2016 ACA TRANSITIONAL REINSURANCE PROGRAM CONTRIBUTIONS FORM DUE BY NOVEMBER 15

NEW FEDERAL OVERTIME RULE EFFECTIVE DECEMBER 1

NEW EXPIRATION DATE FOR MODEL CHIP NOTICE

HHS PENALTIES INCREASE

HEALTHCARE ALERT

2016 ACA Transitional Reinsurance Program Contributions Form Due by November 15

Employers sponsoring certain self-insured plans that use a third-party administrator in connection with claims processing, claims adjudication, and enrollment functions ("contributing entities") **must submit their 2016 Annual Enrollment and Contributions Submission Form and schedule a payment for the 2015 benefit year no later than November 15.**

The 2016 reinsurance contribution rate is **$27.00 per covered life**

Reinsurance Contribution Process
To successfully complete the reinsurance contribution process, contributing entities (or third-party administrators or administrative services-only contractors on their behalf) must register on Pay.gov (or confirm a password if such entities registered for the previous benefit years of the program) and submit their annual enrollment counts of the number of covered lives of reinsurance contribution enrollees for the 2016 benefit year using the 2016 form.

2016 Contribution Amounts
The 2016 reinsurance contribution rate is **$27.00 per covered life**. For the 2016 benefit year, contributing entities have the option to pay:

- The entire 2016 benefit year contribution in one payment, no later than **January 17, 2017** reflecting **$27.00 per covered life**; or
- In two separate payments for the 2016 benefit year, with the first remittance due by **January 17, 2017** reflecting **$21.60 per covered life**, and the second remittance due by **November 15, 2017**, reflecting **$5.40 per covered life**.

New Federal Overtime Rule Effective December 1

Effective **December 1**, a new rule updates the regulations governing which executive, administrative, professional, and highly compensated employees are entitled to the minimum wage and overtime pay protections of the federal Fair Labor Standards Act (FLSA).

Current Rules
The current federal rules provide an **exemption** from both the **minimum wage** and **overtime pay** requirements of the FLSA for bona fide executive, administrative, and professional employees who meet certain tests regarding their job duties and who are paid on a salary basis at not less than $455 per week ($23,660 per year). "Highly compensated employees" (HCEs) who are paid total annual compensation of $100,000 or more and meet certain other conditions are also deemed exempt.

The new rule updates the salary and compensation levels needed for executive, administrative, professional, and highly compensated employees to be exempt.

New Rule
The new rule updates the salary and compensation levels needed for executive, administrative, professional, and highly compensated employees to be exempt. In particular, the final rule:

- Raises the salary threshold from $455 a week to **$913 per week (or $47,476 annually)** for a full-year worker;
- Increases the HCE total annual compensation level to **$134,004 annually**;
- Amends the regulations to allow employers to use **nondiscretionary bonuses, incentives, and commissions** to satisfy up to **10%** of the new standard salary level, so long as employers pay those amounts on a quarterly or more frequent basis; and
- Establishes a mechanism for automatically updating the salary and compensation levels **every 3 years**, beginning on **January 1, 2020**.

Note: When both the FLSA and a state law apply, the employee is entitled to the most favorable provisions of each law.

HHS Penalties Increase

On September 6, 2016, the Department of Health and Human Services ("HHS") issued an interim final regulation that adjusts civil penalties for inflation. The interim final regulation does not follow the usual procedures that offer a notice and comment period. As such, a Notice of Proposed Rulemaking has not been issued and a comment period is not provided due to potential delay in the applicability of the regulation.

The adjusted penalties are applicable to penalties assessed after August 1, 2016, whose associated violations occurred after November 2, 2015.

