CBP
creative benefit plans

Compliance Compilation

For January through December of 2015

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JANUARY

Published on January 9, 2015

Proposed Rules Issued Regarding Wraparound Coverage

On December 19, 2014, the Departments of Labor, the Internal Revenue Service and Health and Human Services issued a proposed rule that provides helpful guidance with respect to certain wraparound programs. The concept of the wraparound coverage excepted benefit was first introduced in a proposed rule issued December 24, 2013. According to the DOL, these proposed rules would give employees who otherwise may not be able to get generous employerbased benefits access to high level benefits and would give businesses, including small businesses, new flexibility to meet the unique needs of their workforce.

Background

As background, an employer cannot offer employees cash to reimburse the purchase of an individual policy, whether the employer treats the money as pre-tax or post-tax to the employee. Such arrangements are subject to the market reform provisions of the Affordable Care Act, including prohibition on annual limits and the requirement to provide certain preventive services without cost sharing with which it cannot comply. Such an arrangement may be subject to a $100/day excise tax per applicable employee (which is $36,500 per year, per employee).

Limited Wraparound Coverage

"Limited wraparound coverage" is limited benefits provided through a group health plan that wrap around either "eligible individual health insurance" or coverage under a Multi-State Plan. "Eligible individual health insurance" is individual health insurance coverage that is not a grandfathered health plan, not a transitional individual health insurance market plan, and does not consist solely of excepted benefits (which include certain dental and vision plans, health FSAs, and HRAs). To qualify as excepted benefits, the limited benefits must meet all of the following requirements:

1. **Cover additional benefits.** The limited wraparound coverage provides meaningful benefits beyond coverage of cost sharing under either the eligible individual health insurance or Multi-State Plan coverage. The wraparound coverage must not provide benefits only under a coordination-of-benefits provision and must not merely be an account-based reimbursement arrangement. 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.
2. **Limited in amount.** The annual cost of coverage per employee (and any covered dependents) under the limited wraparound coverage does not exceed the indexed maximum annual salary reduction contributions toward health FSAs ($2,550 for 2015). For this purpose, the cost of coverage includes both employer and employee contributions towards coverage and is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.
3. **No discrimination.** The limited wraparound coverage (a) does not impose any preexisting condition exclusion; (b) does not discriminate against individuals in eligibility, benefits or premiums based on any health factor of an individual; and (c) does not, nor does any other group health plan coverage offered by the plan sponsor, discriminate in favor of highly compensated individuals.
4. **Plan eligibility.** Individuals eligible for the wraparound coverage cannot be enrolled in excepted benefit coverage that is a health FSA.
5. **Reporting.** The plan sponsor of a group health plan offering wraparound coverage must report to HHS, in a form and manner specified in guidance, information HHS reasonably requires.

When Can Limited Wraparound Coverage be Offered?

The provisions apply to limited wraparound coverage that is first offered no later than December 31, 2017 and that ends on the later of:

- The date that is three years after the date wraparound coverage is first offered; or
- The date on which the last collective bargaining agreement relating to the plan terminates after the date wraparound coverage is first offered (determined without regard to any extension agreed to after the date wraparound coverage is first offered).

Under What Circumstances can Limited Wraparound Coverage be Offered?

Wraparound benefits offered in conjunction with eligible individual health insurance must satisfy all of the following requirements:

- Eligibility for the wraparound coverage is limited to employees who are not full-time employees ("FTEs") and their dependents, including retirees and their dependents.
- For each year for which wraparound coverage is offered, the employer that is the sponsor of the plan offering wraparound coverage, or the employer participating in a plan offering wraparound coverage, offers to its FTEs coverage that is substantially similar to coverage that the employer would need to offer to its FTEs in order not to be subject to a potential assessable payment under the employer penalty, if such provisions were applicable; provides minimum value; and is reasonably expected to be affordable (applying the safe harbor rules). If a plan or issuer providing limited wraparound coverage takes reasonable steps to ensure that employers disclose to the plan or issuer necessary information regarding their coverage offered and affordability information, the plan or issuer is permitted to rely on reasonable representations by employers regarding this information, unless the plan or issuer has specific knowledge to the contrary.
- Other group health plan coverage, not limited to excepted benefits, is offered to the individuals eligible for the wraparound coverage. Only individuals eligible for the other group health plan coverage are eligible for the wraparound coverage.

Limited wraparound coverage offered in conjunction with Multi-State Plan coverage must satisfy all of the following conditions:

- The limited wraparound coverage is specifically designed and approved by the Office of Personnel Management ("OPM") to provide benefits in conjunction with coverage under a Multi-State Plan.
- The employer has offered coverage in the plan year that begins in 2014 that is substantially similar to coverage that the employer would need to have offered to its FTEs in order to not be subject to an assessable payment under the employer penalty provisions, if such provisions had been applicable.
- In the plan year that begins in 2014, the employer has offered coverage to a substantial portion of FTEs that provided minimum value and was affordable (applying the safe harbor rules).
- The employer's annual aggregate contributions for both primary and wraparound coverage are substantially the same as the employer's total contributions for coverage offered to FTEs in 2014.
- A self-funded plan, or a health insurance issuer, offering or proposing to offer Multi-State Plan wraparound coverage reports to the OPM, in a form and manner specified in guidance, information OPM reasonably requires to determine whether the plan or issuer qualifies to offer such coverage or complies with the applicable requirements.

Published on January 9, 2015

ACA Impact on Expatriate Plans Eased

On December 16, 2014, as part of the Consolidated and Further Continuing Appropriations Act, 2015, President Obama signed into law amendments to the Affordable Care Act ("ACA") that largely exempt expatriate plans from most ACA compliance requirements. While federal regulators had allowed expatriate plans certain transition relief on an ad-hoc basis for various ACA requirements, the regulatory approach was piecemeal and temporary, while leaving many compliance issues unresolved. The new legislation significantly clarifies the ACA requirements applicable to expatriate plans. While it is too soon to expect regulatory guidance, the legislation is surprisingly detailed and is the first significant legislative change to the ACA since the law was passed in 2010.

The new provisions are applicable to expatriate health plans issued or renewed after July 1, 2015, except for the health insurance fee, as noted below.

Expatriate plans are defined as self-funded and fully insured plans that offer coverage to qualified expatriates and their dependents. Qualified expatriates are: (1) certain foreign employees transferred or assigned to the U.S. for a specific and temporary employment purpose or assignment, (2) individuals working outside the U.S. for at least 180 days in a 12-month period, and (3) individuals who are members of certain groups, such as students or religious missionaries.

The new law:

- Exempts fully insured and self-funded expatriate health plans from most of the ACA's market reforms (though not the adult dependent/age 26 requirement).

- Deems expatriate health plans to be "minimum essential coverage" for expatriate employees and their dependents, regardless of where they are located in the world.

- Deems expatriate health plans to be "minimum essential coverage under an eligible employersponsored plan" for purposes of the employer mandate with respect to certain foreign employees working in the U.S. and certain U.S. expatriates working abroad, but does not exempt employers that provide or purchase these plans from other employer mandate requirements including reporting responsibilities.

- Exempts expatriate plans from the health insurance fee (after 2015) (transition rules for 2014 and 2015), the transitional reinsurance program fee, and the PCORI fee.
- Exempts employer-sponsored coverage owf most categories of expatriates from the excise tax on high cost employer-sponsored health coverage.
- Exempts expatriate health plans from a change in the definition of a "small group," which could have prevented the sale of expatriate coverage to employers with 50 to 99 lives.
- Exempts insurers of expatriate health plans and expatriate health plans from the so-called "administrative simplification" requirements, including SBC requirements.

Plan sponsors of expatriate plans should review their plan design carefully to ensure they are in compliance with certain provisions of the ACA still applicable to such plans, including employer shared responsibility and its associates reporting/disclosure rules, certain fees and adult-child age 26 mandates.

Published on January 23, 2015

Proposed Regulations on Summary of Benefits and Coverage

On December 22, 2014, the Departments of Labor, the Internal Revenue Service and Health and Human Services issued proposed regulations and supporting documents addressing the SBC requirement. The majority of the proposed regulations incorporate the guidance previously published in numerous FAQs, but some new information is provided. Key items in the proposed regulations, if adopted, would (a) clarify when and how a plan administrator or insurer must provide an SBC, (b) shorten the length of the SBC, (c) amend the uniform glossary and (d) add a third coverage example regarding "simple foot fracture with emergency room visit." If finalized, the new requirements would be effective for plan years and open enrollment periods beginning on or after September 1, 2015. Below you will find pertinent information found in the proposed regulations.

Types of Plans to which SBCs Apply

The proposed regulations confirm that SBCs are not required for expatriate health plans, Medicare Advantage plans, health savings accounts, or plans that qualify as excepted benefits. Excepted benefits include (when certain requirements are met) employee assistance programs, dental and vision coverage and health FSAs. SBCs are required for health reimbursement arrangements; however, an HRA integrated with other major medical coverage under a group health plan does not need to separately satisfy the SBC requirements. The SBC is prepared for the other major medical coverage and the effects of employer allocations to an account under the HRA can be denoted in the appropriate spaces on the SBC.

Shortened SBC

The regulations propose to shorten the sample SBC template from four double-sided pages to two and a half double-sided pages. The proposed regulations would remove a significant amount of information that is not required by law and that has been identified as not useful to consumers in choosing a plan.

Content Changes to New SBC Template

Other changes to the SBC template include:

- Adding a cost example for a simple foot fracture treated in an emergency room
- Authorizing the continued use of the coverage example calculator

- Removing references to annual limits for essential health benefits and preexisting condition exclusions
- Revising minimum essential coverage and minimum value information and requiring it to be included in the SBC
- Allowing (but not requiring) premium information to be included in an SBC
- Clarifying that for contact information, only issuers must include an Internet web address where a copy of the actual individual coverage policy or group certificate coverage can be reviewed and obtained
- Some definitions in the uniform glossary have been changed and new medical terms have been added. Additional terms related to health care reform such as minimum value and cost-sharing reductions have also been added.

Clarification on Providing the SBC

Issued by Issuer: When a health insurance issuer offering group health insurance provides the SBC to the employer before application for coverage, the requirement to provide an SBC upon application would be deemed satisfied unless there is a change to the information required to be in the SBC. If the information changes, a new SBC that includes the correct information would have to be provided upon application. If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, the issuer would not be required to provide an updated SPD (unless requested) until the first day of coverage. The updated SBC would have to reflect the final coverage terms under the contract, certificate or policy of insurance that was purchased.

Issued by Employer: If a plan provides an SBC to employees prior to application for coverage, the plan is not required to automatically provide another SBC upon application if there is no change to the information required to be in the SBC. However, if there is any change to the information by the time the application is filed, the plan must update and provide a current SBC as soon as practicable following receipt of the application, but in no event later than 7 business days following receipt of the application. If the terms of coverage are not finalized after an application has been filed and the information changes, the plan is not required to provide an updated SBC (unless requested) until the first day of coverage. The updated SBC should reflect the final coverage terms under the contract, certificate or policy of insurance that was purchased.

Elimination of Duplication

The proposed regulations clarify prior guidance and would help prevent unnecessary duplication where (a) a group health plan contracts with another party who agrees to assume responsibility to provide the SBC,(b) a group health plan uses two or more insurance products from different issuers to insure benefits under a single group health plan, and (c) the SBC for student health insurance coverage is provided by another party, such as an institution of higher education.

Employer Action

No employer action is required at this time until final regulations are issued. For templates, instructions and related materials, visit: http://www.dol.gov/ebsa/healthreform/regulations/ summaryofbenefits.html

Published on January 15, 2014

Retroactive 2014 Qualified Transit/ Vanpooling Exclusion Adjustment

The monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass was previously announced as $130 for calendar year 2014, and the monthly exclusion limitation for qualified parking expenses was $250.

Congress recently enacted the Tax Increase Prevention Act. Section 103 of the Act amends the prior limits and raises the 2014 pre-tax transit and vanpool limit from $130 to $250, once again retroactively establishing parity with the pre-tax parking benefit for the year.

Employers interested in making adjustments will need to comply with the procedures in IRS Notice 2015-2 released on January 8, 2015.

Administrators of these programs are working to implement the increased benefit level into their systems and will be communicating the process for moving forward with the increased limits.

The limits for 2015 are not affected by this change and remain at $130 and $250, respectively.

Further information, including how an employer can use its fourth quarter Form 941 to reflect changes in the excludable amount for transit benefits provided in all quarters of 20-14 can be accessed in IRS Notice 2015-2 at: http://www.irs.gov/pub/irs-drop/n-15-02.pdf

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Published on February 3, 2015

2015 Federal Poverty Line Amounts Issued

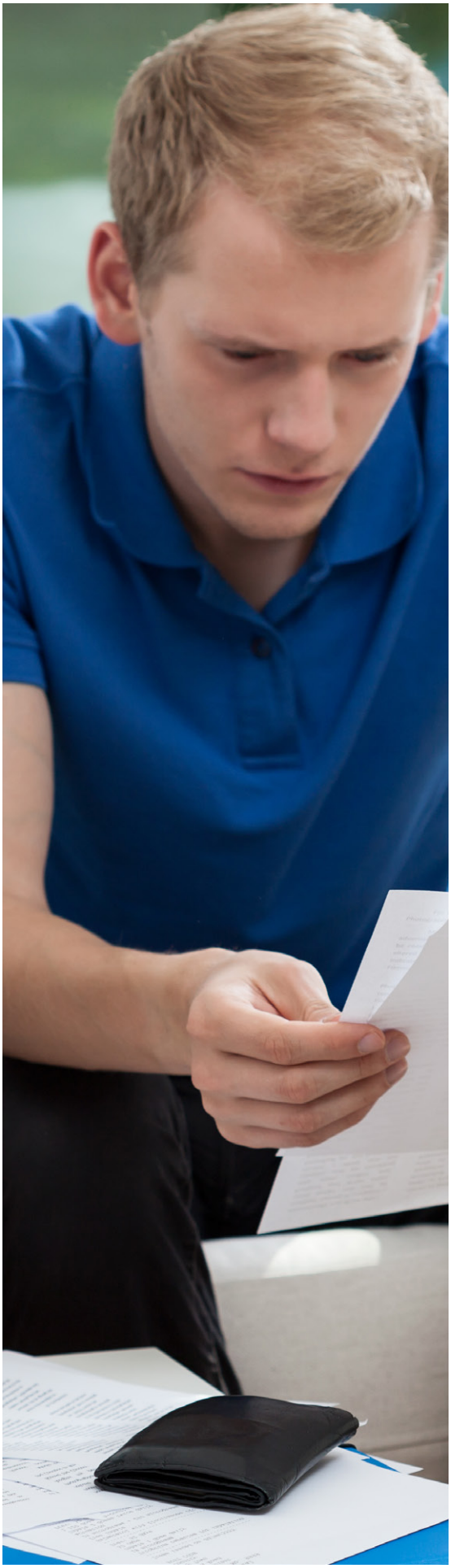
The Department of Health and Human Services has announced the Federal Poverty Line ("FPL") amounts, as indexed for 2015.

Why is this Important?

Beginning in 2015, large employers may be subject to the employer penalty under the Affordable Care Act if they do not offer affordable, minimum value coverage to all full-time employees and at least one full-time employee receives a subsidy in the Exchange. The FPL is relevant to the affordability of the coverage, as well as eligibility for a subsidy.

Regarding affordability, coverage is considered to be affordable if an employee's required contribution does not exceed 9.5% of the employee's household income. For affordability purposes, a large employer satisfies the FPL safe harbor with respect to an employee for a calendar month if the employee's required contribution for the large employer's lowest cost self-only coverage that provides minimum value does not exceed 9.5% of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12. For example, based on the 2015 levels (see below), for affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The FPL is $11,770 for a single individual for every state (and Washington D.C.) except Alaska or Hawaii. So, if the employee's required contribution for the calendar month for the lowest cost self-only coverage that provides minimum value is $93.18 (9.5% of $11,770/12) or less, the employer meets the FPL safe harbor.

Regarding eligibility for a subsidy, an individual is only eligible for a subsidy in the Exchange if s/he is within 100-400% of the FPL and is not offered affordable, minimum value group coverage. For subsidy eligibility purposes, for 2015, the applicable FPL is the FPL for the



state in which the employee resides. 100-400% of the FPL is $11,770-$47,080 for a single individual and $24,250-$97,000 for a family of four for every state (and Washington D.C.), except Alaska or Hawaii.

Below are the 2015 HHS poverty guidelines:

2015 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family/household	Poverty guideline
1	$11,770
2	$15,930
3	$20,090
4	$24,250
5	$28,410
6	$32,570
7	$36,730
8	$40,890
For families/households with more than 8 persons, add $4,160 for each additional person.	

2015 Poverty Guidelines for Alaska	
Persons in family/household	Poverty guideline
1	$14,720
2	$19,920
3	$25,120
4	$30,320
5	$35,520
6	$40,720
7	$45,920
8	$51,120
For families/households with more than 8 persons, add $5,200 for each additional person.	

2015 Poverty Guidelines for Hawaii	
Persons in family/household	Poverty guideline
1	$13,550
2	$18,330
3	$23,110
4	$27,890
5	$32,670
6	$37,450
7	$42,230
8	$47,010
For families/households with more than 8 persons, add $4,780 for each additional person.	

Final regulations specify that employers are permitted to use the guidelines in effect 6 months prior to the beginning of the plan year, in order to provide employers with adequate time to establish premium amounts in advance of the plan's open enrollment period.

Published on February 18, 2015

Medicare Part D

Reminder to Notify CMS

Employers sponsoring a group health plan are required to report information on the creditable status of the plan's prescription drug coverage to the Centers for Medicare and Medicaid Services (CMS). Employers must use CMS's online reporting system to provide this information at: https://www.cms.gov/CreditableCoverage/45_CCDisclosureForm.asp#TopOfPage

As a reminder, notice must be provided by the following deadlines:

- Within 60 days after the beginning date of the plan year;
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status.

An employer with a calendar-year plan (January 1 – December 31, 2014) must complete this reporting no later than March 1, 2015.

You can find additional guidance on completing the form, including screen shots, at: https://www.cms.gov/CreditableCoverage/40_CCDisclosure.asp#TopOfPage

A Help Line is also available, should you experience technical issues or an error message when submitting the online disclosure form. The Help Line can be reached at 1-877-243-1285.

Published on February 19, 2015

Final Forms Released for Individual and Employer Mandate Reporting

Recently, the Internal Revenue Service released final forms and instructions for reporting on the individual mandate (Code Sec. 6055) and the employer mandate (Code Sec. 6056). While these final forms (1094-C and 1095-C) reference calendar year 2014, reporting for 2014 is not required. Employers will be subject to these reporting requirements for 2015 with filings due in early 2016. We expect revised forms reflecting the year 2015 to be issued in the future.

These finalized forms and instructions provide us with better insight into the information that employers must collect and track during 2015 in order to comply with this reporting requirement. In general, the instructions provide general clarification and additional examples that make the instructions more manageable than before.

Notable changes include the following:

- Previously, there was confusion as to how to report self-insured employer-sponsored health insurance coverage for non-employees such as non-employee directors, an individual who was a retired employee during the entire year, or a non-employee COBRA beneficiary. The final instructions clarify that employers with self-insured plans may use Forms 1095-C and 1094-C for non-employees (as opposed to Forms 1094-B and 1095-B) to report minimum essential coverage. Those individuals will be reported on Form 1095-C by using Code 1G (offer of coverage to employee who was not a full-time employee for any month of the calendar year and who enrolled in self-insured

coverage for one or more months of the calendar year) and completing Part III.

- The instructions clarify that an employee who is treated as having been offered health coverage for purposes of section 4980H (even though not actually offered) is treated as offered minimum essential coverage for reporting purposes. For example, for the months for which the employer is eligible for dependent coverage transition relief, non-calendar year transition relief, or multiemployer arrangement interim guidance (if the employer is contributing on behalf of an employee but the employee is not eligible for coverage under the multiemployer plan) with respect to an employee, that employee should be treated as having been offered minimum essential coverage.

- Waiting periods may be reported using the limited nonassessment period code, 2D.

- Employees in an initial measurement period will not be counted for purposes of determining the total percentage of full-time employees offered coverage.

- Additional clarification is provided in areas where completing the forms for a self-insured plan are different than for an insured plan.

- There is clarification on which code prevails when more than one code could be used. Code 2C generally trumps everything. Employers should always use Code 2C if the employee was enrolled in coverage, but only if he or she was enrolled for the entire month.

- Under the Qualifying Offer Method and the Qualifying Offer Transition Relief Method, it is now clear that full-time employees covered by a self-insured plan cannot be furnished the alternative statement for purposes of Part III, but should be provided Form 1095-C.

We will be providing additional information on these forms in the coming weeks. Large employers should review these forms and instructions and begin tracking and collecting data in 2015.

For the revised forms and instructions, visit:

- http://www.irs.gov/uac/About-Form-1095-C
- http://www.irs.gov/uac/About-Form-1094-C

Published on March 10, 2015

Anthem Cyber Attack

Frequently Asked Questions

On January 29, 2015, Anthem discovered that it had experienced a cyber attack where a hacker gained unauthorized access to Anthem's computer systems and obtained certain personal information regarding Anthem's consumers who were or are currently covered by Anthem or other independent Blue Cross and Blue Shield plans that work with Anthem. This includes, but is not limited to, employer-sponsored group health plans (both insured and self-insured). Anthem believes the suspicious activity occurred over the course of several weeks beginning in early December 2014. The below FAQs are intended to provide you with information regarding the recent cyber attack experienced by Anthem. Information on this situation is changing and should be closely monitored.

Whose Information Was Compromised?

Anthem's cyber attack resulted in an improper disclosure of nearly 80 million records and may affect participants who received services from an Anthem Blue Cross and Blue Shield contracted health provider from 2004 through the date of the cyber attack. Any health plan participant that was covered under a Blue Cross and Blue Shield Plan could have been impacted if they received services in a state serviced by the Anthem network of health care providers.

