? The answer to this question is far from clear.

One aspect of health care reform that may get some bipartisan attention relates to the reimbursement of certain cost share requirements (CSR) for low income individuals who purchase coverage through the marketplace. As background, the legality of reimbursing insurers for these CSRs of low income individuals has been challenged in court. Thus far, the matter has not been resolved and currently, these reimbursements have only been authorized on a month-by-month basis. There is indication that there may be a bipartisan effort to provide a more long term fix for this issue by passing legislation that would authorize the reimbursement of these amounts on an on-going basis to stabilize the individual market.

Another track that is being pursued involves states seeking what is referred to as a **Section 1332 waiver** from the Department of Health and Human Services (HHS). An approved HHS waiver would exempt a state from compliance with certain aspects of the ACA by proposing its own specific program and process to accomplish the basic tenants of the law.

Until further court or legislative action occurs, the Affordable Care Act remains the law of the land. That said, following are some updates to law.

IRS Releases Draft 2017 Forms 1094/1095 Series

The Internal Revenue Service issued draft 2017 forms for the annual reporting that will be due in 2018 by employers subject to the Affordable Care Act's shared responsibility requirements, as well as by plans providing minimum essential coverage (MEC):

- Form 1095-B, *Health Coverage*
- Form 1094-B, *Transmittal of Health Coverage Information Returns*
- Form 1094-C, *Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns*
- Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*

These forms are used to satisfy the IRC Section 6055 and 6056 reporting requirements. The Form 1094-B and 1095 B-series is used for reporting MEC; and the Form 1094 and 1095-C series is used for reporting employer provided coverage by employers subject to the ACA's shared responsibility requirement. It is important to note that these forms are drafts only and subject to change.

At this point, it appears that these draft forms are substantially similar to the 2016 forms, with the exception of removal of transitional relief on the Form 1094-C which is no longer available. As soon as these forms and the relevant instructions are finalized and released by the IRS, we will provide additional information.

Summary of Benefits and Coverage Reminder

The Affordable Care Act requires individual and group health plans, including grandfathered plans, whether insured or self-funded, to provide participants with a written summary of benefits and coverage (SBC) of the plan. Last year, both the Departments of Labor (DOL) and Health and Human Services (HHS) modified the model SBC templates, the uniform glossary, and related materials that can be used by plan sponsors and insurers. The revised SBC template is to be used beginning on the first day of the first open enrollment period that begins on or after April 1, 2017 relating to coverage for plan years beginning on or after that date. For calendar year plans, this means January 1, 2018. For plans and insurers that do not use an annual open enrollment period, the revised SBC template is to be used beginning on the first day of the first plan year that begins on or after April 1, 2017.

As a reminder, there are five occurrences of providing the SBC to plan participants:

1. Upon application;
2. By the first day of coverage;
3. Within 90 days of enrollment by special enrollees;
4. Upon contract renewal; and
5. Upon request.

The English version of the model summary of benefits and coverage template to be used on or after April 1, 2017 is available from the **DOL's website** in both pdf and word formats. The model **Uniform Glossary of Coverage and Medical Terms** is also available. The Chinese, Navajo, Spanish and Tagalog versions are available from the Center for Consumer Information and Insurance Oversight's **website**.

Return of the Annual Health Insurer Provider Fee

The Affordable Care Act imposes an annual fee upon "covered entities", such as insurers who engage in providing health insurance for U. S. health risks. The assessed fees are apportioned amongst all applicable covered entities (insurers) based on a ratio of net premiums for insuring U. S. risks during the preceding calendar year as compared to the aggregate net premiums for that same year. The fee is assessed when net premiums covering US risks exceed $25 million for the previous year.

The *Consolidated Appropriations Act of 2016* and *Protecting Americans from Tax Hikes Act of 2015* enacted on December 18, 2015, placed a one-year moratorium for the annual fee paid by insurers for 2017 (see HRB 116, *Year-end Wrap Up*, 12/29/15). This means that the fee will re-commence beginning January 1, 2018.

Although employers are not subject to these fees, the covered entity/insurer may pass along some of these costs to employer/policyholders; thus, employers with insured plans may begin seeing this fee reflected in their renewals. Notably, the IRS considers the fee to be part of the insurer's cost of doing business and does not permit any exemption or exclusion from gross income it pays to offset the fees.