The following chart contains updated penalties applicable to group health plans only:

Description	Current Penalty	Updated Penalty
Pre-February 18, 2009 violation of HIPAA administrative simplification provisions	$100 per violation $37,561 annual cap	$150 per violation $37,561 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision without knowledge	$100 minimum $50,000 maximum $1,500,000 annual cap	$110 minimum $55,010 maximum $1,650,300 annual cap

February 18, 2009 or later violation of HIPAA administrative simplification provision with reasonable cause and not to willful neglect	$1,000 minimum $50,000 maximum $1,500,000 annual cap	$1,100 minimum $55,010 maximum $1,650,300 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect **AND** corrected during 30-day period	$10,000 minimum $50,000 maximum $1,500,000 annual cap	$11,002 minimum $55,010 maximum $1,650,300 annual cap
February 18, 2009 or later violation of HIPAA administrative simplification provision due to willful neglect **AND NOT** corrected during 30-day period	$50,000 minimum $1,500,000 maximum $1,500,000 annual cap	$50,000 minimum $1,500,000 maximum $1,500,000 annual cap
Failure to provide the Summary of Benefits and Coverage	$1,000 per day	$1,087 per day
Penalty for an employer or other entity to offer financial or other incentive to individual entitled to Medicare/Medicaid benefits not to enroll under a group health plan that would be primary	$5,000	$8,908
Penalty for entity serving as insurer, TPA, or fiduciary for a group health plan that fails to provide information to HHS Secretary identifying when the GHP was primary payer to Medicare	$1,000	$1,138

Employer Action
Covered entities subject to the HIPAA regulation must ensure proper application and compliance with HIPAA's privacy and security requirements. Furthermore, employers with a large Medicaid/Medicare employee eligible population should be cautious not to offer incentives not to enroll in the employer's health plan. Finally, employers should be aware of the Summary of Benefits and Coverage disclosure requirement and ensure that employees receive SBCs in a timely fashion (e.g. Open Enrollment).

New Expiration Date for Model CHIP Notice is November 30, 2016

Model Notice Previously Set to Expire on October 31, 2016
The US Department of Labor has extended the effective date of its model Employer Children's Health Insurance Program (CHIP) Notice through **November 30, 2016**. Previously, this model notice was set to expire on October 31, 2016.

Annual Notice Requirement
Employers that provide coverage in states with premium assistance through Medicaid or CHIP must inform employees of potential opportunities for assistance in obtaining health coverage. Employers can satisfy this requirement by providing a notice annually before the start of each plan year.

An employer may provide the notice **applicable to the state in which an employee resides** concurrent with the furnishing of:

- Materials notifying the employee of health plan eligibility;
- Materials provided to the employee in connection with an open season or open election process conducted under the plan; or
- The summary plan description

The model notice includes information on how employees can contact their state for additional information and how to apply for premium assistance, with information current as of **July 31, 2016**.

Forms 1095-C Due to Full-Time Employees by January 31, 2017

Under the Affordable Care Act, applicable large employers (ALEs) - generally those with **at least 50 full-time employees**, including full-time equivalent employees, in the preceding calendar year - must report certain information to their full-time employees and the Internal Revenue Service (IRS) about the health care coverage they have offered

(if any). With deadlines for 2016 reporting just a few months away, ALEs should begin thinking about these five information reporting facts:

1. ALEs are required to furnish a statement (Form 1095-C) to each of their full-time employees by **January 31, 2017.**
2. ALEs must file Forms 1095-C, accompanied by the transmittal Form 1094-C, with the IRS no later than **February 28, 2017** (or March 31, 2017, if filing electronically).
3. Self-insured ALEs must also report via Forms 1094-C and 1095-C.
4. ALEs that file **250 or more information returns** during the calendar year must file the returns electronically.
5. ALEs can find a complete list of resources and the latest news at the IRS's Applicable Large Employer Information Center.

For further details on filing and furnishing Forms 1094-C and 1095-C, please see the 2016 instructions.

Understanding the ACA's 90-Day Waiting Period Limitation

The Affordable Care Act (ACA) limits waiting periods applied by group health plans to **90 days** after an employee is otherwise eligible for coverage. The discussion below is intended to help employers understand this limitation - however, please keep in mind that compliance with the waiting period rules is **not determinative of compliance with other ACA provisions** (such as pay or play).

"Waiting Period" Defined
A waiting period is the period of time that must pass before coverage for an employee or dependent who is **otherwise eligible to enroll** under the terms of a group health plan can become effective. Being "otherwise eligible" for coverage means having met the plan's substantive eligibility requirements (such as, for example, being in an eligible job classification or satisfying a reasonable and bona fide employment-based orientation period).