It may be prudent for any participant who had Blue Cross and Blue Shield coverage from 2004 on to review the www.anthemfacts.com website and request credit protection services. Plan sponsors may wish to include in any notice to employees that the breach relates to records created from 2004 on and may affect employees who had previously been covered under other employer sponsored health plans accessing Blue Cross and Blue Shield network providers. Anthem, formerly known as Wellpoint, runs health care plans under the Blue Cross Blue Shield, Empire Blue Cross, Amerigroup, Caremore, Unicare, Healthlink, DeCare, HealthKeepers and Golden West brands.

What Information Was Compromised In The Breach?

Anthem has indicated that to date, they believe certain personal information, including names, dates of birth, member ID numbers, social security numbers, street addresses, emails and employment and income information has been compromised. Anthem does not currently believe that credit card or detailed medical information (such as claims, test results or diagnostic codes) were compromised.

Is The Anthem Cyber Attack A Breach Under HIPAA?

According to a Town Hall conference call on February 11, 2015 and a letter provided to plan sponsors dated February 23, 2015 from Kenneth Goulet, President, Commercial and Specialty Business at Anthem, Anthem views the unauthorized access of information as a result of this cyber attack a breach under HIPAA and under certain state privacy laws. Anthem continues to investigate this issue and work with applicable regulators at the federal and state level.

Generally, self-insured group health plans that contract with Anthem as a TPA are subject to HIPAA breach rules, while Anthem is solely responsible for HIPAA breach issues for fully insured plans that do not receive PHI. Larger fully insured health plans that have access to or are provided with PHI will need to assure that they are compliant with HIPAA breach rules if their participants were affected.

What Are Plan Sponsor Obligations?

Because group health plans are subject to the HIPAA Privacy and Security Rules, the plan sponsor has obligations to determine whether a breach of protected health information (PHI) has occurred and, if so, provide notification to affected participants, cure the cause of the breach, and attempt to address any harm that may have occurred to a participant as a result of the breach.

What Do Plan Sponsors Need To Do?

Hopefully not much. Anthem has outlined, in the letter previously referenced, that they will be assisting clients in fulfilling obligations under HIPAA or state privacy laws. Their goal is to promote a consistent message to potentially impacted individuals. In that regard, Anthem intends to issue notices to affected participants and to appropriate state and federal regulators. Anthem has indicated that it believes these notices will satisfy the plan sponsor notice requirements, including notice obligations under the HIPAA breach notification regulations issued.

Specifically, according to the letter, Anthem has taken or intends to take the following actions:

- As a business associate with health plans, Anthem will provide to the plan sponsor written notice of the breach and provide information as required by HIPAA within sixty (60) days after Anthem discovered the breach;
- Anthem will provide, on behalf of the health plan, notice to potentially impacted individuals for whom Anthem has contact information within legally required timeframes;
- Anthem will deliver written notice to identified state regulators as required by state data breach notification laws and that notice will reference any affected health plan by name;
- Anthem will make substitute notice under HIPAA or state data breach notification laws on behalf of the affected health plan to potentially impacted individuals for whom Anthem has insufficient or out-of-date contact information or where otherwise permitted by law; and
- Anthem will notify federal regulators on behalf of the health plan, including the Department of Health and Human Services' Office for Civil Rights, and that notice will reference specifically affected health plans by name.

Anthem has indicated that while it does not provide legal advice, it believes that all notices already delivered, and those that will be delivered in the future, comply with the applicable laws that require those notices. It is Anthem's position that these notices will fulfill both Anthem and affected health plan's notice obligations relating to the breach of participant information. However, Anthem encourages affected health plans to seek advice from counsel to address specific questions or concerns.

What Is Anthem Doing To Help Affected Participants?

Anthem is notifying potentially impacted current and former members by U.S. Postal mail regarding the cyber attack and is including information on how individuals may protect themselves. One service Anthem is offering includes identity protection and repair services free of charge. Anthem is working with AllClear ID, an identity protection provider, to offer 24 months of identity theft repair and credit monitoring services to current or former members of an affected Anthem plan dating back to 2004.

Anthem established a website for ongoing information regarding this situation, www.anthemfacts.com.

What Steps Should Plan Sponsors Take Now?

Plan sponsors should do the following:

- Assess whether health plan participants may have been affected by the Anthem breach.
- For self-insured plans using Anthem as a TPA, determine what contracts the plan might have with Anthem (TPA service agreement, BAA agreements, etc.) and whether those contracts impact Anthem's obligations to the plan.
- For insured plans, Anthem is the Covered Entity so it is directly responsible for contacting affected participants.
- Notify affected participants of the opportunity to obtain identity protection by directing them to the www.anthemfacts.com website.
- Consult with counsel to assess whether Anthem's actions on behalf of your health plan satisfy any applicable HIPAA and state law privacy or notice obligations the plan may have.

Published on March 11, 2015

Final FMLA Rules Regarding Same-Sex Spouses

The DOL amended the regulatory definition of "spouse" under the Family and Medical Leave Act ("FMLA") so that "spouse" for purposes of FMLA rights includes a same-sex spouse, regardless of where the employee and spouse live. This means the "place of celebration" will determine whether an individual is a "spouse" under FMLA. This change is effective March 27, 2015. Current FMLA regulations use a "state of residence rule," recognizing a spouse under the law of the state in which the couple resides.

Background

In June 2013, the Supreme Court, in United States v. Windsor, struck down the federal definition of "marriage" and "spouse" under Section 3 of the Defense of Marriage Act ("DOMA"), holding that same-sex marriages valid under state law are recognized at the federal level. The decision affects over 1,100 sections of federal law that have a provision based on marriage, including the FMLA.

In a nutshell, the FMLA requires certain employers to permit eligible employees to take up to 12 weeks (26 weeks in the case of caring for an injured service member) of unpaid, job-protected leave each year because of a new baby, to care for an immediate family member who has a serious health condition, or because of their own serious health condition, or because of an emergency when a family member is called to active military duty. A covered employer is required to maintain group health plan benefits for an employee on FMLA leave on the same terms and conditions as if the employee had continued to work. When the employee returns from FMLA leave, the employer must restore the all the employee's benefits.

Following Windsor, the DOL's FMLA guidance, revised in August 2013, required employers subject to the FMLA to extend FMLA rights to an eligible employee in connection with his or her same-sex spouse only when the employee and spouse reside in a state that recognizes same-sex marriage; FMLA rights related to a same-sex spouse currently do not apply to an employee residing in a state that does not recognize same-sex marriage.

The Change

Spouse, as defined in the statute, means a husband or wife. For purposes of this definition, as proposed in June 2014, final regulations now have "husband or wife"

refer to the other person with whom an individual entered into marriage as defined or recognized under state law for purposes of marriage in the state in which the marriage was entered into or, in the case of a marriage entered into outside of any state, if the marriage is valid in the place where entered into and could have been entered into in at least one state. This definition includes an individual in a same-sex or common law marriage that either (1) was entered into in a state that recognizes such marriages or, (2) if entered into outside of any state, is valid in the place where entered into and could have been entered into in at least one state.

The rule means that an eligible employee, regardless of where s/he lives, is able to:

- take FMLA leave to care for his/her same-sex spouse with a serious health condition;
- take qualifying exigency leave due to his/her same-sex spouse's covered military service; or
- take military caregiver leave for his/her same-sex spouse.

The change entitles eligible employees to take FMLA leave to care for their stepchildren (children of the employee's same-sex spouse) even if the in loco parentis requirement of providing day-to-day care or financial support for the child is not met. The change also entitles eligible employees to take FMLA leave to care for their stepparents (same-sex spouses of the employee's parents), even though the stepparents never stood in loco parentis to the employee.

Published on March 12, 2015

CMS Announces Special Enrollment Period in Federaal Exchanges

The Centers for Medicare & Medicaid Services ("CMS") announced on February 20, 2015 a special enrollment period for individuals and families who did not have health coverage in 2014 and are subject to the "shared responsibility le their 2014 taxes in states which use the Federally-facilitated Marketplaces ("FFM"). This special enrollment period will allow those individuals and families who were unaware or didn't understand the implications of this new requirement to enroll in 2015 health insurance coverage through the FFM.

For those who were unaware or didn't understand the implications of the fee for not enrolling in coverage, CMS will provide consumers with an opportunity to purchase health insurance coverage from March 15 to April 30. Those eligible for this special enrollment period live in states with a

Federally-facilitated Marketplace and:

- currently are not enrolled in coverage through the FFM for 2015,
- attest that when they filed their 2014 tax return they paid the fee for not having health coverage in 2014, and
- attest that they first became aware of, or understood the implications of, the Shared Responsibility Payment after the end of open enrollment (February 15, 2015) in connection with preparing their 2014 taxes.

If a consumer enrolls in coverage before the 15th of the month, coverage will be effective on the first day of the following month.

Many state-based Exchanges are offering an extension as well. Below are the special enrollment periods for the California, Connecticut and New York state-based Exchanges:

California: February 23 through April 30
Connecticut: April 1, through April 30
New York: March 1 through April 30

Published on March 19, 2015

Guidance Issued

Regarding Supplemental Excepted Benefits

The Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, the "Departments") have become aware of health insurance carriers selling supplemental products that provide a single benefit. At least one carrier is characterizing this type of coverage as an excepted benefit. These carriers claim that the products meet the criteria for supplemental coverage to qualify as an excepted benefit outlined in the Departments' guidance and are designed to fill in the gaps of primary coverage in the sense that they are providing a benefit that is not covered under the primary group health plan. The Departments issued an FAQ that provides guidance on whether health insurance coverage that supplements group health coverage by providing additional categories of benefits can be characterized as supplemental excepted benefits.

Background

The Public Health Service Act ("PHSA") does not apply to "excepted benefits" including "supplemental excepted benefits." The PHSA requirements include:

- Dependent coverage for children under age 26;
- Coverage of preventive services;
- Preexisting condition prohibition;
- Lifetime limits on essential benefits prohibition;
- Annual limits on essential benefits restriction;
- Nondiscrimination rule for insured plans; and
- New appeals process.

A supplemental excepted benefit, under a safe harbor, is a separate policy, certificate, or contract of insurance that satisfies all of the following requirements:

1. **Independent of primary coverage.** The supplemental policy, certificate, or contract of insurance must be issued by an entity that does not provide the primary coverage under the plan. For this purpose, entities that are part of the same controlled group of corporations or part of the same group of trades or businesses under common control, within the meaning of section 52(a) or (b) of the Code, are considered a single entity.

2. **Supplemental for gaps in primary coverage.** The supplemental policy, certificate, or contract of insurance must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not include a policy, certificate, or contract of insurance that becomes secondary or supplemental only under a coordination-of-benefits provision.

3. **Supplemental in value of coverage.** The cost of coverage under the supplemental policy, certificate, or contract of insurance must not exceed 15% of the cost of primary coverage. Cost is determined in the same manner as the applicable premium is calculated under a COBRA continuation provision.

4. **Similar to Medicare supplemental coverage.** The supplemental policy, certificate, or contract of insurance that is group health insurance coverage must not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual (or any dependent of the individual).

Relief Provided by the FAQ

One of the requirements that must be satisfied in order to qualify as a supplemental excepted benefit, as stated above, is the policy must be supplemental for gaps in primary coverage. Regarding this requirement, the Departments will not initiate an enforcement action as long as the coverage that provides coverage of additional categories of benefits are not "essential health benefits" in the applicable state where marketed (as opposed to filling in cost-sharing gaps under the primary plan).

The Departments encourage states that have primary enforcement authority over the provisions of the PHSA, to utilize the same enforcement discretion under such circumstances.

Published on March 19, 2015

Relief for Small Employers Reimbursing Individual Policies

An employer cannot offer employees cash to reimburse the purchase of an individual policy, whether or not the employer treats the money as pre-tax or post-tax to the employee. Such arrangements (called "employer payment plans") are subject to the market reform provisions of the Affordable Care Act ("ACA"), including prohibition on annual limits and the requirement to provide certain preventive services without cost sharing with which it cannot comply. These arrangements may be subject to a $100/day excise tax per applicable employee (which is $36,500 per year, per employee).

Recently, the Departments of Labor ("DOL"), Health and Human Services ("HHS"), and the Treasury (collectively, the "Departments") provided temporary relief to employers that are not applicable large employers ("ALEs") from this rule until July 1, 2015. An ALE for a calendar year is generally an employer who employed an average of at least 50 full-time employees (taking into account full-time equivalent employees) on business days during the preceding calendar year. For determining whether an entity was an ALE for 2015, an employer may determine its status as an applicable large employer by reference to a period of at least six consecutive calendar months, as chosen by the employer, during the 2014 calendar year. Since ALE status is determined annually, the specific relief is (1) for 2014 for employers that are not ALEs for 2014 and (2) for January 1 through June 30, 2015 for employers that are not ALEs for 2015.

This relief does not extend to stand-alone HRAs or other arrangements to reimburse employees for medical expenses other than insurance premiums.

Published on March 25, 2015

Should Plan Years be Changed to Delay Compliance with ACA Provisions?

Representatives from several insurance carriers are encouraging employers with 51-100 full-time employees to move their policy years to December 1 – November 30, effective December 1, 2015, to delay certain design requirements applicable to non-grandfathered group health plans for plan years beginning on or after January 1, 2016. These design requirements are:

- Small, insured group health plans must offer essential benefits and provide a bronze level of coverage.

- Insurance carriers will be subject to new underwriting rules with respect to small, insured groups. Instead of using experience rating, carriers will use community rating. Rating variations will be restricted to (a) benefit coverage elected (plan and tier), (b) geographic area, (c) age, limited to a ratio of 3 to 1 for adults, and (d) tobacco use, limited to a ratio of 1.5 to 1.

The definition of "small employer" will increase from an employer with up to 50 employees to an employer with up to 100 employees, beginning with the 2016 plan year. However, it is possible that this could be delayed.

There are compliance issues associated with changing a plan year – importantly:

- Changing the plan year to later in the calendar year will expose a mid-sized employer to the employer penalty as of January 1, 2015 rather than the first day of the 2016 plan year.

- Changing plan years to delay the effective date of certain ACA-related mandates is arguably impermissible.

Below is a summary of these compliance issues. It is important that employers considering changing their policy years consult counsel.

Plan Year vs. Policy Year

First, changing a policy year is not relevant for health care reform purposes. The plan year is relevant. A plan year is an accounting period. It is usually the same as the policy year (the period for which rates are locked in), but not always. To confirm the plan year, employers can examine the summary plan description and/or Form 5500.

In addition to any policy year change, there should be a plan year change. Additionally, if employees pay premiums on a pre-tax basis, there should be a plan year change for the cafeteria plan. Any plan year change would have to be properly documented. It may be desirable to change other policy years and plan years (e.g., for the disability and

life insurance plans) as well to maintain a consistent program.

2015 Transition Relief for Employers with 50-99 Full-Time Employees

Beginning in 2015, large employers can be subject to a penalty when not offering affordable, minimum value coverage to all full-time employees. The final rules provide relief for midsized employers to delay the employer penalty until 2016.

The transition relief applies to all calendar months of 2015 plus any calendar months of 2016 that fall within the employer's 2015 plan year; it will cover non calendar-year plans, but only if the employer satisfies certain criteria – one of which is that the employer did not modify the plan year after February 9, 2014 to begin on a later calendar date (for example, changing the start date of the plan year from January 1 to December 1).

Thus, if a mid-sized employer changes its plan year to later in the calendar year, it will no longer be eligible for the transition relief and may be subject to the employer penalty as of January 1, 2015.

Changing the Plan Year to Avoid Federal Law

Although there does not appear to be any specific prohibition at this time, changing a plan year for the purpose of avoiding Federal law has been prohibited historically in various benefits contexts, including one provision applicable to health care reform. Examples include the following:

- Under guidance issued under health care reform, for a health FSA, a short plan year may only be used for a valid business purpose which does not include delaying application of the $2,500 limit. If a change in the plan year does not satisfy this valid business purpose requirement, the plan year for the cafeteria plan remains the plan year that was in effect prior to the attempted change. IRS Notice 2012-40.

- A cafeteria plan can have a short plan year for a valid business purpose. A plan year may not be changed if a principal purpose of the change is to circumvent the requirements of Code § 125 or the regulations thereunder. IRS Prop Reg. § 1.125-1(d)(2).

- For merger and acquisition purposes, changing a plan year must be done for a valid business purpose. Where a transaction has no substantial business purpose other than the avoidance or reduction of Federal tax, the tax law will not regard the transaction. See Gregory v. Helvering, 293 U.S. 465 (1935).

- For COBRA purposes, if a principal purpose of establishing separate plans is to evade any requirement of law, then the separate plans will be considered a single plan to the extent necessary to prevent the evasion. IRS Reg. § 54.4980B-2, Q&A-6(c).

- For ERISA purposes, a plan is deemed to not be established under a collective bargaining agreement for any plan year in which the agreement is a scheme, plan, stratagem, or artifice of evasion, a principal intent of which is to evade compliance with state law and regulations applicable to insurance. 29 CFR § 2510.3-40(c)(2).

- In the multiemployer pension plan context, withdrawal liability exists under ERISA § 4212(c) where one of the primary purposes of the transaction is to avoid withdrawal liability, even if that isn't the only purpose. See Santa Fe Pacific Corp. v Central States, Southeast & Southwest Areas Pension Fund, 22 F3d 725 (7th Cir. 1994).

In addition, with respect to any IRS or DOL audit, senior agents/investigators have wide discretion in assessing and waiving penalties. They have been known to go much easier on employers that appear to be making honest efforts to comply; they are generally less inclined to be kind when plan sponsors are taking advantage of the flexibility they have with respect to operating and administering plans.

SBC

Notice of a modification to enrollees should be provided no later than 60 days prior to the date the modification will take effect because the group health plan is making a material modification to the SBC outside of renewal or reissuance (e.g., a mid-year plan design change).

Published on April 9, 2015

2016 Cost-Sharing Limits, Reinsurance Fee, and Other Changes Related to the Exchange

On February 27, 2015, the Department of Health and Human Services ("HHS") changed cost-sharing and transitional reinsurance program fee limits and released standards for health insurers and the Exchange (a.k.a. the Health Insurance Marketplace). This article identifies a few items of note for employers.

2016 Cost-sharing Limits

For 2016, the maximum annual out-of-pocket limits for non-grandfathered plans are $6,850 for individual coverage and $13,700 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 with 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.

Transitional Reinsurance Program

The reinsurance fee for 2016 is $27 per covered individual. 2016 is the final year for the transitional reinsurance program. Generally, enrollment counts for the reinsurance fee are due by November 15 of the benefit year. Payment is due by January 15 of the following year (and November 15 of the following year if paying in two installments). The regulations make clear that when these dates fall on a Saturday, Sunday, or holiday, submission of this information and/or payment is due by the next business day.

For 2015:

- Enrollment counts are due by November 16, 2015.
- The fee of $44/per covered life:
- if making a single payment, is due by January 15, 2016; or
- if paying in two installments, the first payment of $33/covered life is due by January 15, 2016 and the second payment of $11/covered life is due by November 15, 2016.

For 2016:

- Enrollment counts are due by November 15, 2016.
- The fee of $27/covered life:
- if making a single payment, is due by January 16, 2017; or
- if paying in two installments, the first payment of $21.60 per covered life is due by January 16, 2017 and the second and final payment of $5.40 per covered life is due by November 15, 2017.

The regulations clarify the application of the snapshot count and snapshot factor counting methods to a plan that is established or terminated, or that changes funding mechanisms, in the middle of a quarter. Specifically, if the plan had enrollees on any day during a quarter and if the contributing entity uses either the snapshot count or snapshot factor method, it must choose a set of counting dates for the counting period such that the plan has enrollees on each of the dates, if possible. The enrollment count for a date during a quarter in which the plan was in existence for only part of the quarter can be reduced by a factor reflecting the amount of time during the quarter for which the plan or coverage was not in existence.

Consistent with the proposed regulations, the final regulation provides that self-funded expatriate plans are not required to pay the reinsurance fee for 2015 and 2016 benefit years. Insured expatriate plans do not make reinsurance contributions. Self-insured plans that do not use a TPA do not make reinsurance contributions in the 2015 and 2016 benefit years. The final regulations clarify that a TPA is an entity that is not under

common ownership with the self-insured group health plan or its sponsor that provides administrative functions in connection with the core administrative services. Common ownership should be determined under Code Sec. 414(b) and (c).

Open Enrollment Period for the Exchange

For benefit year January 1, 2016, the annual enrollment period for the Exchange begins November 1, 2015 and extends through January 31, 2016. For the benefit year beginning on January 1, 2016, the Exchange must ensure coverage is effective:

- January 1, 2016 for plan selections received by the Exchange on or before December 15, 2015;
- February 1, 2015 for plan selections received by the Exchange from December 16, 2015 through January 15, 2016; and
- March 1, 2016 for plan selections received by the Exchange from January 16, 2016 through January 31, 2016.

Small Business Health Options Program (SHOP)

In an effort to streamline the administration of the SHOP, the regulations allow the SHOP to assist employers in the management of COBRA continuation of coverage. The regulations provide that the SHOP is permitted to collect COBRA premium from any person enrolled in COBRA coverage through the SHOP consistent with applicable and the terms of the group health plan. The regulations also align the SHOP rules with the COBRA rules, including COBRA eligibility for dependents and former dependents. Note that SHOP does not have capabilities to manage the entire COBRA process (e.g., send out the notices).

Minimum Value Plans

In November 2014, in Notice 2014-69, HHS, the Treasury, and the Internal Revenue Service (collectively, the "Departments") announced their intent to issue regulations clarifying that a group health plan will not provide minimum value (MV) if it excludes substantial coverage for in-patient hospitalization services or physician services (or both) (referred to as a "Narrow MV Plan"). There is a very narrow exception to this general rule if, and only if, an employer with a plan year that begins on or before March 1, 2015 has entered into a binding written commitment to adopt or has begun enrolling employees in a Narrow MV Plan prior to November 4, 2014, in which case it will not be subject to the Employer Penalty for the 2015 plan year.