Update on Preventive Services

The Affordable Care Act requires health plans to cover certain preventive services, without imposing any cost-sharing requirements (co-pay, co-insurance, or deductible), when such services are delivered by in-network providers. The types of covered preventive services, some of which are recommended by the U. S. Preventive Services Task Force (USPSTF), are updated periodically.

Following are some recently released recommended preventive services. Generally, compliance with USPSTIF recommendations becomes applicable as of the first plan year beginning one year following issuance of the recommendation.

- *Behavioral Counseling: Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults Without Known Risk Factors*. When recommended by the attending primary care physician, non-obese adults without hypertension, dyslipidemia, abnormal blood glucose levels, or diabetes must be offered behavioral counseling for purposes of promoting a healthful diet and physical activity. Release date of recommendation: July 2017.
- *Obesity screening: children and adolescents.* The USPSTF recommends that clinicians screen for obesity in children and adolescents aged 6 years and older, as well as offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status. Release date of recommendation: June 2017.
- *Folic acid supplement*. The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement of folic acid of approved strength. Release date of recommendation: January 2017.
- *Statin preventive medication.* The USPSTF recommends that adults with no history of cardiovascular disease (CVD) to use a low- to moderate-dose statin for the prevention of CVD events when criteria are met. Release date of recommendation: November 2016.

A complete list of ACA-required preventive services can be accessed from the **USPSTF website**, as well and the **Healthcare.gov website**.

Reporting QSEHRA Reimbursements

The *21st Century Cures Act*, enacted on December 13, 2016, re-establishes the ability for certain small employers to provide their employees a stand-alone HRA, known as a "qualified small employer HRA" or "QSEHRA". In order to establish a QSEHRA, the employer must provide no other health coverage. The QSEHRA can be used to reimburse health insurance premium for individual coverage purchased either through or outside the marketplace. As is true for all health reimbursement arrangements, the plan can only be funded with employer dollars. See HRB 124, *Qualified Health Plans and Year-End Reminders* (12/14/16) for additional background information about QSEHRAs.

There are two reporting and disclosure obligations for a QSEHRA. One of them is a Form W-2 reporting obligation. An employee's total permitted benefits received under a QSEHRA must be reported on the Form W-2, after the employees provide proof of coverage. The IRS has added a new Code FF for Box 12 of the Form W-2 to report the total amount of permitted benefits under a QSEHRA. The maximum reimbursement for an eligible employee under a QSEHRA is $4,950 ($10,000 if it also provides reimbursements for family members), before indexing for inflation.

It should also be noted that the IRS recently released the draft Form 8962, *Premium Tax Credit*. This form is used by individuals when filing their Form 1040 to calculate the amount of premium tax credit received during the tax year, as well as for purposes of reconciling the advanced payment of the premium tax credit. The draft Form 8962 has been updated to reflect amounts individuals may receive from a QSEHRA. Specifically, if the individual was covered under a QSEHRA, then the employer would have reported the annual permitted benefit on the individual's Form W-2. According to the instructions, if the QSEHRA is deemed affordable for a month, then no premium tax credit would be allowed for the

month. If the QSEHRA is deemed unaffordable for a month, then the individual must reduce the monthly premium tax credit by the monthly permitted benefit amount, and then write "QSEHRA" in the top margin on page 1 of Form 8962 to explain the entry.

HPID Requirement Remains Suspended

The HIPAA Administrative Simplification Rules set forth standards relating to privacy, electronic transactions and security of medical information. A portion of the electronic transaction rules require implementation standards for purposes of streamlining the payment of claims. Specifically, the law requires insured and self-funded health plans to obtain a health plan identifier (HPID).

The Affordable Care Act (ACA) subsequently amended the HIPAA electronic transaction rules to require plans to obtain an HPID for purposes of streamlining claim payments. In addition, plans with an HPID were required to certify its compliance with the electronic transaction standards and operating procedures as it relates to eligibility for health plan transactions, health care claim status transactions, health care electronic funds transfers and remittance advice transactions.

However, on October 31, 2014, the Health and Human Services (HHS) suspended the use of the HPID as well as the certification requirement, due to questions raised by its advisory board about the efficacy of the use of these unique identifiers.

The HHS advisory board conducted a follow-up hearing on the matter on May 3, 2017 and based on testimony it received, it reiterated its former recommendations to rescind the HPID requirement imposed by HIPAA altogether. The board suggested other uses for the HPID for identification of health plans in the federal and state marketplaces, or for the ACA-imposed health plan certification requirement. Nonetheless, health plans should stay tuned in the event future guidance is issued.

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