90-Day Waiting Period Limit
After an individual is determined to be otherwise eligible for coverage, he or she cannot wait more than 90 days before coverage is effective. **All calendar days** are counted for purposes of the 90-day limit, **including weekends and holidays**, beginning on the individual's enrollment date. For example, if a group health plan provides that full-time employees are eligible for coverage and Employee A begins employment as a full-time employee on January 19, Employee A's coverage must become effective no later than April 19 (assuming February lasts 28 days).

Eligibility Conditions
Conditions for eligibility under the terms of a group health plan are generally permissible, unless the condition is designed to avoid compliance with the 90-day waiting period limitation. Federal regulations provide the following guidelines regarding two specific conditions for eligibility:

- **Cumulative Service Requirements**: If a group health plan conditions eligibility on an employee's having completed a number of cumulative hours of service, the eligibility condition is not considered to be designed to avoid compliance with the 90-day waiting period limitation if the cumulative hours-of-service requirement **does not exceed 1,200 hours**.
- **Orientation Periods**: An orientation period is permitted only if it **does not exceed one month**, and the 90-day waiting period must begin on the first day after such orientation period. (Note: applicable large employers may not be able to impose the full one-month orientation period and the full 90-day waiting period without potentially becoming subject to pay or play penalties).
  - For this purpose, one month is determined by adding one calendar month and subtracting one calendar day, measured from an employee's start date in a position that is otherwise eligible for coverage (or, if there is not a corresponding date in the next calendar month, the last day of the next calendar month). For example, if an employee's start date in an otherwise eligible position is May 3, the last permitted day of the orientation period is June 2.

Be sure to check the US Department of Labor's 90-day waiting period limitation webpage for the latest guidance.

DOL Releases New Online Tool to Help Employers Understand Medical- and Disability-Related Leave

New Resource Now Available
The US Department of Labor (DOL) has unveiled a new online tool to help employers (and employees) understand the leave that employees may be entitled to take for purposes of managing medical conditions and disabilities.

The new **Medical- and Disability-Related Leave Advisor** asks users a few questions, such as type of business or organization, workforce size, and if the entity receives federal financial assistance. With that information, the advisor quickly directs users to federal employment laws that apply and provides additional information.

These laws include the federal Family and Medical Leave Act which provides eligible employees of covered employers up to 12 work weeks of leave in a 12-month period for certain reasons, among them the employee's own serious health condition; and the federal Americans with Disabilities Act and other disability nondiscrimination laws, under which leave may be considered a reasonable accommodation.

The leave advisor is one of a series of elaws Advisors (Employment Laws Assistance for Workers and Small Businesses) that the DOL provides to help employers and employees understand their rights and responsibilities under federal employment laws.

Click here to access the new Medical- and Disability-Related Leave Advisor.

Note: Employers may also be subject to state and local medical- and disability-related leave laws.

Applicable Dollar Amount Used to Determine PCORI Fee Adjusted to $2.26

Increase Applies to Plan Years Ending On or After October 1, 2016 and Before October 1, 2017
The Internal Revenue Service (IRS) recently issued guidance that increases the applicable dollar amount used to determine the Patient-Centered Outcomes Research Institute (PCORI) fee, for plan years that end on or after October 1, 2016 and before October 1, 2017.

Background
PCORI fees are imposed on plan sponsors of applicable self-insured health plans for each plan year ending on or after October 1, 2012 and before October 1, 2019. The fees support research to evaluate and compare health outcomes and the clinical effectiveness of certain medical treatments, services, procedures, and drugs.

For plan years ending on or after October 1, 2015 and before October 1, 2016, the fee for an employer sponsoring an applicable self-insured plan was $2.17 multiplied by the average number of lives covered under the plan. Details on how to determine the average number of lives covered under a plan, as well as various examples, are included in final regulations.

Fee Increase
Pursuant to IRS Notice 2016-64, **for plan years ending on or after October 1, 2016 and before October 1, 2017, the fee is $2.26** (multiplied by the average number of lives covered under the plan).

For plan years ending on or after October 1, 2017 and before October 1, 2019, the fee will be further adjusted to reflect inflation.