Consistent with Notice 2014-69 and proposed regulations, these regulations finalized the requirement that an employersponsored plan must provide substantial inpatient hospital services and physician services, as well as meet the quantitative standard of the actuarial value of benefits plan (cover 60% of the total allowed costs) in order to provide MV.

Pediatric Age

The regulations provide that pediatric benefits must be provided at least until the end of the month in which the enrollee turns 19.

Habilitative Services

Habilitative services and rehabilitative services are part of the EHB package. The final regulations adopt a uniform definition of habilitative services to clarify the difference between habilitative and rehabilitative services. Habilitative services are provided for a person to attain, maintain, or prevent

deterioration of a skill or function never earned or acquired due to a disabling condition. Rehabilitative services, are provided to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost due to illness, injury or disabling condition.

The final regulations adopt the definition of habilitative services from the Uniform Glossary of Health Coverage and Medical terms, effective for plan years beginning in 2016, and require carriers to have separate visit limits on habilitative services and rehabilitative services for plan years beginning in 2017.

Medical Loss Ratio

The final rule clarifies that that federal and state employment taxes should not be excluded from premium in the MLR and rebate calculations. It also provides that subscribers of non-federal governmental or other group health plans not subject to ERISA must receive the benefit of MLR rebates within three (3) months of receipt of the rebate by their group policyholder, just as subscribers of group health plans subject to ERISA do.

Published on April 16, 2015

Cadillac Tax

Preliminary Guidance, Part 1

The IRS issued preliminary guidance regarding the excise tax on high cost employer-sponsored health coverage, commonly known as the "Cadillac Tax." Notice 2015-16 describes potential approaches being considered in developing guidance under Section 4980I. Specifically the Notice addresses (1) the definition of applicable coverage, (2) the determination of the cost of applicable coverage, and (3) the application of the annual statutory dollar limit to the cost of applicable coverage. The IRS will seek comments on potential approaches to a number of issues both with respect to this Notice and a subsequent notice that is expected to address other issues. Additionally, there will be an opportunity to comment after the proposed rule is issued.

The Notice is lengthy and full of complicated details. To simply the information, we will release two articles regarding this information. This first article addresses the definition of applicable coverage.

Background

Beginning January 1, 2018, Code Section 4980I imposes a 40% excise tax on any excess benefit provided to an employee that exceeds prescribed thresholds. An excess benefit is the excess, if any, of the aggregate cost of the applicable coverage of the employee for the month over the applicable dollar limit for the employee for that month. The 2018 thresholds are $10,200 for self-only coverage and $27,500 for coverage other than self-only (these thresholds are annualized and adjusted in certain circumstances). For example, an employee's aggregate cost of applicable coverage for a month is $600. Since she has self-only coverage, the threshold is $850 ($10,200/12). There would be no excise tax because the $600 falls below the $850 threshold. However, if the aggregate cost was $1,000, then a 40% excise tax on $150 applies ($1,000 - $850), totaling $60 for the month.

Applicable Coverage

"Applicable coverage" generally means coverage under a group health plan (insured or self-insured) that is made available to an employee by an employer that is excludable from the employee's income (or would be excludable if it were employer-provided coverage). In determining Cadillac Tax liability, it is important to first determine what health plan benefits are considered applicable coverage. While the Notice provides helpful clarification as to types of benefits potentially impacted by this tax, it also raises a number or questions regarding HSAs, on-site clinics, self-insured dental and vision coverage and EAPs.

Applicable Coverage

- Major medical coverage
- Health FSA
- HSA (employer contributions and pre-tax employee contributions through a cafeteria plan)
- On-site medical clinics
- Coverage for specified disease, illness or hospital indemnity policy when paid by the employer or on a pre-tax basis
- Executive physicals
- HRAs

Not Applicable Coverage

- Many excepted benefits
- Long-term care
- Insured dental and vision (see discussion of self-insured dental and vision)
- Coverage for specified disease, illness or hospital indemnity policy when paid for on an after tax basis
- Employee after tax contributions to an HSA

It is important to note that governmental plans, retiree plans, and multiemployer plans are included as applicable coverage.

Health Savings Accounts

The IRS anticipates that employer contributions to health savings accounts (HSAs) are applicable coverage. This includes pre-tax salary reduction contributions. The cost of the coverage equals the amount of all "employer contributions" (including employee pre-tax salary reductions). While the statute defines HSA contributions as applicable coverage (and the IRS's interpretation appears consistent with that definition), the potential implications of this definition are troubling. Notably:

- While many employers use qualified HDHPs to control cost, the inclusion of employer contributions and employee pre-tax contributions to the HSA associated with this coverage may result in many of these arrangements hitting the excise tax threshold. For example, if an employee with self-only coverage contributed the maximum HSA contribution amount in 2018 and that amount was $3,500, this would leave only $6,700 for the major medical plan and any of the other "applicable coverages" before an excise tax would apply.

- If these contributions are included as applicable coverage, employers may be discouraged from making contributions to the employee's HSA to avoid exposure to the Cadillac Tax. In addition, should the employer continue to make a contribution to employees' HSAs, the employer likely will become subject to rather stringent comparability rules if pre-tax contributions (through a cafeteria plan)

to the HSA account are eliminated in order to reduce potential excise tax liability

- In the event the ability for an employee to make pre-tax salary reduction elections to an HSA is removed, the convenience factor of contributing to the HSA may be lost which may result in employees contributing less to their HSAs.

After-tax contributions made to an HSA are not applicable coverage and will not be included in the calculation of the year-end above-the-line deduction of after-tax HSA contributions made during the calendar year on their personal tax returns. This deduction does not affect the excise tax.

On-site Medical Clinics

Coverage provided through an on-site medical clinic is generally applicable coverage. However, the IRS anticipates that forthcoming guidance will exclude on-site medical clinics that offer only de minimis medical care to employees. De minimis is not defined and the IRS seeks comments in this area. Notable, the IRS references the COBRA regulations which exclude an on-site clinic located on the employer's premises from the definition of a group plan if the health care provided:

1. Consists primarily of first aid that is provided during the employer's working hours for treatment of a health condition, illness, or injury that occurs during those working hours;

2. Is available only to current employees; and

3. Is free of charge to employees who use the facility.

The IRS seeks comments on the treatment of clinics that meet the criteria described in the COBRA regulations as well as clinics that may provide certain services in addition to (or in lieu of) first aid.

While not specifically addressed in the Notice, it is likely that final guidance will include robust on-site clinics in the definition of applicable coverage. Such arrangements that provide a wide array of services beyond first aid and allow employees and their family members to receive services will likely not be considered de minimis.

Dental and Vision Coverage

Insured dental and vision coverages are excluded from the applicable coverage definition and will not be included in the aggregate cost of coverage for purposes of determining excise tax liability. However, it is unclear whether self-insured limited-scope dental and vision coverage are applicable coverage. The regulators may consider excluding self-insured dental and vision benefits that are excepted benefits from applicable coverage, thus excluding the cost of such coverage from the excise tax calculation.

Employee Assistance Programs

Under recently issued regulations, employee assistance programs (EAPs) that meet certain criteria are considered excepted benefits. The IRS is considering excluding excepted EAPs from the definition of applicable coverage. The IRS seeks comments opposing this exclusion.

Unaddressed Benefits

The Notice contains no discussion of certain benefits that may be viewed as applicable coverage, including wellness programs and telemedicine. Further guidance on these benefits would be helpful.

Additional guidance is expected and it is anticipated that the benefits community will be actively voicing comments in response to this Notice.

Published on April 29, 2015

Reinsurance Fee Overpayment Refund Request Deadline is April 30

For the 2014 benefit year, contributing entities (insurance carriers and employers with self-insured group health plans) were required to submit their annual enrollment count and remit their resulting contributions utilizing the "ACA Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form" (Form) via www.pay.gov by December 5, 2014. By using this website, the contributing entity (or third party administrators or administrative servicesonly contractors on their behalf) entered their self-reported annual enrollment count in the Form which auto-calculated the annual contribution amount due based on the 2014 contribution rate of $63.00 per covered life.

The Centers for Medicare & Medicaid Services (CMS) is aware that some contributing entities may have misreported their annual enrollment count for the 2014 benefit year due to misapplying the permitted counting methods or including individuals who are otherwise exempt for purposes of reinsurance payments. This potentially may have resulted in an overpayment. In the case of such an overpayment, where payment has been processed, the contributing entity must re-file the Form with the correct annual enrollment count and CMS will rerun the payment associated with the erroneous filing.

An employer must also send an email to: reinsurancecontributions@cms.hhs.gov

For the 2014 benefit year, contributing entities must send refund requests resulting from annual enrollment count misreporting to CMS by April 30, 2015 or 90 days from the date of their Form submission, whichever is later.

For the 2015 and 2016 benefit years, refund requests resulting from annual enrollment count misreporting must be submitted 90 days from the date of Form submission.

Please note that the deadlines outlined above do not apply when a contributing entity:

- requests a refund because it has paid reinsurance contributions more than once for the same covered life; or

- correctly applied one of the counting methods requests to change its annual enrollment count and associated payment after the reporting deadline for the applicable benefit year.

Inquiries the reinsurance contribution submission process should be sent to reinsurancecontributions@cms.hhs.gov.

For more information, contact CMS at the above email address. A copy of the announcement of this refund process is available here: http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RIC-Guidance-Refund-Request-Deadline-final-.pdf

Published on May 8, 2015

2016 HSA Limits

The IRS released the 2016 limits for health savings accounts (HSAs) and their accompanying high deductible health plans (HDHPs) effective for calendar year 2016. Some limits were adjusted from the 2015 amounts.

Annual Contribution Limitation

For calendar year 2016, the limitation on deductions for an individual with self-only coverage under a HDHP is $3,350. For calendar year 2016, the limitation on deductions for an individual with family coverage under a HDHP is $6,750.

High Deductible Health Plan

For calendar year 2016, a HDHP is defined as a health plan with an annual deductible that is not less than $1,300 for selfonly 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 selfonly 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 (i.e., a fiscal year HDHP), 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 HDHP may make additional catch-up contributions each year until they enroll in Medicare. The additional contribution, as outlined by the statute, is $1,000 for 2009 and thereafter.

Published on May 16, 2015

Cadillac Tax

Preliminary Guidance, Part 2

The IRS issued Notice 2015-16 to begin the process of developing regulatory guidance regarding the excise tax on high cost employer-sponsored health coverage, commonly known as the “Cadillac Tax.” Beginning January 1, 2018, a 40% excise tax will apply on the cost of applicable coverage that exceeds prescribed thresholds (described later in this article).

Our previous article (Part I, dated April 16, 2015) addressed the definition of applicable coverage. Part II looks at how the applicable statutory limit may apply with respect to the cost of coverage and methods to determine the cost of applicable coverage.

The IRS seeks comments on these proposed approaches.

Dollar Limit Adjustments

The statute provides two baseline per-employee dollar limits for 2018:

- $10,200 for self-only coverage, and
- $27,500 for coverage other than self-only.

The guidance clarifies that these amounts are subject to certain adjustments, as follows:

- **Health cost adjustment percentage** (applicable in 2018 only). This adjustment will be applied to the peremployee dollar limit for 2018 to determine the actual dollar limits for that year.
- **Cost of living adjustment** (applicable after 2018). For taxable years after 2018, a cost-of-living adjustment based on

CPI-U plus one percent will be applied to determine applicable dollar limits.

- **Qualified retirees[1] and high-risk professions[2].** An additional amount is added to the dollar limits for qualified retirees and individuals who participate in a plan sponsored by an employer the majority of whose employees covered by the plan are engaged in highrisk professions or who repair or install electrical or telecommunication lines. The additional amounts added to the prescribed thresholds are $1,650 for self-only coverage and $3,450 for coverage other than self-only.
- **Age and gender adjustment.** For 2018 and beyond, the dollar limits for an employer may be increased by an age and gender adjustment if the age and gender characteristics of an employer's workforce are different from those of the national workforce. The amount of this adjustment is to be determined.
- **Multiemployer plans.** Coverage provided under a multiemployer plan is treated as coverage other than self-only (e.g., the $27,500 threshold applies to both self-only coverage and coverage other than self-only).

Determination of the Cost of Applicable Coverage

This new excise tax will apply on the excess, if any, of the aggregate cost of applicable coverage of an employee for a month over the applicable dollar limit.

Under the existing framework, rules similar to the COBRA rules for determining applicable premium will be used to determine the cost of applicable coverage. Given that the regulators have provided limited guidance on determining the cost of COBRA coverage, in particular for self-insured plans and HRAs, guidance issued under section 4980I is likely to affect existing COBRA rules (section 4980B).

Currently, the COBRA applicable premium must be determined for a 12-month determination period, and must be determined before the start of such period. For self-insured plans there are two methods to determine the COBRA applicable premium:

- the actuarial basis method, and
- the past cost method.

Absent guidance employers and plans must operate in good faith compliance with a reasonable interpretation of the section 4980B statutory requirements.

Briefly, the Notice outlines potential approaches to determining the cost of applicable coverage:

- **Similarly situated individuals.** The IRS proposes determining similarly situated individuals through mandatory aggregation, aggregating individuals by elected benefit package (e.g., PPO, HMO, or HDHP). Then, individuals will be disaggregated by those who have self-only coverage and those with other than self-only coverage. This is referred to as mandatory disaggregation.
    - In addition, the IRS is considering whether to allow permissive disaggregation, meaning separate determination of costs of coverage within family coverage based on the number of covered individuals. Another type of permissive disaggregation under consideration is disaggregation based on an employee's similarly situated status such as bona fide employmentrelated criteria (current employee versus former employee status, compensation, bona fide geographic

distinctions, etc.).

- The IRS has requested comments on these various aggregation methodologies.

- **Self-insured plans.** The IRS is looking to provide guidance that will likely affect not only how the cost of applicable coverage is determined for purposes of the excise tax, but how self-insured plans determine the COBRA applicable premium as well. Notably:

  - With limited exception, the method chosen (actuarial or past cost) would need to be used for at least 5 years (exception for the past-cost method due to significant plan changes).

  - Under the actuarial method, a reasonable estimate of the cost of providing coverage under the group health plan would be based on the actual cost the plan is expected to incur and not minimum or maximum exposure.

  - The IRS asks for comments on whether an accreditation of individuals making these actuarial estimates should be required and whether it would be preferable to provide a specific list of factors that must be satisfied to make this actuarial determination.

  - For the past-cost method, the IRS proposes specific cost factors that would be taken into account to determine cost and how those factors can be applied.

- **HRAs.** The IRS has issued very limited guidance on determining the COBRA premium for HRAs. Briefly, the IRS has stated that the COBRA applicable premium for an HRA may not be based on a qualified beneficiary's reimbursement amounts available from the HRA. The IRS proposes a number of mechanisms for determining COBRA costs for HRAs and requests comments on these approaches.

- **Determination period.** The IRS also seeks comments as to how the determination period should be set for COBRA and whether that same determination period can be used to determine the cost of applicable coverage. Under existing COBRA rules, the method for calculating the applicable premium must be elected prior to the determination period for which the applicable premium applies.

Conclusion

Determining the cost of applicable coverage raises a number of issues that affect the

Cadillac Tax, COBRA continuation of coverage, and other areas of benefits law (e.g., W-2 health coverage reporting). This Notice provides early indications of how the IRS contemplates addressing these issues. Future guidance will have a broad impact on employer sponsored group health plan compliance and plan designs. We will be monitoring future regulatory developments, along with legislative changes that may impact the 2018 excise tax. This is the start of a long regulatory process and additional guidance and opportunity for comments will be forthcoming.

For a copy of the Notice and information on how to submit comments, visit: http://www.irs.gov/pub/irs-drop/n-15-16.pdf

Footnotes

1. A qualified retiree means an individual who is receiving coverage by reason of being a retiree, has achieved the age of 55, and is not entitled to benefits or eligible for enrollment in Medicare.
2. High risk professions include:
   - Law enforcement officers
   - Employees in fire protection activities
   - Individuals who provide out-of-hospital emergency medical care (emergency medical technicians, paramedics and first responders)
   - Longshore workers
   - Construction, mining, agriculture (but not food processing, forestry and fishing industries; and
   - Employees retires from one or more of the listed high risk professions who was engaged in that high risk profession for at least 20 years.

Published on June 1, 2015

FAQs Further Clarify New Embedded Out-of-Pocket Requirement

As reported earlier, starting with the 2016 plan year, the selfonly annual limitation on cost sharing for non-grandfathered plans ($6,850 for 2016) applies to each individual, even if the individual is enrolled in family coverage.

On May 26, 2015, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments) issued new FAQs further clarifying this new rule, confirming that it applies to all non-grandfathered group health plans, including self-insured plans, large group health plans, and high deductible health plans.

The Departments also provided the following example:

Assume that a family of four individuals is enrolled in family coverage under a group health plan in 2016 with an aggregate annual limitation on cost sharing for all four enrollees of $13,000. Assume that individual #1 incurs claims associated with $10,000 in cost sharing and that individuals #2, #3, and #4 each incur claims associated with $3,000 in cost sharing (in each case, absent the application of any annual limitation on cost sharing).

In this case, because the self-only maximum annual limitation on cost sharing ($6,850 in 2016) applies to each individual, cost sharing for individual #1 for 2016 is limited to $6,850, and the plan is required to bear the difference between the $10,000 in cost sharing for individual #1 and the maximum annual limitation for that individual, or $3,150. With respect to cost sharing incurred by all four individuals under the policy, the aggregate $15,850 ($6,850 + $3,000 + $3,000 + $3,000) in cost sharing that would otherwise be incurred by the four individuals together is limited to $13,000, the annual aggregate limitation under the plan, under the assumptions in this example, and the plan must bear the difference between the $15,850 and the $13,000 annual limitation, or $2,850.

For the FAQs, visit: http://www.dol.gov/ebsa/pdf/faq-aca27.pdf

Published on June 9, 2015

Guidance Issued on Coverage for Preventive Items and Services

Frequently asked questions (FAQs), prepared jointly by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury were issued on May 12, 2015 with respect to the Affordable Care Act (ACA) requirement for a non-grandfathered group health plan to provide coverage for in-network preventive items and services (including contraception) without any cost-sharing requirements, as summarized below.

Contraception

Plans must cover without cost sharing at least one form of contraception in each method that is identified by the FDA. FAQs provide that, therefore:

1. Because a plan covers some forms of oral contraceptives, some types of IUDs, and some types of diaphragms without cost sharing does not mean that it can exclude completely other forms of contraception.

2. If multiple services and FDA-approved items within a contraceptive method are medically appropriate for an individual patient, the plan may use reasonable medical management techniques to determine which specific products to cover without cost sharing with respect to that individual. However, if the individual's attending a particular service or FDAapproved item based on a determination of medical necessity with respect to that individual, the plan must cover that service or item without cost sharing.

3. For hormonal contraceptive methods, coverage must include all 3 oral contraceptive methods (combined, progestin-only, and extended/continuous use), injectables, implants, the vaginal contraceptive ring, the on (Plan B/Plan B One Step/Next Choice, Ella), and IUDs with progestin.

This clarifying guidance applies to plan years beginning on or after August 1, 2015.

Well-woman Preventive Care for Dependents

If a plan covers dependent children, the plan is required to cover without cost sharing recommended women's preventive care services for dependent children, including recommended preventive services related to pregnancy, such as preconception and prenatal care.

Colonoscopies

It is not permissible for a plan to impose cost sharing with respect to anesthesia services performed in connection with the preventive colonoscopy if the attending provider determines that anesthesia is medically appropriate for the individual.

BRCA Genetic Testing

Plans must cover without cost sharing recommended genetic counseling and breast cancer ("BRCA") genetic testing for a woman who has not been diagnosed with BRCA-related cancer but who previously had breast cancer, ovarian cancer, or other cancer as long as the woman has not been diagnosed with BRCA-related cancer.

Sex-specific Recommended Preventive Services

Plans cannot limit sex-specific recommended preventive services based on an individual's sex assigned at birth, gender identity, or recorded gender. Whether a sex-specific recommended preventive service that is required to be covered without cost sharing is medically appropriate for a particular individual is determined by the individual's attending provider such as, for example, providing a mammogram or pap smear for a transgender man who has residual breast tissue or an intact cervix.

For the FAQs, visit:
http://www.dol.gov/ebsa/pdf/faq-aca26.pdf

Published on June 9, 2015

Protections for LGBT Workers

The EEOC has explained on its website that lesbian, gay, bisexual, and transgender ("LGBT") individuals may bring valid sex discrimination claims against employers. A memorandum lists insurance issues involving benefits for same-sex couples as an issue of particular interest to the EEOC.

Background

Title VII, in part, requires that employers may not discriminate as to employment or benefits based on sex. There is no official statutory extension of Title VII's protections to LGBT employees. Older court decisions have concluded that Title VII does not provide a cause of action for sexual orientation discrimination (as opposed to discrimination against women), although recent case law is evolving.

EEOC Post

A recent EEOC post explains that, based on recent rulings and lawsuits, the EEOC has instructed its investigators and attorneys to counsel individuals who believe they have been discriminated against because of their sexual orientation or transgender status that they may file a complaint of sex discrimination under Title VII. The instructions are derived from a number of actions, including a 2012 EEOC ruling that employment discrimination because of an employee's gender identity is prohibited discrimination based on sex, as well as a 2012 EEOC strategic enforcement plan designating this as an emerging and developing issue. The EEOC position is not binding on courts, although it can carry significant weight.

Other Developments

In related news:

- The EEOC and other federal Government agencies released a guide on the rights and processes available to applicants and employees of federal agencies who allege sexual orientation or gender identity discrimination.

- OSHA published a Guide to Restroom Access for Transgender Workers, providing guidance to employers on best practices regarding restroom access for transgender workers.

Employer Action

In light of these developments, employers may want to revisit their anti-discrimination policies to ensure that they extend to LGBT employees. With respect to group plans, employers may want to begin to review:

- Current plan eligibility and coverage rules; and

- Plan documentation and communications.

Employers should look for further guidance.

Published on June 11, 2015

PCOR Fee Filing Reminder for Self-Insured Plans

The PCOR filing deadline is **July 31, 2015** for all self-funded medical plans and HRAs.

This is the third filing for plans with the following plan years. The amount for these plan years is **$2.08 per covered life**.

- November 1, 2013 – October 31, 2014
- December 1, 2013 – November 30, 2014
- January 1, 2014 – December 31, 2014

This is the second filing for plans with the following plan years. The amount for these plan years is **$2 per covered life**.

- February 1, 2013 – January 31, 2014
- March 1, 2013 – February 28, 2014
- April 1, 2013 – March 31, 2014
- May 1, 2013 – April 30, 2014
- June 1, 2013 – May 31, 2014
- July 1, 2013 – June 30, 2014
- August 1, 2013 – July 31, 2014
- September 1, 2013 – August 31, 2014
- October 1, 2013 – September 30, 2014

For the Form 720 and Instructions, visit: http://www.irs.gov/uac/Form-720,-Quarterly-Federal-Excise-Tax-Return

The information is reported in Part II.

Please note that Form 720 is a tax form (not an informational return form such as Form 5500). As such, the employer or an accountant would need to prepare it. Parties other than the plan sponsor, such as third party administrators and My Benefit Advisor, cannot report or pay the fee.

Short Plan Years

Recently, the IRS issued FAQs that address how the PCOR fee works with a self-insured health plan on a short plan year.

Does the PCOR fee apply to an applicable self-insured health plan that has a short plan year?
Yes, the PCOR fee applies to a short plan year of an applicable self-insured health plan. A short plan year is a plan year that spans fewer than 12 months and may occur for a number of reasons. For example, a newly established applicable self-insured health plan that operates using a calendar year has a short plan year as its first year if it was established and began operating beginning on a day other than Jan. 1. Similarly, a plan that operates with a fiscal plan year experiences a short plan year when its plan year is changed to a calendar year plan year.

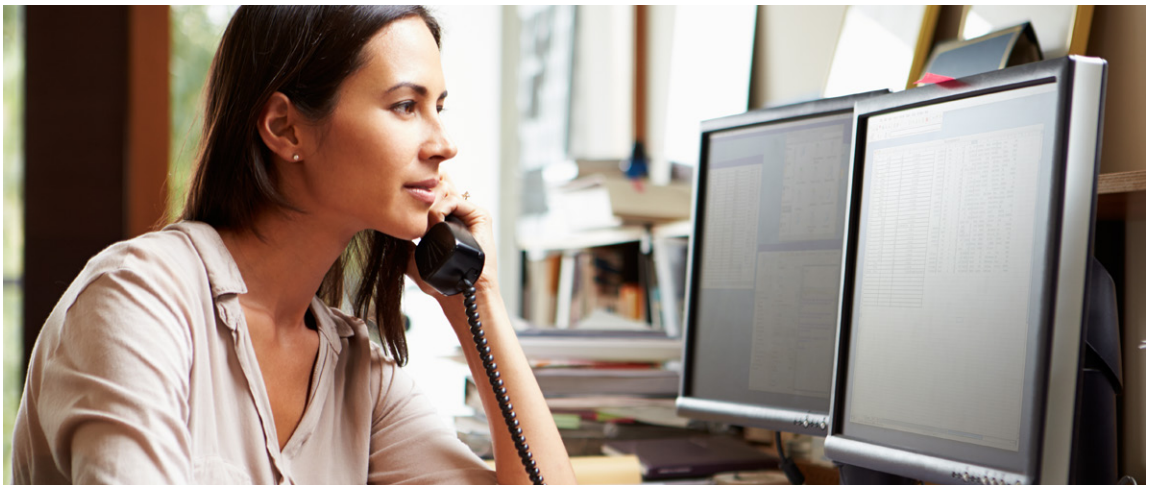
What is the PCOR fee for the short plan year?
The PCOR fee for the short plan year of an applicable selfinsured health plan is equal to the average number of lives covered during that plan year multiplied by the applicable dollar amount for that plan year.

Thus, for example, the PCOR fee for an applicable selfinsured health plan that has a short plan year that starts on April 1, 2013, and ends on Dec. 31, 2013, is equal to the average number of lives covered for April through Dec. 31, 2013, multiplied by $2 (the applicable dollar amount for plan years ending on or after Oct. 1, 2013, but before Oct. 1, 2014).

See FAQ 12 & 13: http://www.irs.gov/uac/Patient-Centered-Outcomes-Research-Trust-Fund-Fee:-Questions-and-Answers

Published on June 15, 2015

Form 5500 Filing Reminder



For calendar year-end plans, the 2014 Form 5500 is due to be filed electronically on EFAST2 no later than July 31, 2015.

ERISA requires that Form 5500 be filed with the Department of Labor for most health and welfare plans (for example, medical, dental, and life insurance plans) by the last day of the seventh month following the end of plan year unless an extension (Form 5558) is completed and mailed to the IRS.

A plan with fewer than 100 covered employees as of the first day of the plan year that is unfunded (no trust) or fully insured is exempt from this requirement. Certain other exceptions apply such as for church plans and governmental plans.

Form 5500 also applies to retirement plans, regardless of employee count.

Should you have any questions, please contact your Account Executive.

Published on June 25, 2015

Supreme Court Upholds Subsidies

On June 25, 2015, the Supreme Court confirmed in a 6-3 decision that premium tax credits and cost-sharing subsidies (referred to as "subsidies") are available in the federal Health Insurance Marketplaces (also referred to as the "Exchange").

This ruling effectively removes any challenges to the ability of Exchanges to offer subsidies to qualified individuals.

What was the Issue?

The Affordable Care Act ("ACA") established Exchanges as a means of offering health insurance coverage. A state is permitted to establish its own Exchange (known as a staterun Exchange), rely on the federal government to establish an Exchange (known as a federally-run Exchange), or enter into a state/federal partnership Exchange.

The issue in this case was whether the IRS set forth rules consistent with the statutory language (as is within its authority) or overstepped its bounds.

Under the text of the ACA (creating Code § 36B), subsidies are available in "an Exchange established by the State under § 1311 of the ACA."

Subsequent IRS regulations interpreted § 36B to permit eligible individuals enrolled in qualified health plans in either a state-based or a federally-facilitated Exchanges to access these subsidies.

As described, any such assessment is predicated on an FTE receiving a subsidy in a Marketplace. If subsidies were ruled unavailable to FTEs because coverage is accessed through a federal marketplace, there may have been nothing to trigger a penalty. However, this did not happen.

Employer Action

As subsidies are available in the 50 states and District of Columbia, employers should do nothing different. Employers should continue to monitor their employer penalty exposure and prepare for future requirements such as the requirement to complete Forms 1094-C and 1095-C and the 2018 "Cadillac Plan" Tax.

Published on June 26, 2015

IRS Releases Draft 2015 Forms 1094-C and 1095-C

Last week, the IRS issued draft 2015 Forms 1094-C and 1095-C.

The forms are substantially the same as the 2014 forms, except for a couple of changes:

- Form 1094-C
    - Line 19 (designating the authoritative transmittal) moves from Part II to Part I
- Form 1095-C
    - A new "Plan Start Month" field is added (optional for 2015, required for 2016 & beyond)
    - Two new codes will be available to indicate if the employer's offer to a spouse is a conditional offer; the codes will be announced later, presumably when the draft instructions are released

Further guidance will be welcome, and we are watching for the draft instructions to be released. However, it is encouraging to see that the regulators did not contemplate significant changes from the 2014 forms. Once finalized, these are the forms that will be used for calendar year 2015 reporting, due in early 2016.

For more information, see the draft forms, here:

- Form 1094-C: http://www.irs.gov/pub/irs-dft/f1094c--dft.pdf
- Form 1095-C: http://www.irs.gov/pub/irs-dft/f1095c--dft.pdf

More information on the large employer reporting requirement is also available here: http://www.irs.gov/Affordable-Care-Act/Employers/Information-Reporting-by-Applicable-Large-Employers.

JULY

Published on July 1, 2015

Supreme Court Ends State Bans on Same-Sex Marriage

On June 26, 2015, in an historic 5-4 decision in Obergefell v. Hodges, the Supreme Court held that the Fourteenth Amendment requires a state to:

- license a marriage between two people of the same sex; and
- recognize a marriage between two people of the same sex when the marriage was lawfully licensed and performed out-of-state.

Before the decision, 13 states banned same-sex marriage, mostly in the Midwest and South.

What was the Issue?

Per the 2013 Supreme Court case decision in U.S. v. Windsor and subsequent guidance, same-sex spouses were recognized for all federal purposes, including federal taxation, COBRA, HIPAA, and FMLA, based on the validity of the marriage in the state of celebration and not on the married couple's residence. However, Windsor did not address whether state bans on same-sex marriage (or a refusal to recognize a same-sex marriage validly performed in another state) were valid.

The plaintiffs filed lawsuits in their respective states claiming that state officials violated their Fourteenth Amendment rights by refusing to issue marriage licenses denying them the right to marry and/or by failing to recognize their marriages that were legally performed in a state which fully recognized the right for same-sex couples to legally marry.

The Court held that the Fourteenth Amendment requires a state to license a marriage between any two adults, including a couple of the same sex, and to recognize marriages of same-sex couples lawfully performed in other states.

Similar Concepts

There are various related benefit eligibility concepts.

Domestic Partners

There are domestic partner registries in some states.Domestic partner status does not necessarily affect medical insurance eligibility, but it might. Employers can voluntarily extend benefits to domestic partners, using a definition created by the employer (and approved by any carrier). This may (or may not) include opposite-sex couples. Employers who voluntarily extend benefits to same-sex domestic partners because same-sex couples could not get married may want to amend their plans to remove this eligibility class.

Civil Unions

Some states recognize civil unions which is marriage-like status for same-sex couples. Employees' civil union partners must be treated in the identical manner as employees'

opposite-sex spouses with respect to any insurance policy issued in Colorado, for example. We may see states eliminate this concept in the future, but it remains for now.

Neither of the above concepts is altered by the recent Supreme Court decision.

Common Law Marriage

Common law marriage is a valid marriage that is entered into informally in certain states. Now, states will have to extend this concept to same-sex couples. Self-funded plans may exclude common law spouses when reflected in plan documentation. Insured plans may not.

Coverage for any of the above classifications is not required as to self-funded plans. Coverage for the above classifications is generally required under insured plans.

California, for example, requires eligibility for domestic partners, regardless of where the policy is written.

How does this Impact Employee Benefit Plans?

Obergefell prohibits a state from banning same-sex marriage. However, it does not

directly address what employers must do as a result of this ruling. Because many states already recognized same-sex marriages as legal, the impact of the Court's decision may mostly affect employer-sponsored fullyinsured health and welfare plans in states that currently ban same-sex marriage, as well as employer-sponsored self-funded plans that exclude same-sex spouses from eligibility. Although state law does not generally apply to self-funded plans, there may be increased risk under federal and state discrimination laws for plans that have a definition of spouse that is not consistent with the Supreme Court ruling since the Court held that marriage is a fundamental right under the Constitution.

Employer Action

- Employers already extending benefits to same-sex spouses are not affected. Review existing plan documents and SPDs to ensure eligibility terms align with practices.
- Sponsors of insured plans in states that have banned same-sex marriage are required to include lawfully married samesex spouses, even if the marriage was conducted in another state.
- Public employers such as state and local governments are required to treat same-sex spouses like opposite-sex spouses for benefits purposes.
- For private employers, the ERISA preemption generally thought to be available to self-funded plans that define "spouse" as being only a opposite-sex spouse will likely be weakened by this decision.
- Employers should expect related guidance to be issued.

For tax treatment of premium payments at the federal level, all legal spouses should be treated the same. As a result of this decision, it is expected that state tax rules should align with the federal rules; however, further guidance is expected. Payroll systems may need to be adjusted.

Published on July 2, 2015

Final SBC Rules Issued

As background, the Affordable Care Act ("ACA") requires a summary of benefits and coverage ("SBC") and uniform glossary to be provided to plan participants at time of enrollment. Significant penalties (up to $1,000) may be imposed for each individual who does not receive this summary. If any material changes are made to the document outside of renewal, the participant must be notified 60 days prior to the effective date of the change.

On December 22, 2014, the Departments of Labor ("DOL"), the Internal Revenue Service ("IRS"), and Health and Human Services ("HHS") (collectively, "the Departments") issued proposed rules and supporting documents addressing the SBC requirement.

On June 12, 2015, final rules were issued. These final rules largely follow the proposed rules.

The regulations provide new information and also incorporate several FAQs that have been issued since the final SBC regulations were issued in 2012. The rules clarify when and how a plan administrator or insurer must provide an SBC and shorten its length.

The new requirements are effective for plan years and open enrollment periods beginning on or after September 1, 2015. The updated SBC templates and related documents will apply to coverage that begins on or after January 1, 2017.

Additional information follows.

SBC from the Issuer to the Employer

The regulations:

- Clarify that when a health insurance issuer offering group health insurance coverage provides the SBC to the employer before application for coverage, the requirement to provide an SBC upon application is deemed satisfied unless there is a change to the information

required to be in the SBC. If there has been a change in the information required, a new SBC that includes the correct information would have to be provided on application.

- Clarify how to satisfy the requirement to provide an SBC when the terms of coverage are not finalized. If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, the issuer would not be required to provide an updated SBC (unless an updated SBC is requested) until the first day of coverage. The updated SBC would have to reflect the final coverage terms under the contract, certificate, or policy of insurance that was purchased.

SBC from the Employer to Employees

The regulations:

- Clarify when a plan must provide the SBC to employees again if the plan already provided the SBC prior to application. If the plan provides the SBC prior to application for coverage, the plan is not required to automatically provide another SBC upon application, if there is no change to the information required to be in the SBC. However, if there is any change to the information required to be in the SBC by the time the application is filed, the plan must update and provide a current SBC as soon as practicable following receipt of the application, but in no event later than 7 business days following receipt of the application.

- Clarify how to satisfy the requirement to provide an SBC to employees when the terms of coverage are not finalized. If the plan sponsor is negotiating coverage terms after an application has been filed and the information required to be in the SBC changes, the plan is not required to provide an updated SBC (unless an updated SBC is requested) until the first day of coverage. The updated SBC should reflect the final coverage terms under the contract, certificate, or policy of insurance that was purchased.

Online Posting by Insurers

Insurers must include an Internet address where a copy of the actual certificate of coverage is "easily available" to individuals shopping for coverage. Because the actual certificate will not be available until the plan sponsor has negotiated the terms of coverage, insurers should post a sample group certificate of coverage for each product and make the actual certificate (once executed) available to the plan sponsor, participants, and beneficiaries via an Internet address.

Elimination of Duplication

The regulations:

- Add a provision to prevent unnecessary duplication with respect to a group health plan that uses 2 or more insurance products provided by separate issuers to insure benefits under the plan. The regulations place responsibility for providing complete SBCs with respect to the plan in such a case on the group health plan administrator. Under the rule, the group health plan administrator may contract with one of its issuers (or other service providers) to provide the SBC; however, absent a contract to perform the function, an issuer has no obligation to provide an SBC containing information for benefits that it does not insure.

- State that, under circumstances where an entity required to provide an SBC with respect to an individual has entered into a binding contract with another party to provide the SBC to the individual, that the entity would be considered to satisfy the requirement to provide the SBC with respect to the individual if specified conditions are met:

    - The entity monitors performance under the contract;

    - If the entity has knowledge that the SBC is not being provided in a manner that satisfies the requirements of this section and the entity has all information necessary to correct the noncompliance, the entity corrects the noncompliance as soon as practicable; and

    - If the entity has knowledge the SBC is not being provided in a manner that satisfies the requirements of this section and the entity does not have all information necessary to correct the noncompliance, the entity

communicates with participants and beneficiaries who are affected by the noncompliance regarding the noncompliance, and begins taking significant steps as soon as practicable to avoid future violations.

New SBC Template

Revisions to the SBC, coverage examples, and uniform glossary are anticipated to be finalized by January 2016 after the Departments utilize consumer testing and receive additional input from the public. The SBC will be shorter in length and clearer and will apply to coverage that would renew or begin on the first day of the first plan year that begins on or after January 1, 2017 (including open enrollment periods that occur in 2016 for coverage beginning on or after January 1, 2017).

Effective Date

The changes apply for disclosures with respect to participants and beneficiaries who enroll or re-enroll in group health coverage through an open enrollment period beginning on the first day of the first open enrollment period that begins on or after September 1, 2015. For disclosures to participants and beneficiaries who enroll in group health coverage other than through an open enrollment period (including those newly eligible for coverage), the revised requirements would apply beginning on the first day of the first plan year that begins on or after September 1, 2015.

Employer Action

Employers should be ready to comply with the new rules for the 2016 plan year and be ready for the revised template to be used for 2017 plan year.

Published on July 15, 2015

Is Your Company Ready for the New Reporting Requirements?

In early 2016, employers with at least 50 full-time employees (FTEs) must provide Forms 1095-C to their employees and to the IRS. This new requirement applies to both insured and self-insured medical plans. The forms require, in part, tracking per each month in 2015 per each FTE:

- the tier of health plan coverage offered (e.g., employee-only, employee+spouse, or no coverage offered);
- the self-only premium an employee must pay for the lowest-cost plan that provides minimum value; and
- the reason why an employer would not be subject to a penalty for a particular month (e.g., employee is in a waiting period or the affordability safe harbor applies).

This individualized tracking generally requires the assistance of an outside vendor. There are payroll vendors, benefit administration vendors, and independent vendors providing this service. Employers with payroll vendors and/or benefit administration vendors currently in place may still need to purchase this service in addition to what they already have. Implementation can take up to 3 months. Some vendors are no longer accepting new clients. Therefore, Emerson Reid recommends that employers prepare ASAP if they have not already. Waiting until the last quarter of 2015 may make compliance impracticable.

Penalties for failure to file were recently increased. They can range from $50 per form (with a $500,000 annual maximum) to $250 per form (with a $3M annual maximum)

Attached please find additional information.

Published on July 29, 2015

Should an Employer with 51-100 Full-time Employees Change Its Policy Year to Delay Compliance with Certain ACA Provisions?

Representatives from several insurance carriers are encouraging employers with 51-100 full-time employees to move their policy years to October 1 – September 30, effective October 1, 2015, to delay certain Affordable Care Act ("ACA") design requirements applicable to non-grandfathered group health plans for plan years beginning on or after January 1, 2016, summarized as follows:

- Small, insured group health plans must offer essential benefits and provide a bronze level of coverage.

- Insurance carriers will be subject to new underwriting rules with respect to small, insured groups. Instead of using experience rating, carriers will use community rating. Rating variations will be restricted to (a) benefit coverage elected (plan and tier), (b) geographic area, (c) age, limited to a ratio of 3 to 1 for adults, and (d) tobacco use, limited to a ratio of 1.5 to 1.

The definition of "small employer" will increase from an employer with up to 50 employees to an employer with up to 100 employees, beginning with the 2016 plan year.

The compliance issues associated with this proposal are outlined below.

Notably:

- there is transition relief available in some states by some carriers which allows employers to keep their current products through September 30, 2017; and

- changing the plan year to later in the calendar year will expose a mid-sized employer to the employer penalty as of January 1, 2015 rather than the first day of the 2016 plan year.

CMS Transitional Policy

Under a transitional policy, non-grandfathered health insurance coverage in the 51 – 100 market that is renewed for a policy year starting between January 1, 2016 and October 1, 2016 (even if the employer did not previously have health insurance coverage) will not be considered to be out of compliance with newly effective market reforms if permitted by the state and offered by the health insurance issuer.

An employer who employs 51-100 employees is not required to remain with the same insurer between 2013 and 2016 in order to be eligible for transitional relief in 2016.

2015 Transition Relief for Employers with 50-99 Full-time Employees

Beginning in 2015, large employers can be subject to penalty when not offering affordable, minimum value coverage to all full-time employees. Final rules provide relief for mid-sized employers to delay the Employer Penalty until 2016.

The transition relief applies to all calendar months of 2015 plus any calendar months of 2016 that fall within the employer's 2015 plan year so will cover non calendar-year plans, but only if the employer did not modify the plan year after February 9, 2014 to begin on a later calendar date (for example, changing the start date of the plan year from January 1 to December 1).

The other conditions are as follows:

1. **Limited Workforce Size.**
   The employer employs on average at least 50 FTEs (including full-time equivalent employees) but fewer than 100 FTEs (including full-time equivalent employees) on business days during 2014.

2. **Maintenance of Workforce and Aggregate Hours of Service.**
   During the period beginning on February 9, 2014 and ending on December 31, 2014, the employer does not reduce the size of its workforce or the overall hours of service of its employees in order to satisfy the workforce size condition described in (1) above. Bona fide business reasons for a reduction in workforce size or overall hours of service will not be considered to violate this provision. For example, reductions of workforce size or overall hours of service because of business activity such as the sale of a division, changes in the economic marketplace in which the employer operates, terminations of employment for poor performance, or other similar changes unrelated to eligibility for this transition relief are for bona fide business reasons and will not affect eligibility for the transition relief.

3. **Maintenance of Previously Offered Health Coverage.**
   During the coverage maintenance period, the employer does not eliminate or materially reduce the health coverage, if any, it offered as of February 9, 2014. For purposes of this paragraph, the term "coverage maintenance period" means for an employer with a calendar year plan, the period beginning on February 9, 2014 and ending on December 31, 2015; and for an employer with a non-calendar year plan, the period beginning on February 9, 2014 and ending on the last day of the plan year that begins in 2015. An employer is not treated as eliminating or materially reducing health coverage if:

   - it continues to offer each employee who is eligible for coverage during the coverage maintenance period an employer contribution toward the cost of employee-only coverage that either:
     - is at least 95% of the dollar amount of the contribution toward such coverage that the employer was offering on February 9, 2014, or
     - is the same (or a higher) percentage of the cost of coverage that the employer was offering to contribute toward coverage on February 9, 2014;
   - when there is a change in benefits under the employee-only coverage offered, that coverage provides minimum value ("MV") after the change; and
   - it does not alter the terms of its group health plans to narrow or reduce the class or classes of employees (or the employees' dependents) to whom coverage under those plans was offered on February 9, 2014.

4. **Certification of Eligibility for Transition Relief.**
   The large employer certifies on Form 1094-C that it meets the (1) – (3) above.

Plan Year v. Policy Year

The policy year is relevant for transition rule purposes. The plan year is relevant for employer penalty purposes. A plan year is an accounting period. It is usually the same as the policy year (the period for which rates are locked in), but not always.

To confirm the plan year, employers can examine the summary plan description and/or Form 5500.

Employers relying on transition relief for the employer penalty until 2016 will no longer qualify if they change their plan years along

with their policy years.

If employees pay premiums on a pre-tax basis, there should be a plan year change for the cafeteria plan. Any plan year change would have to be properly documented.

It may be desirable to change other policy years (e.g., for the disability and life insurance plans) as well to maintain a consistent program.

Bottom Line

Employers with 51-100 full-time employees can move their policy years to October 1 – September 30, effective October 1, 2015, to delay certain design requirements applicable to non-grandfathered group health plans. In addition to changing a policy year, employers should change the plan years of their cafeteria plans to allow employees to make pre-tax elections for the new period of coverage. Also, if desired, employers should change the policy years of their other underlying benefit plans.

Employers with 50-99 full-time employees relying on transition relief for the employer penalty until 2016 should not change their plan years along with their policy years.

Published on July 31, 2015

Interim Guidance Addresses Expatriate Health Coverage

The Department of the Treasury, Department of Labor, and Department of Health and Human Services (collectively, the "Departments") recognize that insurers and plan sponsors may need additional time to modify their current expatriate health plans to comply with the Affordable Care Act ("ACA") and thus provide relief by allowing application of a reasonable good faith interpretation of the standards in place. Future regulations are expected.

Background

The Departments issued Frequently Asked Questions ("FAQs") providing relief from the ACA market reform requirements for certain expatriate group health insurance coverage in 2013.

On December 16, 2014, the Expatriate Health Coverage Clarification Act of 2014 ("EHCCA") made further changes, applicable to plans issued or renewed on or after July 1, 2015.

Notice 2015-43 and Recap of Previous Guidance

Notice 2015-43 provides that, until the issuance of further guidance, taxpayers can apply this previously-issued guidance using a reasonable good faith interpretation except as to the PCOR Fee or the Health Insurer Fee.

So where are we now? The following summarizes the changes as to expatriate health plans issued or renewed after July 1, 2015:

Expatriate plans are defined as self-funded and fully insured plans that offer coverage to qualified expatriates and their dependents. Qualified expatriates are: (1) certain foreign employees transferred or assigned to the U.S. for a specific and temporary employment purpose or assignment, (2) individuals working outside the U.S. for at least 180 days in a 12-month period, and (3) "similarly situated individuals."

Guidance:

- Exempts fully insured and self-funded expatriate health plans from most of the ACA's market reforms (though not the adult dependent/age 26 requirement).
- Deems expatriate health plans to be "minimum essential coverage" for expatriate employees and their dependents, regardless of where they are located in the world.
- Deems expatriate health plans to be "minimum essential coverage under an eligible employer-sponsored plan" for purposes of the employer mandate with respect to certain foreign employees working in the U.S. and certain U.S.

expatriates working abroad.

- Exempts expatriate plans from the Reinsurance Fee.
- Exempts expatriate plans from the PCOR Fee.
- Exempts expatriate plans from the Health Insurer Fee after 2015 and reduces the fee for 2014 and 2015.
- Exempts employer-sponsored coverage of most categories of expatriates from the Cadillac Plan tax.
- Exempts expatriate health plans from a change in the definition of a "small group," which could have prevented the sale of expatriate coverage to employers with 50 to 99 lives.
- Exempts insurers of expatriate health plans and expatriate health plans from the so-called "administrative simplification" requirements, including SBC requirements.

The Employer Penalty and reporting requirements of Code Sections 6055 and 6056 (Forms 1095-C and 1094-C) still apply. However, for expatriate health plans, statements to individuals reporting minimum essential coverage may be furnished in electronic format unless the recipient refuses consent.

Plan sponsors of expatriate plans should review their plan design carefully to ensure they are in compliance with certain provisions of the ACA still applicable to such plans.

For the Notice, visit:
http://www.irs.gov/pub/irs-drop/n-15-43.pdf

Published on July 31, 2015

Reduction in Hours Subject to Lawsuit in New York

The first complaint was filed challenging the permissibility of reducing hours below 30 per week in order to avoid the Employer Penalty.

The complaint was filed in a New York district federal court on behalf of 10,000 workers at Dave and Buster's. The plaintiffs allege that their hours were cut so that Dave and Buster's could avoid health care costs associated with expanding eligibility in order to avoid the Employer Penalty. Under the Employer Penalty, large employers can be penalized if they do not offer affordable, minimum value coverage to all full-time employees ("FTEs"). FTEs are defined as employees working on average 30 hours per week.

Many other employers have implemented the same strategy.

The plaintiffs are suing under ERISA Section 510 which makes it unlawful for any person to discriminate against a plan participant or beneficiary for the purpose of interfering with any right the he or she may become entitled to under ERISA or under an employee benefit plan.

We will continue to monitor this case.

AUGUST

Published on August 24, 2015

Additional Guidance Issued on the Cadillac Plan Tax

Beginning January 1, 2018, a 40% excise tax will apply on the cost of applicable coverage that exceeds prescribed thresholds. Commonly, this is referred to as the "Cadillac Plan Tax." The 2018 thresholds are $10,200 for self-only coverage and $27,500 for coverage other than self-only. These thresholds are annualized and adjusted in certain circumstances.

The IRS issued Notice 2015-16 to begin the process of developing regulatory guidance regarding the excise tax on high cost employer-sponsored health coverage.

On July 30, 2015, the IRS issued additional guidance in the form of Notice 2015-52. Rather than providing instruction, the notice identifies issues and describes potential approaches which could be incorporated in future proposed regulations and invites comments. After considering the comments on both notices, Treasury and IRS intend to issue proposed regulations. The proposed regulations will provide further opportunity for comment, including an opportunity to comment on the issues addressed in the preceding notices. Proposed regulations are not expected before 2016.

Specifically this notice addresses:

- The effective date
- Identification of who is liable to pay the tax
- Determining the cost of applicable coverage
- Adjustments to the $10,200/$27,500 thresholds based on age and gender
- Allocation of the tax among multiple coverage providers
- Employer aggregation rules
- Payment of the tax
- Below you will find additional information.

Effective Date

The Cadillac Plan Tax is effective for "taxable years beginning after December 31, 2017." The Notice confirms that a taxable year is anticipated to mean a calendar year, not a plan year so that the effective date is January 1, 2018 for all plans. If a non-calendar year plan needs to make changes in order to avoid the tax, such changes must be done either with the 2017 plan year renewal or through a mid-year plan change on or before January 1, 2018.

Identification of the Payer

Under the ACA, the employer is required to determine the amount of the Cadillac Plan Tax on a monthly basis and then allocate that tax among "coverage providers." So, while the employer is the party required to calculate the tax, the coverage provider is the entity responsible for paying the tax. The "coverage provider" is the insurer for an insured plan and the employer for an HSA. For self-funded plans, the coverage provider is the "person that administers the plan benefits" which is not further defined. The IRS proposes two approaches for consideration:

- Under the first approach, the coverage provider would be the person or entity responsible for performing day-to-day functions related to administration of the plan (e.g., processing claims or handling participant inquiries). This would be a third party administrator ("TPA"). This would likely be challenging in the case of multiple TPAs (e.g., one for the medical plan, one for the prescription drug benefit, and one for the health FSA).
- Under the second approach, the coverage provider would be the person or entity that has the ultimate authority or responsibility with respect to administration. Generally, this would be the employer.

Calculation of the Cost of Applicable Coverage

Determination period

To determine excise tax liability, an employer must determine the extent, if any, to which the cost of apOn July 31, 2015, President Obama signed into law H.S. 3236, Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. Notably, the law makes changes affecting the employer mandate and HSA eligibility as to individuals who are (or were formerly) service members.

- Employees with TRICARE or Veterans Benefits are not counted when determining ALE status. When counting employees in a prior calendar year to determine whether an employer is an applicable large employer ("ALE"), thus subject to the employer mandate under 4980H, any employee who has coverage under the TRICARE program or Veterans Coverage is not counted. However, if the employer is an ALE, employees with TRICARE or Veterans Benefits need to be analyzed for full-time employee status. This is effective as of January 1, 2014 (retroactive application).

- Certain Veterans Benefits do not disqualify an individual from HSA eligibility. Effective for months beginning after December 31, 2015, an individual with Veterans Benefits for a service-connected disability will not fail to be eligible to open or make contributions to an HSA. Otherwise, under an existing rule, an individual who receives Veterans Benefits is not HSA eligible for 3 months after receipt of such benefits.

overage provided to an employee during any month of the calendar year exceeds the prescribed dollar limit. As the amount of the tax is calculated per employee per month over the calendar year, the IRS sees potential timing issues to calculate these amounts. In addition, some arrangements create additional complexity to determine the amount over the threshold in any month (e.g., experienced rated contracts or plans with a premium discount or holiday). The IRS seeks further comments on these issues.

Excluding income tax reimbursements from the cost of applicable coverage

If an entity other than the employer is responsible for paying the excise tax, that entity will likely pass the cost of the tax through to the employer in the form of increased service fees. The cost of applicable coverage does not include these amounts. However, there could be income taxes incurred due to the additional service fees. The IRS has requested comments on methods for excluding income tax reimbursements, including what tax rate to use.

Annual contributions to account-based plans

The full annual contributions to account-based plans such as HSAs may be made as of the first day of the plan year or otherwise not on a monthly basis (e.g., on a quarterly basis). This could trigger the excise tax in the months of contribution because the cost of applicable coverage is determined on a monthly basis. To avoid this result, the IRS indicated that it is considering an approach that would allow employers to apply annual contributions on a pro rata basis over the course of the year, regardless of the actual timing of contributions during that period.

Flex credits and carry-overs under health FSAs

The IRS stated that when an employer contributes nonelective flex credits to an FSA on behalf of an employee, the cost of applicable coverage includes:

- the employee's contributions; and

- the amount of non-elective flex credits actually used for reimbursements (i.e., unused nonelective flex credits are not included in the cost of applicable coverage).

In addition, under a safe harbor, amounts carried over from previous years will not be included in the cost of applicable coverage. The IRS plans to restrict the availability of this safe harbor if non-elective flex credits are available.

Age and Gender Adjustments to the Applicable Dollar Limit

The $10,200/$27,500 (as indexed) statutory thresholds can be increased based on the age and gender characteristics of all the employees of the employer in comparison to the national workforce. The IRS is considering rules allowing employers to determine these characteristics based on a "snapshot" on the first day of the plan year. The IRS also indicated that it is developing age and gender adjustment tables to assist employers in applying the adjustment.

Employer Aggregation

For purposes of the excise tax generally, all employers that are part of a controlled group are treated as a single employer. The notice asks for comments on the challenges this statutory requirement presents in identifying applicable coverage, determination of the age and gender adjustment, employees taken into account for adjustment for employees in high risk professions or who repair and install electrical or telecommunications lines, identification of the taxpayer responsible for calculating and reporting the excess benefit, and employer liability for any penalty in the case of failure to properly calculate the tax

Timing and Manner of Payment

The agencies are considering using the same manner of payment for the Cadillac Plan Tax applicable to the PCOR fee – using Form 7202 for payment of the tax.

Published on August 25, 2015

New Law Clarifies Employer Mandate and HSA Eligibility for Veterans

On July 31, 2015, President Obama signed into law H.S. 3236, Surface Transportation and Veterans Health Care Choice Improvement Act of 2015. Notably, the law makes changes affecting the employer mandate and HSA eligibility as to individuals who are (or were formerly) service members.

- Employees with TRICARE or Veterans Benefits are not counted when determining ALE status. When counting employees in a prior calendar year to determine whether an employer is an applicable large employer ("ALE"), thus subject to the employer mandate under 4980H, any employee who has coverage under the TRICARE program or Veterans Coverage is not counted. However, if the employer is an ALE, employees with TRICARE or Veterans Benefits need to be analyzed for full-time employee status. This is effective as of January 1, 2014 (retroactive application).
- Certain Veterans Benefits do not disqualify an individual from HSA eligibility. Effective for months beginning after December 31, 2015, an individual with Veterans Benefits for a service-connected disability will not fail to be eligible to open or make contributions to an HSA. Otherwise, under an existing rule, an individual who receives Veterans Benefits is not HSA eligible for 3 months after receipt of such benefits.

Published on August 25, 2015

Draft 2015 Form 1095-C and Instructions, Increased Penalties, and Electronic Filing Steps Issued

As background, beginning with calendar year 2015, an applicable large employer ("ALE") must use Forms 1094-C and 1095-C to report the information required under Internal Revenue Code sections 6055 and 6056 about offers of health coverage. The information reported allows the IRS to manage the requirements of both the individual and employer mandates and subsidy eligibility under the Affordable Care Act ("ACA").

Draft 2015 Forms 1094-C and 1095-C and Instructions

On August 7, 2015, the IRS issued revised draft 2015 Form 1095-C with instructions. The forms and instructions are substantially the same as those applicable to the 2014 year, but include the following changes:

- Add a first month of the plan year indicator (plan start month) in Part II and a Part III Covered Individuals Continuation Sheet. Completing this new box is optional for the 2015 form. This change was in the previously-issued draft form issued in June 2015.
- Indicate in the Forms 1095-B and 1095-C instructions that ALEs may use Form 1095-B instead of Form 1095-C to report coverage of individuals who are not full-time employees ("FTEs") for any month during the year. However, an ALE must still report any employee (full- or part-time) enrolled in self-insured coverage on Form 1095-C.
- Appear to require insured plans to now report offers of COBRA to former FTEs that actually enroll in the COBRA coverage and to employees offered COBRA based on a reduction in hours.
- Expand the order of priority for line 16 code selection.
- Provide that an automatic 30-day extension is granted by submitting a Form 8809 by the due date of the forms.
- Provide that a waiver from the required filing of information returns electronically by submitting Form 8508 at least 45 days before the due date of the returns.

- Provide information regarding when and how a corrected form is filed.
- Clarify that Form 1095-C may be hand delivered to individuals.
- Indicate that for Line 14 of the Form 1095-C for the 2015 tax year, an employer using the multiemployer arrangement interim guidance can use code 1H (no offer) for any month for which it enters code 2E (multiemployer plan relief) on line 16 without regard to whether the employee was actually eligible to enroll in coverage under the multiemployer plan. The 2014 instructions required that the employer report the code for the actual coverage offered to the employee where the employer qualified for the relief.
- Include important clarifications on how to report for COBRA participants, reflective of previously-issued Q&As. Those Q&As provide that when an offer of COBRA coverage is made to a former employee as the result of a termination from employment, the employer should indicate on Form 1095-C that an offer of coverage was made only if the former employee actually elects to enroll in the coverage. The reason for this is that the IRS does not want to disqualify a terminated employee from a premium subsidy based on an offer of COBRA coverage that was not accepted. However, when an offer of COBRA coverage is made to an employee due to a reduction in hours, the employer should indicate on Form 1095-C that an offer of coverage was made, whether or not the employee elects to enroll in the coverage. In this situation, the cost used to determine affordability should be the employee's self-only COBRA premium or contribution.

Also, per previously-issued draft Form 1094-C, line 19 (Is this the Authoritative Transmittal for this ALE Member?) was moved from Part II into Part I of the form and to allow for an entry in the "All 12 Months field" in Part III, Line 23, column (b) Full-Time Employee Count for ALE Member.

As stated above, the forms and instructions are only in draft form at present and are subject to further changes prior to being made final. Once finalized, these are the forms that will be used for calendar year 2015 reporting, due in early 2016.

For more information, see the draft forms and instructions here:

Form 1094-C: http://www.irs.gov/pub/irs-dft/f1094c--dft.pdf

Form 1095-C: http://www.irs.gov/pub/irs-dft/f1095c--dft.pdf

Instructions: http://www.irs.gov/pub/irs-dft/i109495c--dft.pdf

Also note that the IRS indicated that for 2016 reporting, due in early 2017, new indicator codes will be established to require employers to report conditional offers to spouses. A conditional offer is one that is subject to a reasonable, objective condition such as offering coverage upon certification that the spouse does not have group health coverage available from another employer. Currently, the instructions to Form 1095-C provide that a conditional offer such as this should be treated as an offer for reporting purposes only. However, the new indicator codes are needed so that the IRS can determine whether the spouse should be eligible for a premium tax credit.

Increased Penalties

Penalties for filing failures have been increased via the Trade Preferences Extension Act of 2015 (the "Act"), effective with this first year as follows:

Penalty	Previous Amount	Revised Amount
Failure to file/furnish an annual IRS return or provide individual statements to all full-time employees	$100	$250
Annual cap on penalties	$1,500,000	$3,000,000
Failure to file/furnish when corrected within 30 days of the required filing date	$30	$50
Annual cap on penalties when corrected within 30 days of required filing date	$250,000	$500,000
Failure to file/furnish when corrected by August 1 of the year in which the required filing date occurs	$60	$100
Cap on penalties when corrected by August 1 of the year in which the required filing date occurs	$500,000	$1,500,000
Lesser cap for entities with gross receipts of not more than $5,000,000	$500,000	$1,000,000
Lesser cap for entities with gross receipts of not more than $5,000,000 when corrected within 30 days of required filing date	$75,000	$175,000
Lesser cap for entities with gross receipts of not more than $5,000,000 when corrected by August 1 of the year in which the required filing date occurs	$200,000	$500,000
Penalty per filing in case of intentional disregard. No cap applies in this case.	$250	$500

To access the Act, visit: https://www.congress.gov/114/bills/hr1295/BILLS-114hr1295enr.pdf?elqTrackId=3d8f383c69614727a7601244c2f57972&elq=f15626ced81d4b068dc139147d4d8c33&elqCampaignId=&elqaid=9563&elqat=1

For additional information, see: http://www.irs.gov/Affordable-Care-Act/Employers/Information-Reporting-by-Providers-of-Minimum-Essential-Coverage

Electronic Filing Steps

Filers of 250 or more information returns must file the returns electronically, subject to waiver via Form 8508. Filers of less than 250 information returns may file the returns electronically.

Employers (and vendors on behalf of employers) are required to use the ACA Information Return ("AIR") system and complete the following steps prior to being able to electronically submit any forms:

1. Register with the IRS's e-services website, including submission of personal information about the person registering for the Submitting Entity;
2. Obtain an AIR Transmitter Control Code ("TCC"), a unique identifier authorizing each Submitting Entity to submit the

Reporting Forms; and

3. Pass a series of technical/system tests to ensure that Reporting Forms will be properly submitted when due.

The first two steps can be completed now. The third step is anticipated to become available in the fall.

For more information on the AIR program, visit: http://www.irs.gov/for-Tax-Pros/Software-Developers/Information-Returns/Affordable-Care-Act-Information-Returns-AIR-Program-Did-You-Know%3F?elqTrackId=f29970dbb4384383a49cc85c0c3afc53&elq=f15626ced81d4b068dc139147d4d8c33&elqCampaignId=&elqaid=9563&elqat=1

For the reference guide, visit: http://www.irs.gov/PUP/for_taxpros/software_developers/information_returns/AIR_Composition_and_Reference_Guide.pdf

For the updated draft of IRS Publication 5164, Test Package for Electronic Filers of ACA Information Returns, visit: http://www.irs.gov/PUP/for_taxpros/software_developers/information_returns/Pub%2

Published on August 28, 2015

Final Rules Address the Contraceptives Mandate

The Affordable Care Act ("ACA") requires non-grandfathered group health plans to cover certain mandated preventive care services, including contraception, at no cost. This requirement does not apply to grandfathered plans.

On July 14, 2015, the Departments of Labor, the Treasury, and Health & Human Services (jointly, "the Departments") issued final regulations. Briefly the guidance:

- Defines a closely held for-profit employer.
- Describes how a closely held for-profit employer may claim an accommodation and avoid providing contraceptive services that violate religious beliefs.
- Describes an alternative notice process for entities that object to completing the EBSA Form 700 to claim an accommodation.
- Outlines the process for third party administrators (TPAs) to provide contraceptives when a health plan claims an accommodation.

These regulations are effective for plan years beginning on or after October 1, 2015.

Background

Beginning in 2012, the requirement to provide certain preventive care services included coverage of all FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a health care provider (collectively, contraceptive services). Religious employers are exempt from the contraceptives requirement. Additionally, non-profit religious organizations that oppose providing some or all of the required contraceptive services based on religious beliefs (eligible organizations) could qualify for an accommodation by self-certifying their objections using EBSA Form 700. This removed the burden from the non-profit and imposed the requirement to provide free contraceptives on the carriers and TPAs without cost to the individual or the plan.

Before the Hobby Lobby decision no accommodation was available to a for-profit company. Hobby Lobby, a closely held for-profit entity, challenged the contraceptive

services portion of the preventive care mandate, as the organization felt the requirement interfered with religious beliefs. The case made its way to the U.S. Supreme Court and on June 30, 2014, the Court found the contraceptives mandate violated Hobby Lobby's rights under the Religious Freedom Restoration Act of 1993 (RFRA). Over a year after this ruling, the Departments issued final regulations that incorporate for-profit companies into the accommodation process.

Eligible Organizations

The regulations finalize the definition of an eligible organization for purposes of qualifying for an accommodation. An eligible organization is an organization that opposes providing coverage for some or all contraceptive items and services on account of religious objections and is either:

- organized and operated as a non-profit entity and holds itself out as a religious organization; or

- organized and operated as a closely held for-profit entity and the highest governing body (e.g., board of directors, board of trustees, or owners if managed directly by its owners) has adopted a resolution or other similar action establishing that it objects to covering some or all contraceptive services on account of the owner's sincerely held religious beliefs.

Closely Held For-Profit Entity

A closely held for-profit entity, not previously defined, is defined as an entity that:

- is not a non-profit entity;

- has no publically traded ownership interests; and

- has more than 50% of the value of its ownership interest owned directly or indirectly by five or fewer individuals4 (or an ownership structure that is substantially similar to these requirements) as of the date of the entity's self-certification or notice.

For purposes of the 50% threshold (or substantially similar ownership interest), the Departments lay out specific ownership interest considerations that are consistent with other areas of tax law.

Additionally, a for-profit entity may seek clarification from HHS as to whether it qualifies as a closely held entity. The for-profit entity may send a letter describing the ownership structure to HHS. If no response is received by HHS within 60 calendar

days, the requirement is deemed to be satisfied so long as the entity maintains that structure.

Process for Eligible Organizations

To qualify for the accommodation, the organization (non-profit or closely held for-profit) must self-certify status consistent with HHS rules.

1. **EBSA Form 700.** A person authorized to make a certification on behalf of an employer must execute the Form 700 and provide it to the TPA or carriers. The certification must be made available for examination upon request by the first day of the first plan year to which the accommodation applies. It should be maintained consistent with the record retention requirements under ERISA (generally 8 years from the start of the plan year for which the certification relates).

For a copy for EBSA Form 700, visit: http://www.dol.gov/ebsa/preventiveserviceseligibleorganizationcertificationform.doc

2. **Other Notice.** Alternatively, the authorized person may provide notice to HHS that it is an eligible organization and of its religious objection to coverage of all or a subset of contraceptive services. The notice must contain specific information requested by HHS, including names and contact information for any carriers or TPAs. This is outlined in greater detail in the Model Notice at: http://www.dol.gov/ebsa/modelnoticetosecretaryofhhs.doc

Under this option, HHS will send a separate notification to each of the plan's TPAs informing them of receipt of this notice and their obligations with respect to providing contraceptives coverage at no cost to the employee or the plan. In the case of a self-insured group health plan, the DOL will coordinate with HHS to notify the TPAs.

Process for Carriers and TPAs

Insured Health Plans

When the certification is provided by the eligible organization to the carrier or notice is provided by HHS to the carrier, the carrier has the sole responsibility for providing the contraceptive coverage. This must be provided without cost-sharing or a premium, fee or other charge to the eligible organization, the health plan, or participants or beneficiaries.

Self-Insured Health Plans

When the certification is provided by the eligible organization to the TPA or notice is provided by the DOL to the TPA and the TPA agrees to enter into or remain in a contractual relationship with the eligible organization, the TPA will provide or arrange payments for contraceptive services under one of the following methods:

1. Provide payment for contraceptive services for plan participants and beneficiaries; or

2. Arrange for a carrier to provide payments for the contraceptive services for plan participants and beneficiaries to the TPA.

In either case, the TPA may not impose any cost-sharing or a premium, fee, or other charge on the eligible organization, the health plan, or participants or beneficiaries. Both the TPA and carrier may be reimbursed for the cost of arranging such payments though an adjustment to the federally-facilitated Exchange user fee for a participating issuer.

What's Next?

The preventive care requirements remain an area of litigation as ongoing challenges reflect objection to the completion of the Form 700 based on religious beliefs. It may revisit the Court in an upcoming session. Keep in mind that just because a non-profit or closely held for-profit may be excused from the contraceptive requirement under these regulations, there may be other laws that are not as forgiving. For example, following the Hobby Lobby decision, the EEOC came out with guidance stating the Pregnancy Discrimination Act ("PDA") requires an employer providing prescription drugs, devices, or services for the prevention of medical conditions other than pregnancy must cover prescription contraceptives on the same basis. At this point, it is unclear if an entity can successfully apply the same logic of RFRA to the PDA. If employers intend to rely on this accommodation, they should consult with counsel. Interested employers should determine eligibility for an accommodation under the standards described above and review potential qualification for relief. Advice of counsel is recommended.

Published on August 28, 2015

Final Rules Clarify Required Coverage of Preventive Items and Services

The Affordable Care Act requires non-grandfathered group health plans to cover certain mandated preventive care services at no cost. On July 14, 2015, the Departments of Labor, the Treasury and Health & Human Services (the "Departments") issued final regulations. These regulations are effective for plan years beginning on or after October 1, 2015.

Notably, the guidance:

- Clarifies that if a plan that does not have in its network a provider who can provide a particular recommended preventive service, the plan is required to cover the service when performed by an out-of-network provider without cost sharing (i.e., at 100%).
- Indicates the effective date for changing required preventive services when new guidelines are issued.

If there is a change in the guidelines that occurs during a plan year, the group health

plan must provide coverage for that item or service until the end of the plan year, except to the extent the change constitutes a downgrade to a "D" rating or the item was part of a safety recall or otherwise poses a significant safety concern. In such circumstances, the Departments will issue guidance addressing the change during the plan year. Note that any such change that occurs outside of renewal and affects the Summary of Benefits and Coverage will require 60 days advance notice before the change can be made.

Employer Action

Employers should:

- Review existing preventive care practices and, in the event network providers do not perform certain required services, ensure the plan provides them at 100% out-of-network; and
- Be aware that changes to mandated preventive care services will generally take effect with the following plan year, except when downgraded to "D" or are subject to a safety review. The DOL will provide further comment in the event this occurs.

Published on August 25, 2015

Medicare Part D
Reminder to Distribute Creditable Coverage Notice

Employers who sponsor a group health plan with prescription drug benefits are required to notify their Medicare-eligible participants and beneficiaries as to whether the drug coverage provided under the plan is "creditable" or "non-creditable." This notification must be provided **prior to October 15th each year.**

Below you will find detailed information regarding these requirements.

Background

Medicare Part D, the Medicare prescription drug program, imposes a higher premium on beneficiaries who delay enrollment in Part D after initial eligibility unless they have employer-provided coverage that is creditable (meaning equal to or better than coverage provided under Part D).

Employers that provide prescription drug benefits are required to notify Medicare-eligible individuals annually as to whether the employer-provided benefit is creditable or non-creditable so that these individuals can decide whether or not to delay Part D enrollment.

Notice to Participants

CMS has issued participant disclosure model notices for both creditable and non-creditable coverage, which can be found at:

http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html
(notices were last updated by CMS for use on or after April 1, 2011).

Spanish notices are also provided at the above link.

Who must receive the Participant Notice?

Notice should be sent to all Part D-eligible participants. This includes active employees, COBRA qualified beneficiaries, retirees, spouses, and other dependents of the employee covered by the plan. In many cases, the employer will not know whether

an individual is Medicare eligible or not. Therefore, employers may wish to provide the notice to all plan participants (including COBRA qualified beneficiaries) to ensure compliance with the notification requirements.

When Should the Participant Notice be Sent?

Participant disclosure notices should be sent at the following times:

- Prior to October 15th each year;
- Prior to an individual's Initial Enrollment Period for Part D;
- Prior to the effective date of coverage for any Medicare eligible individual under the plan;
- Whenever prescription drug coverage ends or changes so that it is no longer creditable or it becomes creditable; and
- Upon a beneficiary's request.

If the disclosure notice is provided to all plan participants annually, prior to the October 15th, CMS will consider the first two bullet points satisfied. Many employers provide the notice either during or immediately following the annual group plan enrollment period.

In order to satisfy the third bullet point, employers should provide the participant notice to new hires and newly eligible individuals under the group health plan.

How Should the Participant Notice be Sent?

The employer may provide a single disclosure notice to a participant and his or her family members covered under the plan. However, the employer is required to provide a separate disclosure notice if it is known that a spouse or dependent resides at an address different from the address where the participant's materials were provided.

Mail

Mail is the recommended method of delivery, and the method CMS initially had in mind when issuing its guidance.

Electronic Delivery

The employer may provide the notice electronically to plan participants who have the ability to access the employer's electronic information system on a daily basis as part of their work duties (consistent with the DOL electronic delivery requirements 29 CFR § 2520.104b-4(c)(1)).

If this electronic method of disclosure is chosen, the plan sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare eligible dependents covered under the group health plan.

In addition to having the disclosure notice sent electronically, the notice must be posted on the entity's Web site, if applicable, with a link to the creditable coverage disclosure notice.

Sending notices electronically will not always work for COBRA qualified beneficiaries who may not have access to the employer's electronic information system on a daily basis. Mail is generally the recommended method of delivery in such instances.

Open Enrollment Materials

If an employer chooses to incorporate the Part D disclosure with other plan participant information, the disclosure must be prominent

and conspicuous. This means that the disclosure portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded or offset on the first page of the provided information.

CMS provides sample language for referencing the creditable or non-creditable coverage status of the plan per the requirements:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page xx for more details.

How is Creditable Coverage Determined?

Most insurance carriers and TPAs will disclose whether or not the prescription drug coverage under the plan is creditable for purposes of Medicare Part D.

CMS's guidance provides two ways to make this determination, actuarially or through a simplified determination.

Actuarial Determination

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general this is determined by measuring whether the expected amount of paid claims under the employer's drug program is at least as much as what is expected under the standard Part D program. This can be determined through an actuarial equivalency test, which generally requires the hiring of an actuary to perform.

Simplified Determination

Most entities will be permitted to use the simplified determination of creditable coverage status to annually determine whether coverage is creditable or not.

A prescription drug plan is deemed to be creditable if:

- It provides coverage for brand and generic prescriptions;
- It provides reasonable access to retail providers;
- The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
- It satisfies at least one of the following:
    - The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000;
    - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual; or
    - For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000, and has no less than a $1,000,000 lifetime combined benefit maximum.

An integrated plan is any plan of benefits where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

a combined plan year deductible for all benefits under the plan,

a combined annual benefit maximum for all benefits under the plan, and/or

a combined lifetime benefit maximum for all benefits under the plan.

OCTOBER

Published on October 2, 2015

Employees on Leave May be Full-time Employees for Employer Penalty Purposes

Informal guidance indicates that an employee who has attained full-time employee ("FTE") status in the prior measurement period remains an FTE while on leave at any time during the stability period.

Background

Large employers not offering affordable, minimum value coverage to their FTEs may be penalized. In general, under the look back measurement method, FTE status in a stability period is based on hours of service in the prior applicable measurement period, regardless of whether the employee experiences a change in employment status during the stability period. If the change in employment status results in a change in hours of service, that change is captured in a subsequent stability period.

It is clear that employees not working for a long period can be asked to complete the waiting period again upon return to service with no employer penalty exposure. It is clear that an employee whose employment was terminated during the break in service is not an FTE during that time. However, what is not clear is the status of the employee while on leave when employment is not terminated.

Employees on Leave Treated as FTEs

In the American Bar Association's annual Q&A session this year with the IRS, the Committee on Employee Benefits posed a question to better clarify this issue. Specifically, it asked whether an FTE who is on non-FMLA leave for over 21 weeks continues FTE status during the stability period (here, the plan year) even though the employee has no hours of service during this time.

The IRS representative concluded that the individual would be treated as a new hire upon return so that he could be asked to complete the waiting period again; however, the official went on to state that while he was on leave, so as long as he remained an employee of the employer during the stability period, he retained FTE status.

This result seems inconsistent with the fact that there is an exception available allowing employers to discontinue FTE status for employees who switched to part-time status with no penalty exposure. It is unclear in this situation whether the leave would qualify as a "change in employment status," potentially making this exception available. If not, some employees still working for the employer on a part-time basis (e.g., 20 hours per week) are not FTEs while employees working 0 hours are FTEs.

Employer Action

No action is required. These are informal, non-binding comments. However, employers should be aware of this comment. In addition, employers should understand that there are two distinct issues here:

- **Plan language**
  Plan language is legally binding from an ERISA and contractual perspective. Employees and other individuals should not be enrolled in a plan unless eligible according to plan terms and employees and other individuals should have their coverage terminated according to plan terms. Most plans do not allow for continuation of coverage outside being actively at work or at least for a very limited time following the employee's change to inactive status (or under FMLA, USERRA, or COBRA/state continuation).

- **Employer Penalty**
  Under the Employer Penalty, employers do not need to extend coverage to any particular employee or even offer coverage at all. However, penalties may be assessed for failure to do so. For example, an employer with plan language that triggers an offer of COBRA continuation of coverage to the FTE when hours drop to 0 due to the leave could be penalized under the "Offer Coverage" Penalty if that coverage is not "affordable."

Employers can try to bring these two issues

together. Taking into account the IRS representative's informal comments, this could entail:

- Amending plan document language to be consistent with the ACA's full-time employee definition, if necessary. Such a change may not be an option for an insured plan.
- Subsidizing an employee's COBRA while on leave to make coverage "affordable."
- Terminating the employee. Outside laws such as the ADA should be considered before terminating employment.
- Accepting the potential penalty risk in these situations. For failure to offer an affordable plan to an FTE, the penalty is $250 per month for which the FTE received a subsidy under the Exchange.

Published on October 8, 2015

The PACE Act Halts Small Group Expansion

Under the Affordable Care Act ("ACA"), the definition of a small group for purposes of non-grandfathered insured coverage was set to change from an employer with 50 or fewer employees to an employer with 100 or fewer employees, effective for plan years beginning on or after January 1, 2016.

On October 7, 2015, the President signed into law bipartisan legislation, the Protecting Affordable Coverage for Employees ("PACE") Act, which maintains the "50 or fewer" definition of a small employer. The PACE Act contains language that permits a state to use the expanded small group definition (employers with 100 or fewer employees). At this point, it is unclear whether states will retain the "50 or fewer" definition or opt to expand the small group market.

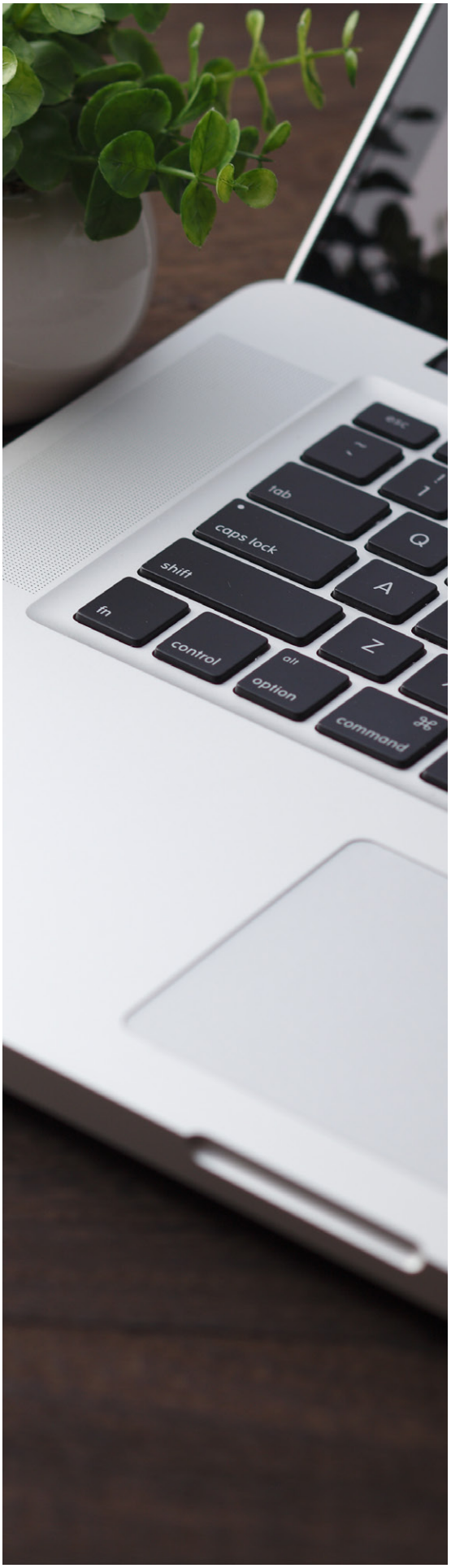
What does this mean?

If a state follows the federal government and retains the existing small group definition (50 or fewer employees), employers with insured non-grandfathered plans in the 51-100 employee market will not be subject to the following:

- The requirement that all of the essential health benefits are provided under the group health plan and the actuarial value of coverage cannot fall below a Bronze level plan (60% actuarial value); and
- New underwriting requirements that limit rating variations to:
- The benefit level and tier of coverage (e.g., single vs. family);
- Geographic area;
- Age (shall not vary by more than a 3 to 1 for adults); and
- Tobacco use (shall not vary by more than 1.5 to 1).

This change has no effect on other aspects the ACA, including the Employer Penalty and reporting on Forms 1094-C and 1095-C.

We will continue to keep you apprised of any new developments.h maintains the "50 or The



Published on October 13, 2015

Adjusted PCOR Fee for Fourth Filing Year Released

Internal Revenue Service (IRS) recently released Notice 2015-60, which provides the adjusted applicable dollar amount for the fourth filing of the PCOR fee. The adjusted dollar amount for plan years ending on or after October 1, 2015 and before October 1, 2016 is $2.17.

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, 2016.

Plan Year	Amount of PCOR Fee	Payment and Filing Date
February 1, 2014 – January 31, 2015	$2.08/covered life/ year	July 31, 2016
March 1, 2014 – February 28, 2015	$2.08/covered life/ year	July 31, 2016
April 1, 2014 – March 31, 2015	$2.08/covered life/ year	July 31, 2016
May 1, 2014 – April 30, 2015	$2.08/covered life/ year	July 31, 2016
June 1, 2014 – May 31, 2015	$2.08/covered life/ year	July 31, 2016
July 1, 2014 – June 30, 2015	$2.08/covered life/ year	July 31, 2016
August 1, 2014 – July 31, 2015	$2.08/covered life/ year	July 31, 2016
September 1, 2014 – August 31, 2015	$2.08/covered life/ year	July 31, 2016
October 1, 2014 – September 30, 2015	$2.08/covered life/ year	July 31, 2016
November 1, 2014 – October 31, 2015	$2.17/covered life/ year	July 31, 2016
December 1, 2014 – November 30, 2015	$2.17/covered life/ year	July 31, 2016
January 1, 2015 – December 31, 2015	$2.17/covered life/ year	July 31, 2016
February 1, 2015 – January 31, 2016	$2.17/covered life/ year	July 31, 2017
March 1, 2015 – February 28, 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

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.

Published on October 15, 2015

Employer Reporting: Final 2015 Instructions and Forms Issued

Employers with at least 50 full-time employees ("FTEs") (including full-time equivalent employees) in the prior calendar year (referred to as Applicable Large Employers ("ALEs")) must comply with new reporting requirements under the Affordable Care Act ("ACA") beginning with calendar year 2015.

Recently, the final Forms 1094-C and 1095-C were issued along with instructions. While the final Forms are substantially similar to the draft versions issued earlier this year, the final instructions provide some helpful clarifications. Notable changes include:

- **Reporting on HRAs (Form 1095-C Part III).** The final instructions make it clear that an ALE with an insured group health plan and a self-insured HRA is not required to report the HRA coverage on Part III of Form 1095-C as long as the individual with the HRA coverage is also enrolled in the employer's insured group health plan. The same is true with a self-insured group health plan with an HRA. However, reporting on the HRA is required in Part III if the individual with the HRA coverage is not enrolled in the employer's group health plan (because, for example, he or she is enrolled in the group health plan of a spouse). Also, reporting on a retiree-only HRA that does not include other major medical coverage would be required. Employers may use either the Form 1095-C or Forms 1094-B and 1095-B to report this information.
- **Reporting COBRA offers (Form 1095-C Line 14).** The instructions clarify that:
    - An offer of COBRA made to a former employee upon termination of employment should not be reported as an offer of coverage on Line 14 of Form 1095-C. Instead, Code 1H (no offer of coverage) in Line 14 should be used for any month in which the offer of COBRA coverage applies.
    - An offer of COBRA made to an active employee as a result of a reduction in hours that resulted in a loss of health plan eligibility is reported using the same code in Line 14 as an offer of that type of coverage to any other active employee.
- **Determine monthly employee contribution (Form 1095-C Line 15).** An employer may, but is not required to, divide the total employee share of the premium for the plan year by the number of months in the plan year to determine the monthly employee contribution for the plan year. This monthly employee contribution would then be reported for any months of that plan year that fall in the 2015 calendar year.
For example:

- If the plan year begins January 1, the employer may determine the amount to report for each month by taking the total annual employee contribution for all 12 months and dividing by 12.
- If the plan year begins April 1, the employer may determine the amount to report for January through March, 2015 by taking the total annual employee contribution for the plan year ending March 31, 2015, and dividing by 12, and may determine the amount to report for April through December, 2015 by taking the total annual employee contribution for the plan year ending March 31, 2016, and dividing by 12.

- **Plan Year Information Requested on Form 1095-C.** In Part II there is a place for an employer to indicate the plan year start date by entering a two digit start month (01 through 12). For calendar year 2015 this is optional. Employers that do not offer group health plan coverage may use "00". An employer that changes the plan year during the calendar year (i.e., runs a short plan year) will use the earliest applicable month. For CY 2016 reporting, it is anticipated that the IRS will require ALEs to complete this plan year information.
- **Multiemployer interim rule relief (Form 1095-C Line 16).** If the employer qualifies for the multiemployer interim relief (Code 2E), then 2E will trump any other code, including 2C.

As a reminder, the Forms 1095-C for CY 2015 must be provided to all FTEs (if self-insured, to any covered individual) no later than February 1, 2016. Employers who file electronically have until March 31, 2016 to submit Form 1094-C and all Forms 1095-C to the IRS. Otherwise, the due date for paper delivery to the IRS is February 29, 2016.

For the final Forms and Instructions visit:

Form 1094-C:http://www.irs.gov/pub/irs-pdf/f1094c.pdf
Form 1095-C:http://www.irs.gov/pub/irs-pdf/f1095c.pdf
Instructions:http://www.irs.gov/pub/irs-pdf/i109495c.pdf

Published on October 16, 2015

Employer Reporting: Aggregated ALE Group and Form 1094-C

Many employers are asking how entities under common control report information to their employees and the IRS on Forms 1094-C and 1095-C. In a recent webinar, the IRS provided an example to better illustrate this process.

Example

Company A is the parent of Company B and Company C. Together the combined group (A, B, and C) has 55 full-time employees (FTEs) and is an Aggregated Applicable Large Employer (ALE) group. An Aggregated ALE is determined under the controlled group rules (Internal Revenue Code section 414(b), (c), (m) and (o)).

The employer mandate and the annual reporting requirements (Forms 1094-C and 1095-C) apply to this Aggregated ALE group and each ALE member as follows:

- Each separate employer (Company A, Company B, and Company C) in an Aggregated ALE group is subject to the employer shared responsibility provisions as collectively they employee at least 50 FTEs in the preceding calendar year.
- Each separate employer is subject to the associated information reporting requirements (Forms 1094-C and 1095-C) and must file its own Form 1094-C Authoritative Transmittal, using its own EIN.
- Company A should not file one Authoritative Transmittal reporting information about Companies A, B, and C combined. Instead, each entity must file as an Authoritative Transmittal with respect to each company's FTEs, as illustrated below:
  - Company A completes its Form 1094-

C as the Authoritative Transmittal as follows:

- Part I: Include Company A's identifying information and check the box in Line 19 indicating this is the Authoritative Transmittal.
- Part II: Report information about Company A as an employer. In Line 21 – "is the ALE member a member of an Aggregated ALE Group" - check the "Yes" box.

Published on October 16, 2015

2015 Transitional Reinsurance Fee
Annual Enrollment & Contribution Submission Form Now Available

By November 16, 2015, employers with self-insured medical plans must report annual enrollment counts to Health and Human Services ("HHS") in order to pay the 2015 Transitional Reinsurance Fee. The fee for 2015 is $44 per covered life per year. Payment is due by January 15, 2016 (and November 15, 2016 if paying in two-installments).

The 2015 Transitional Reinsurance Program Annual Enrollment and Contributions Submission Form ("2015 Form") is **NOW AVAILABLE** at https://www.pay.gov/public/form/start/70746962. If you go directly to www.pay.gov, search for '2015 ACA Transitional Reinsurance' to access the 2015 Form.

In addition, HHS posted a series of FAQs on September 18, 2015 that provide some helpful guidance. Briefly:

- **Contributing Entity.** For purposes of the reinsurance fee, a contributing entity is a:
  - Health insurance carrier; or
  - For 2015 and 2016 benefit years, a self-insured group health plan that uses a third party administrator ("TPA") in connection with claims processing, adjudication (including management of internal appeals), or plan enrollment for services other than for pharmacy benefits or excepted benefits. This definition includes most employer-sponsored self-insured medical plans that use TPAs to process and/or adjudicate claims.
- **Supporting Documentation Relief.** Contributing entities that submit information on behalf of three (3) or fewer contributing entities are not required to include supporting documentation of annual enrollment counts. This is welcome relief for most plan sponsors of self-insured plans as it eliminates a burdensome step in this reporting process. A plan sponsor who reports on behalf of a single contributing entity will not attach supporting documentation. Instead, the plan sponsor may directly input all required information into the 2015 Form.
  - An entity that is submitting information on behalf of four (4) or more contributing entities will be required to complete the supporting documentation files via Job Aid. Examples of such entities include a health insurance carrier or a TPA who is submitting the information and payment on behalf of four or more self-insured health plans.
- **Errors for 2015 and 2016.** The Centers for Medicare & Medicaid Services (CMS) is aware that some contributing entities may misreport their annual enrollment counts due to misapplying an allowable counting method or including individuals in their annual enrollment counts who are exempt from consideration for purposes of reinsurance contributions potentially resulting in an overpayment. For the 2015 and 2016 benefit years, refund requests

- resulting from annual enrollment count misreporting must be submitted 90 days from the date of form submission. These requests and other inquiries regarding the reinsurance contribution submission process should be sent to reinsurancecontributions@cms.hhs.gov.

You may also visit https://www.regtap.info/ for upcoming educational opportunities related to the 2015 reinsurance contributions submission process. In addition, all FAQs regarding Reinsurance Contributions, including the September 18th additions, are available on REGTAP under the FAQ Search > Program Area > Reinsurance Contributions.

Published on October 27, 2015

2016 Cost of Living Adjustments

On October 21, 2015, the IRS released cost of living adjustments for 2016 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans

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.

For plan years beginning in 2016, the dollar limitation under Section 125 for voluntary employee salary reductions for contributions to health flexible spending arrangements is $2,550.

Qualified Transportation Fringe Benefits

For calendar year 2016, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) remained unchanged at $130; the monthly exclusion limitation for qualified parking expenses (under Section 132(f)(2)(B)) increased to $255.

Non-grandfathered Plan Cost-Sharing Limits

The 2016 maximum annual out-of-pocket limits for all non-grandfathered plans are $6,850 for individual coverage and $13,700 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.

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) remains unchanged at $120,000 for 2016.

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). Prop. Treas. Reg. 1.125-7(a)(9).

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2016 again remains unchanged at $170,000.

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. Prop. Treas. Reg. 1.125-7(a)(10).

Health Savings Accounts

As announced in May 2015, the inflation adjustments for health savings accounts (HSAs) for 2016 were provided by the IRS in Rev. Proc. 2015-30.

Annual contribution limitation

For calendar year 2016, the limitation on deductions for an individual with self-only coverage under a high deductible health plan is $3,350. For calendar year 2016, 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 2016, 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. See IRS Notice 2004-50, 2004-33 I.R.B. 196, Q/A-86 (Aug.16, 2004).

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.

Published on November 3, 2015

ACA Automatic Enrollment Provision Repealed

The Affordable Care Act requires employers with more than 200 full-time employees to automatically enroll new full-time employees in one of the employer's health benefit options, subject to an opt out. Originally scheduled to take effect in 2014, this requirement was delayed while regulators developed guidance (which, to date, has not been issued).

On November 2, 2015, the President signed into law the "Bipartisan Budget Act of 2015" (H.R. 1314). Among other things, the Act repeals the automatic enrollment provision. This relief is appreciated by many employers who have been struggling to implement the various compliance requirements under the ACA.

For a copy of the legislation, visit: https://www.congress.gov/bill/114th-congress/house-bill/1314/text#toc-H6C5145772D8F42B6A29F59E88ED1FF22

Published on November 9 2015

2016 New Plan Design Requirements Checklist

The following are important new employer-provided health and welfare plan design issues to consider for 2016.

Cost-sharing Limits

☐ Done
☐ N/A

Affected Plans/Employers:
Non-grandfathered medical plans

Description:
Group health plans must limit in-network out-of-pocket cost sharing to **$6,850 self-only/$13,700 family** in 2016. But see the lower limit for *HDHPs* below.[1]

Starting with 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.

Limits and Requirements

☐ Done
☐ N/A

Affected Plans/Employers:
HSAs and HSA-compatible HDHPs

Description:
The 2016 HSA contribution limits and HSA-compatible HDHP requirements are as follows:

- Maximum contributions of **$3,350 self-only/$6,750 family**
  - Catch-up contribution (for those 55 or older) of **$1,000**
- Minimum deductibles of **$1,300 self-only/$2,600 family**
- Maximum out-of-pocket expenses of **$6,550 self-only/$13,100 family**

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.

Thresholds

☐ Done
☐ N/A

Affected Plans/Employers:
Health FSAs

Description:
There is a **$2,550** limitation on employee salary reductions to health FSAs for plan years beginning in 2016.

Thresholds

☐ Done
☐ N/A

Affected Plans/Employers:
Employers offering qualified transportation fringe benefits

Description:
For calendar year 2016:

- the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass is **$130**;
- the monthly exclusion limitation for qualified parking expenses is **$255**.

EEOC's Proposed Wellness Program Rules

☐ Done
☐ N/A

Affected Plans/Employers:
Employers with wellness programs

Description:
Under new proposed ADA regulations, the 30% premium differential cap applies to:

- Participatory only (not just health-contingent) wellness programs;
- The cost of employee-only coverage (not family coverage when family members participate); and
- Tobacco-related wellness programs if there is a medical exam (such as a biometric screening that tests for the presence of nicotine).

There are also notice and confidentiality provisions.

Employers may want to consider compliance now rather than awaiting final regulations.

Employer Penalty

☐ Done
☐ N/A

Affected Plans/Employers:
Large Employers

Description:
Review plans for offers of affordable, minimum value coverage.

Employer Penalty

☐ Done
☐ N/A

Affected Plans/Employers:
Large Employers

Description:
For the federal poverty line affordability safe harbor, the employee's monthly contribution amount for the self-only premium of the employer's lowest cost is $93.18 or less for plan years beginning on and after March 1, 2015.

Published on December 15 2015

The Departments Issue 29th Set of ACA FAQs

The Departments of Labor, Treasury, and Health and Human Services (collectively, the Departments) have issued the 29th set of Affordable Care Act ("ACA") frequently asked questions ("FAQs"). This time, the Departments tackle various questions on the preventive care mandate, wellness programs, and medical necessity determinations under the Mental Health Parity and Addiction Equity Act of 2008.

Unless otherwise noted, this guidance is effective as of October 23, 2015.

Preventive Care

A non-grandfathered group health plan must provide coverage for in-network preventive items and services and may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) with respect to those items or services. The FAQs address some of those preventive items and services.

Lactation counseling

Comprehensive prenatal and postnatal lactation support, counseling, and equipment rental are part of the ACA's mandated preventive care requirements. This includes lactation counseling. FAQs 1-4 address a number of issues related to lactation counseling:

- Plans are required to provide a list of lactation counseling providers within a network. This requirement is generally met through providing the SBC, which includes an Internet address for obtaining a list of the network providers. Further, ERISA requires a group health plan to provide an SPD that, among other things, provides information on providers including a description of any provider networks and how to obtain a provider list without charge.
- If a plan does not have in its network a provider who can provide lactation counseling services, the plan must cover the item or service when performed by an out-of-network provider without cost sharing.
- If a state does not license lactation counseling providers, then, subject to reasonable medical management, lactation counseling must be covered without cost sharing by the plan when it is performed by any provider acting within the scope of his or her license or certification under applicable state law (e.g., a registered nurse).
- It is not a reasonable medical management technique to limit coverage for lactation counseling to services provided on an in-patient basis (e.g., in a hospital setting). Moreover, coverage for lactation support services without cost sharing must extend for the duration of the breastfeeding.

Breastfeeding equipment

Under the preventive care mandate, the rental or purchase of breastfeeding equipment must be covered without cost-sharing. A plan may not require individuals to obtain breastfeeding equipment within a specified time period (e.g., 6 months from the date of delivery) in order for the equipment to be covered without cost sharing. Additionally, the coverage extends for the duration of breastfeeding, provided the individual remains continuously enrolled in the plan or coverage.

Weight management exclusions

Screening for obesity in adults is a preventive service. Additionally, the guidelines currently recommend, for adult patients with a body mass index ("BMI") of 30 kg/m2 or higher, intensive, multi-component behavioral interventions for weight management. While plans and issuers may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified in the recommendation or guideline, plans are not permitted to impose general exclusions that would encompass recommended preventive services.

Colonoscopies

FAQs 8-9 clarify that if the colonoscopy is scheduled and performed as a preventive screening procedure, it is not permissible for the plan to impose cost-sharing on a required

specialist consultation or any pathology exam or biopsy in connection with a preventive colonoscopy. This clarifying guidance is effective for plan years that begin on or after January 1, 2016.

Eligible organizations and contraceptive services

FAQ 9 outlines the two methods a qualifying non-profit or closely held for-profit employer with a self-insured group health plan can use to claim an accommodation:

- Complete EBSA Form 700 and provide the form to the third party administrator (TPA):http://www.dol.gov/ebsa/pdf/preventiveserviceseligibleorganizationcertificationform.pdf; or
- Provide notice of the objection to HHS: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Model-Notice-8-22-14.pdf.

The accommodation generally relieves the employer from any obligation to contract, arrange, or pay for the objectionable contraceptive and that has the legal effect of designating the third party administrator ("TPA") as the ERISA plan administrator responsible for separately providing payments for those services.

Note, the Supreme Court granted review of 7 cases contesting the contraceptives services mandate under the ACA, mainly centered on this accommodation process. The Court is expected to hear oral arguments in late March of 2016 with a decision likely in June.

BCRA Testing

FAQ 10 states that women found to be at increased risk, using a screening tool designed to identify a family history that may be associated with an increased risk of having a potentially harmful gene mutation, must receive coverage without cost sharing for genetic counseling and, if indicated, testing for harmful BRCA mutations. This is true regardless of whether the woman has previously been diagnosed with cancer, as long as she is not currently symptomatic of or receiving active treatment for breast, ovarian, tubal, or peritoneal cancer.

Wellness Programs

Non-financial rewards

FAQ 11 provides that if a group health plan offers non-financial (or in-kind) incentives (e.g., gift cards, thermoses, sports gear) to participants who adhere to a health-contingent wellness program, the program must comply with HIPAA's 5-factor test.

Mental Health Parity and Addiction Equity Act ("MHPAEA")

The final two FAQs (12 and 13) address issues under the MHPAEA. In general, MHPAEA requires that the financial requirements (such as coinsurance and copays) and treatment limitations (such as visit limits) imposed on mental health and substance use disorder ("MH/SUD") benefits cannot be more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits.

Medical necessity

Notably, the FAQ clarifies:

- If a participant requests from the plan administrator a copy of its medical necessity criteria for both medical/surgical and MH/SUD, including any information regarding the processes, strategies, evidentiary standards, or other factors used in developing the medical necessity criteria and in applying them, the plan administrator may not refuse to provide this information based on the assertion that such information is "proprietary" and/or "has commercial value." Such information needs to be disclosed upon request, even if the source of the information is a commercial third-party vendor.
- While not required to do so, a plan may provide a document written in layperson's terms that provides a description of the medical necessity criteria. Providing this information is not a substitute for supplying the actual underlying medical necessity criteria, if those documents are requested.

Published on December 17, 2015

House Proposes Two-Year DELAY of the Cadillac Plan Tax

The Cadillac Plan tax is a 40% non-deductible excise tax on the value of health insurance coverage that exceeds $10,200 for self-only coverage and $27,500 for coverage other than self-only (e.g., family coverage).

Yesterday, the House introduced bipartisan legislation for a year-end spending and tax package. The legislation includes a two-year delay of the Cadillac Plan tax. If enacted in its current form, the tax would go into effect after December 31, 2019 (and not after December 31, 2017 as currently scheduled). This is welcomed news for employers who are currently looking at mechanisms to mitigate this potential tax burden.

Additionally, the legislation:

- Permits a tax deduction of any Cadillac Plan tax assessment.
- Authorizes a study of the age and gender adjustment benchmarks related to the Cadillac Plan tax.
- Suspends the medical device excise tax for two years and the annual fee on health insurance providers (the Health Insurer Tax) for one year.
- Extends parity between mass transit and parking benefits under Code section 132(f).

The House is expected to vote on the bill Friday. If approved, the bill will be sent to the Senate where it will also need to be approved before it can be presented to the President for signature. While there appears to be some bipartisan support for these changes, it is unclear whether the President will approve such legislation.

We will continue to monitor and update you with the latest information.

Published on December 18, 2015

Regulations Address Mandated Benefits

On November 18, 2015, the Departments of Treasury, Labor, and Health and Human Services ("Departments") issued final regulations regarding certain mandated benefits under the Affordable Care Act ("ACA"). The regulations largely incorporate various FAQs and remove outdated provisions (e.g., annual limitations on essential health benefits, now phased out). However, there are a few items worthy of note.

Lifetime and Annual Limits

Background: There can be no lifetime or annual dollar limits on "essential health benefits" ("EHBs").

Rules: The regulations provide that:

- a reasonable interpretation of EHBs for self-funded plans includes choosing from among any of the 51 EHB base-benchmark plans; and
- lifetime and annual dollar limits on EHBs are generally prohibited, regardless of whether such benefits are provided on an in-network or out-of-network basis.

Health Reimbursement Arrangements

Background: Health reimbursement arrangements ("HRAs"), in part, must allow the employee (or former employee) to permanently opt out of and waive future reimbursements from the HRA at least annually and, upon

termination of employment, either the remaining amounts in the HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA.

Rule: The Departments clarify that, for purposes of the HRA integration rules, forfeiture or waiver occurs even if the forfeited amounts or waived reimbursements may be reinstated upon a fixed date, a participant's death, or the earlier of the two events (the reinstatement event). For this purpose, an HRA is considered forfeited or waived prior to a reinstatement event only if the participant's election to forfeit or waive is irrevocable (i.e., beginning on the effective date of the election, the participant and participant's beneficiaries have no access to amounts credited to the HRA until the reinstatement event).

Account-based Products

The Departments state that it has come to their attention that there are a wide variety of account-based products being marketed, often with subtle but insubstantial differences, in an attempt to circumvent the guidance set forth by the Departments on the application of the annual dollar limit prohibition and the preventive services requirements to account-based plans. The Departments intend to continue to address these specific instances of noncompliance.

Rescissions

Background: A group health plan must not rescind coverage under the plan with respect to an individual once the individual is covered under the plan, unless the individual performs an act, practice, or omission that constitutes fraud, or unless the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan. A rescission is a cancellation or discontinuance of coverage that has retroactive effect.

Rules: The regulations state:

that a retroactive cancellation is not a rescission if it is initiated by an individual and the plan, issuer, employer, or sponsor does not take any actions to influence such individual's decision or to retaliate against such individual;

that rescissions are subject to internal claims and appeals and external review; and

with respect to an individual who is found to have reported false or inaccurate information about their tobacco use, the individual may be charged the appropriate premium that should have been paid retroactive to the beginning of the plan year; however, coverage cannot be rescinded on such basis.

Dependent Coverage

Background: Any group health plan or health insurance carrier that provides coverage of dependent children must continue to make dependent coverage available until the children turn 26 years of age. There is no definition of dependent. A previously-issued FAQ indicated that a plan can limit eligible children to the following:

- natural children;
- children adopted or placed for adoption;
- stepchildren; and
- eligible foster children (individuals placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction).

It has been unclear whether this is a minimum required definition, safe harbor, or example.

Rule: The regulations incorporate the FAQ without further clarification so the answer remains unclear.

In addition, the rule indicates that eligibility restrictions requiring individuals to work, live, or reside in a service area cannot be applied to dependent children up to age 26. However, plans and issuers can continue to provide coverage only within a certain service area.

Grandfathered Plans

Background: Grandfathered status is lost when, among other things, the employer or employee organization decreases its contribution rate based on cost of coverage towards the cost of any tier of coverage for any class of similarly situated individuals by more than 5% below the contribution rate for the coverage period that includes March 23, 2010.

There was some question as to what percentage increase could be allowed when the employee contribution was $0 on March 23, 2010. While 5% of $0 = $0, should there be allowed some small increase?

Rule: The Departments confirmed that no increase is allowed.

The Departments also confirmed that once grandfathered status is lost, there is no opportunity to cure the loss of grandfather status; a reversal of a change that causes the loss of grandfathered status (e.g., an elimination of benefits) after the effective date will not allow the plan to regain grandfather status.

Patient Protections

Background: If a non-grandfathered group health plan requires or provides for designation by a participant or beneficiary of an in-network primary care provider, then the plan must permit each participant or beneficiary to designate any participating primary care provider who is available to accept the participant or beneficiary.

Rule: Plans and issuers may apply reasonable and appropriate geographic limitations with respect which participating primary care providers are considered available to be designated as primary care providers.

Emergency Care

Background: Non-grandfathered plans must cover emergency services without prior authorization and even if out-of-network.

Rule: A plan or issuer must provide coverage for emergency services that meet the definition of emergency services, without any time limit within which treatment must be sought. For example, emergency care is not limited to treatment within 24 hours of the onset of an emergency.

Claims and Appeals

Background: A non-grandfathered group health plan and a health insurance carrier must implement an effective appeals process for appeals of coverage determinations and claims under which the plan or carrier must:

- have in effect an internal claims appeal process;
- allow an enrollee to review his file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the appeals process; and
- provide an external review process for such plans and carriers that, at a minimum, includes the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners ("NAIC") and is binding on such plans.

Rules:

1. Plans and issuers must provide the claimant, free of charge, with new or additional evidence considered, relied upon, or generated by the plan or issuer in connection with the claim, as well as any new or additional rationale as soon as possible and in advance of the notice of final adverse benefit determination. The final rule clarifies that this information must be provided automatically. Merely providing a notice informing participants of the availability of such information or rationale is not sufficient.
2. If the new or additional evidence is received so late that it would be impossible to provide it to the claimant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the claimant has a reasonable opportunity to respond.
3. The NAIC-similar external review process transition period is extended through December 31, 2017. Through this date, State external review processes may be considered to meet minimum standards if they meet the temporary standards for a process similar to the NAIC Uniform Model Act.
4. While the general rule is that plans and coverage must pay for the full cost of an independent review organization ("IRO") for an external review, state external review processes with a nominal filing fee that does not exceed $25 remain valid.
5. A plan's or issuer's determination of whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program is subject to the claims and appeals procedures.
6. A plan's or issuer's determination of whether a plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques, is subject to the claims and appeals procedures.

Published on December 29, 2015

Extension of Deadlines for Forms 1095-C and 1094-C

On December 28, 2015, the IRS issued Notice 2016-4 which provides an extension of the deadlines to provide Forms 1095-C to individuals and Forms 1095-C and 1094-C to the IRS and provides other related guidance. The following Q&As summarize the Notice.

Q 1: What are the new deadlines?

A 1:

- 2015 Forms 1095-C must be furnished to individuals by **March 31, 2016** (rather than February 1, 2016).
- 2015 Forms 1095-C and Form 1094-C must be furnished to the IRS by:
    - **May 31, 2016** (rather than February 29, 2016) if not filing electronically; and
    - **June 30, 2016** (rather than March 31, 2016) if filing electronically.

The deadlines have likewise been extended for carriers providing Forms 1095-B to individuals (and the IRS) for insured plans.

Q 2: Do I need to file for the extension?

A 2: No. The extension is automatic.

Q 3: Can I comply early?

A 3: Yes.

Employers are encouraged to furnish statements to individuals as soon as they are ready.

The IRS is prepared to accept filings of the information returns beginning in January 2016.

Q 4: What if the submissions are still late?

A 4: Employers that do not comply with these extended 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. The IRS will also take into account whether an employer made reasonable efforts to prepare for reporting such as gathering and transmitting the necessary data to an agent to prepare the data for submission to the IRS or testing its ability to transmit information to the IRS. In addition, the IRS will take into account the extent to which the employer is taking steps to ensure that it is able to comply with the reporting requirements for 2016.

Q 5: What if employees do not have Forms 1095-C (or Forms 1095-B from the carrier) before they file their tax returns?

A 5: For 2015 only, individuals who rely upon other information received from employers or carriers about their coverage need not amend their returns once they receive their Forms 1095-C or any corrected Forms 1095-C. Individuals need not send this information to the IRS when filing their returns but should keep it with their tax records.

For the Notice, visit: http://www.irs.gov/pub/irs-drop/n-16-4.pdf

APPENDIX

CBP
creative benefit plans

Employer Reporting Guide for Large Employers

6055 and 6056 Reporting for Large Groups

732-992-1500
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CBP
creative benefit plans

Table of Contents

Overview of Employer Responsibilities

Beginning with calendar year (CY) 2015, an applicable large employer (ALE or "large employer," as referenced in this summary) must use Forms 1094-C and 1095-C to report the information required under Internal Revenue Code (Code) sections 6055 and 6056 about offers of health coverage to full-time employees' (FTEs) and individuals' enrollment in health coverage.

Briefly:

- Form 1094-C is used to report to the IRS summary information of each employer and to transmit all Forms 1095-C to the IRS.
- Form 1095-C is used to report information about each FTE (and in the case of a self-insured plan, each covered individual).

These forms are used by the IRS to determine whether:

- a large employer owes a (shared responsibility) penalty payment under the employer mandate,
- an employee is eligible for subsidies to purchase health insurance coverage in the Marketplace, and
- an individual has MEC [1] in order to avoid potential tax penalties under the individual mandate.

As the following chart illustrates, an ALE must complete, distribute, and file these forms in the calendar year immediately following the year to which the reporting relates. The first required filing is due in early 2016 for CY 2015.

	What to complete?	When?
Large employer with an insured health plan	All applicable parts of Form 1094-C Parts I and II of Form 1095-C	A Form 1095-C must be furnished to each FTE by Feb. 1, 2016 for CY 2015 Form 1094-C and all Forms 1095-C must be furnished to the IRS by Feb. 29, 2016 (unless filing electronically, then Mar. 31, 2016)
Large employer with a self-insured health plan	All applicable parts of Form 1094-C All parts of Form 1095-C	A Form 1095-C must be furnished to each FTE and each covered employee/individual by Feb. 1, 2016 Form 1094-C and all Forms 1095-C must be furnished to the IRS by Feb. 29, 2016 (unless filing electronically, then Mar. 31, 2016)

1 Minimum essential coverage (MEC) is the technical term for most types of health insurance coverage under the ACA. It includes, but is not limited to, employer sponsored group health plan coverage, Medicare, Medicaid, and individual health insurance coverage. MEC does not include excepted benefits (e.g., most dental and vision plans, health FSAs, on-site clinics and some EAPs). For this purpose, it means eligible employer-sponsored group health plan.

2 The health insurance carrier will be responsible for providing information to the IRS and covered employees regarding MEC (using Form 1095-B).

Final forms and instructions for 2014 were recently issued. While no reporting is required for 2014, this information provides helpful insight on what data will be collected for CY 2015, the first year of applicability.

- Instructions: http://www.irs.gov/pub/irs-pdf/i109495c.pdf
- Form 1094-C: http://www.irs.gov/pub/irs-pdf/f1094c.pdf
- Form 1095-C: http://www.irs.gov/pub/irs-pdf/f1095c.pdf

While payroll vendors and other third parties will likely help employers through this process, it is important that an employer begins to identify the information that must be collected during the CY to satisfy this requirement.

This guide is intended to provide you with a comprehensive overview of the reporting requirements under Code sections 6055 and 6056 as it pertains to a large employer with more than 50 full time employees and equivalents. These requirements are effective for CY 2015, forms due in early 2016.

This guide will:

- outline the various pieces of information and data needed during the CY to complete year-end reporting;
- provide a step-by-step guide to completing the Forms; and
- identify additional requirements for a large employer with self-insured health plan coverage.

Some rules to follow when using this guide:

- While the 2014 Forms and Instructions were recently finalized, the final versions for 2015 have not been issued. Thus, information requested for 2015 may differ from what is outlined in this summary. We will keep you updated with any changes.
- Regardless of an employer's plan year, reporting is done based on the CY (January–December). Notably, non-CY plans and other changes that occur mid-year will need to be reflected for the applicable month(s). This may include changes in affordability, plan changes from insured to self-insured (or vice versa) or mid-year enrollment changes in a self-insured health plan.
- Much of this data is reported for each month of the calendar year, with some opportunities to report on a 12-month basis. Prepare to track data and pull reports for each month of the CY.

The information contained in this guide is general in nature and is subject to change as guidance develops. The information contained herein is not intended to be construed as legal advice or opinion and does not take into account any particular facts and circumstances of a specific situation. Advice of counsel or tax professionals is recommended.

Background

Beginning in 2015, large employers may be subject to an assessable payment (referred to as a "penalty") if any FTE receives a premium tax-credit or cost-sharing subsidy (collectively a "subsidy" or "subsidies") to purchase health insurance through the Marketplace. There are two possible penalties ("No Coverage" and "Offer Coverage"). The penalty that may apply will depend on the particular circumstances of the employer.

For this purpose, an FTE means an employee with at least 30 hours of service per week or 130 hours of service per month as determined under the applicable measurement method (look-back or monthly).

Only applicable large employers must complete the Forms 1094-C and 1095-C. Generally, this means an employer that had 50 or more FTEs (including full-time equivalent employees) on business days in the preceding calendar year. Large employer status is determined on an annual basis and requires aggregating all employees within a controlled group[3]. For 2015 only, medium-sized employers (50-99 FTEs) may qualify for relief from the employer mandate, subject to certain rules[4]. However, these employers are still required to comply with reporting requirements for 2015 and certify eligibility for the relief on Form 1094-C.

"No Coverage" Penalty

This penalty applies when an ALE does not offer at least **95%** of FTEs and their dependent children a group health plan (i.e., MEC) and at least one FTE receives a subsidy in the Marketplace to purchase qualified health plan coverage.

The penalty is $166.67/month (or $2,000/year) multiplied by the total number of FTEs – **30**.

"Offer Coverage" Penalty

This penalty applies when an ALE offers at least **95%** of FTEs and their dependent children a group health plan (i.e., MEC) but the coverage is not affordable[5], does not provide minimum value[6], or excludes **5%** or fewer FTEs and one (or more) of those FTEs receive a subsidy in the Marketplace.

The penalty is the lesser of:

- $250/month (or $3,000 annually) multiplied by each FTE who receives a subsidy in the Marketplace to purchase health insurance coverage; or
- the "No Coverage" penalty.

For 2015 only, an ALE may use **70%** (as opposed to 95%) and **80** (as opposed to 30) to determine liability under the "No Coverage" penalty. However, this relief is not available if the employer changed a non-CY plan after February 9, 2014 to begin at a later date. Employers eligible for transition relief may use **30%** (as opposed to **5%**) to determine its "Offer Coverage" penalty exposure in 2015.

The penalty amounts may be adjusted for inflation – no adjustment has been announced for 2015. Penalties are assessed monthly, but paid annually.

3 For purposes of determining whether an employer is a large employer, all persons treated as a single employer under Code §414(b), (c), (m), or (o) are considered to be employed by a single employer. Consult with counsel or tax advisors on questions of common ownership or controlled group participation.

4 Medium Sized Employer Relief. Certain medium sized employers may delay the application of the employer mandate until the first plan year that begins in 2016 (e.g., January 1, 2016 for a calendar year plan). This relief is available only if the employer did not modify the plan year after February 9, 2014 to begin on a later calendar date and if the employer satisfies all of the following conditions:

a. Limited Workforce Size The employer employs on average at least 50 but fewer than 100 FTEs (including full-time equivalent employees) on business days during 2014.

b. Maintenance of Workforce and Aggregate Hours of Service. Between February 9, 2014 and ending on December 31, 2014, the employer does not reduce the size of its workforce or employees' hours of service to satisfy the workforce size condition.

c. Maintenance of Previously Offered Health Coverage The employer does not eliminate or materially reduce the health coverage, if any, it offered as of February 9, 2014.

d. Certifies eligibility for relief on Form 1094-C..

5 Coverage is affordable if the cost for self-only coverage does not exceed 9.5% of household income for the lowest cost minimum value plan. The regulations provide three safe harbors (W-2, FPL and rate of pay) that may be used to determine affordability.

6 Minimum value (MV) means a plan that covers at least 60% of the total allowed cost of benefits that are expected to be incurred by the plan. Guidance provides four ways to satisfy this threshold (MV calculator, safe harbor plan designs, actuarial certification and any metal coverage purchased in a Marketplace).

What Information To Collect

Basic Information (1094-C and 1095-C)

- ☐ Name, EIN, address, contact person and phone number for the employer.
- ☐ If part of a controlled group, name and EIN of other employer members.
- ☐ If health plan coverage is offered, funding status during the calendar year (insured or self-insured).
- ☐ Calendar year (CY) reported (e.g., 2015).
- ☐ Name, address, tax identification number (usually the social security number) for each FTE.

Employer Information Reported on a Monthly Basis

- ☐ Was MEC offered to at least 95% of FTEs and children to age 26 for each month of CY?
- ☐ Total number of FTEs for each month of the CY.
- ☐ Total number of all employees (this includes all FTEs and non FTEs and employees in a limited non-assessment period[7]) for each month of the CY.
- ☐ 2015 transition relief eligibility: medium sized employer relief or 70%/80 relief.

Full-Time Employee Information Reported on a Monthly Basis

- ☐ Each FTE for the CY – this means any employee who is considered full-time for at least one month during the CY
- ☐ The health plan coverage, if any, offered to the FTE (and any family members) each month of the CY (e.g., self only, self+ family, no coverage offered)
- ☐ The self-only premium an employee must pay for the lowest-cost plan that provides minimum value.
- ☐ The reason why an employer would not be subject to a penalty for a particular month (e.g., employee in waiting period, employee in initial measurement period, affordability safe harbor applies).
- ☐ The months for which the employer relied on non-CY relief with respect to FTEs.

If Self-Insured, Covered Employee/Individual Information Reported on a Monthly Basis

- ☐ Names, SSN (or tax identification number of non-employees), and months of coverage for any covered employee/individual (e.g., retiree or COBRA qualified beneficiary) and family members during the CYThe months for which the employer relied on non-CY relief with respect to FTEs.

7 A limited non-assessment period includes: an Initial Measurement Period and associated Initial Administrative Period, the first calendar month of employment if the employee is not hired on the first day of the month, the period following change in status to FT during IMP, and/or the waiting period.

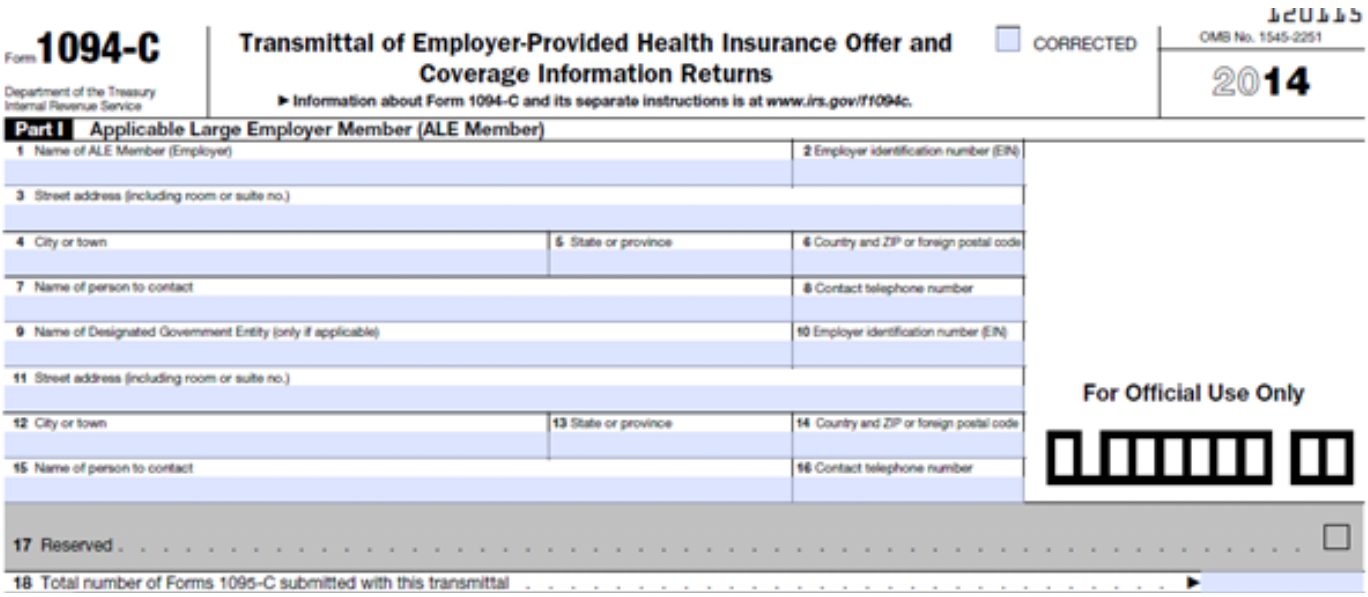
Form 1094-C

Overview

Form 1094-C is the summary form used to transmit all Forms 1095-C to the IRS. It provides specific employer-level data.

How to Complete Form 1094-C

PART I



Form **1094-C** — Department of the Treasury, Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

► Information about Form 1094-C and its separate instructions is at www.irs.gov/f1094c.

CORRECTED

OMB No. 1545-2251

2014

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)		2 Employer identification number (EIN)
3 Street address (including room or suite no.)		
4 City or town	5 State or province	6 Country and ZIP or foreign postal code
7 Name of person to contact		8 Contact telephone number
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)
11 Street address (including room or suite no.)		
12 City or town	13 State or province	14 Country and ZIP or foreign postal code
15 Name of person to contact		16 Contact telephone number

For Official Use Only

17 Reserved . . . . . ☐

18 Total number of Forms 1095-C submitted with this transmittal . . . . . ►

Lines 1-7. Complete the name of the large employer, the employer's tax identification number (EIN), address, and the name and phone number of a contact person responsible for answering any questions.

Lines 9-16. Complete these lines only if a Designated Governmental Entity (DGE) filing on behalf of an employer. Otherwise skip these lines. Non-governmental employers will always skip Lines 9-16. For more information refer to the instructions.

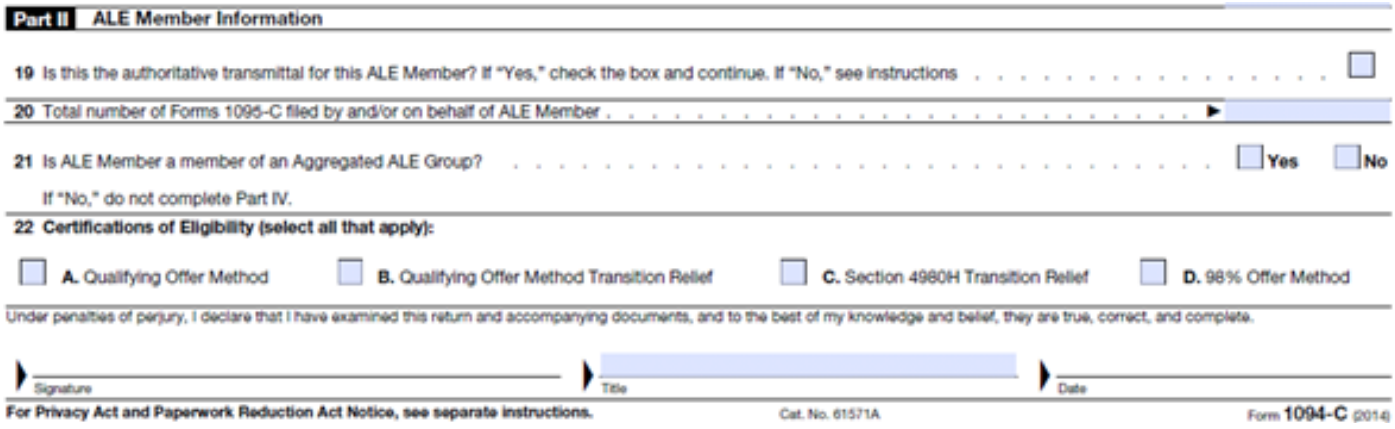
What's a DGE? DGE is a person or persons that are part of or related to the Governmental Unit[8] that is the ALE Member and that is appropriately designated for purposes of these reporting requirements. In the case of a Governmental Unit that has delegated some or all of its reporting responsibilities to a DGE with respect to some or all of its employees, one Authoritative Transmittal must still be filed for that Governmental Unit reporting aggregate employer-level data for all employees of the Governmental Unit (including those for whom the Governmental Unit has delegated its reporting responsibilities). Note, special rules apply if there is self-insured health plan coverage and the employer delegates responsibilities to the DGE. Review the instructions.

Line 17. Reserved for future use, do not complete.

8 A Governmental Unit is the government of the United States, any state or political subdivision thereof, or any Indian tribal government (as defined in section 7701(a)(40)) or subdivision of an Indian tribal government (as defined in section 7871(d)). For purposes of these instructions, references to a Governmental Unit include an Agency or Instrumentality of a Governmental Unit. Until guidance is issued that defines the term Agency or Instrumentality of a Governmental Unit for purposes of section 6056, an entity may determine whether it is an Agency or Instrumentality of a Governmental Unit based on a reasonable and good faith interpretation of existing rules relating to agency or instrumentality determinations for other federal tax purposes.

Line 18. Enter the total number of Forms 1095-C that are submitted with this Form 1094-C. For example, if the employer generates 200 Forms 1095-C, 200 will go in Line 18.

PART II



Part II ALE Member Information

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions . . . . . ☐

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member . . . . . ▶

21 Is ALE Member a member of an Aggregated ALE Group? . . . . . ☐ Yes ☐ No

If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):

☐ **A.** Qualifying Offer Method ☐ **B.** Qualifying Offer Method Transition Relief ☐ **C.** Section 4980H Transition Relief ☐ **D.** 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

▶ Signature ▶ Title ▶ Date

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2014)

Line 19. Mark this box if the Form 1094-C serves as the Authoritative Transmittal that reports aggregate employer-level data for the employer. Check this box in Line 19 if this Form 1094-C is the only Form 1094-C being filed for the employer.

However, if multiple Forms 1094-C are being filed for the employer so that Forms 1095-C for all FTEs of the employer are not attached to a single Form 1094-C transmittal (because some of the Forms 1095-C are being transmitted separately), one of the Forms 1094-C associated with the employer must be designated as the Authoritative Transmittal and report aggregate data.

When might an employer have multiple Forms 1094-C? A single employer may have two divisions (e.g., Washington and California) and decide instead of using a single 1094-C to transmit all of the Forms 1095-C to the IRS, the employer will file separate Forms 1094-C for each of its two divisions to transmit the Forms 1095-C for their respective FTEs in each division. In this case, one of the Forms 1094-C must be designated as the Authoritative Transmittal and report aggregate employer data for both divisions in Parts II, III and IV, as applicable.[9]

Note, in the case of a controlled group (an aggregated ALE), each member of the controlled group (each ALE member) must file its own authoritative transmittal. The various employers under common control may not submit one Authoritative Transmittal.

These rules also apply to DGE.[10]

9 Likely, most employers will not have multiple Forms 1094-C. However, if an employer takes that approach, consider the following example:

ABC company is a single employer (not part of controlled group). It has two divisions, Washington and California. The Washington division has 200 Forms 1095-C and the California division has 100 Forms 1095-C. Each division will submit its own 1094-C and applicable Forms 1095-C. The Washington division acts as the authoritative transmittal for the employer. Therefore:

The 1094-C for the California division will reflect 100 as the number of Forms 1095-C submitted with this transmittal (Line 18). California will not check Line 19 and will not complete Lines 20-22 or Part III or IV (if applicable).

The 1094-C for Washington will reflect 200 as the number of Forms 1095-C submitted with this transmittal (Line 18). Washington will check Line 19 on Form 1094-C and complete Lines 20-22. Line 20 will reflect 300, the total number of Forms filed on behalf of the employer (the two divisions combined). Washington will sign the 1094-C and complete Parts III and Part IV (if applicable).

10 **Example**. County is an ALE made up of ALE Members School District, Police District, and County General Office. School District designates the state to report on behalf of the teachers and reports for itself for its remaining FTEs. In this case, either the School District or the state must file an Authoritative Transmittal reporting aggregate employer-level data for all FTEs of the School District.

If Line 19 is checked, complete the rest of Part II (Lines 20-22 and signature) and Parts III and IV, as applicable. If Line 19 is not checked, sign the Form, but do not complete Lines 20-22 or Parts III and IV.

Line 20. Enter the total number of Forms 1095-C that will be filed by, or on behalf of, the employer. This includes all Forms 1095-C filed with respect to this transmittal, including any individuals covered by a self-insured health plan. This number should match the number reflected in Line 18, unless the employer is required to aggregate employer data as the Authoritative Transmittal for multiple Forms 1094-C.

Line 21. If, during any month of the CY the employer was a member of a controlled group (also referred to as an Aggregated ALE Group) check the box in Line 21. You will also need to complete Part III, column (d) and Part IV to list the other members of the controlled group. If the employer was not a member of a controlled group during the calendar year, do not check this box and do not complete Part III, column (d) and Part IV.

Line 22. If the employer meets the eligibility requirements and is using one of the Offer Methods, the employer must check either box "A", "B", or "D". See appendix for further discussion. If the employer qualifies for and uses the medium-sized employer transition relief or the 70%/80 transition relief, the employer must check box "C" on Line 22 and complete Part III column (e).

PART III — Do not complete any of Part III if the 1094-C is not the authoritative transmittal

120215

Form 1094-C (2014) Page 2

Part III ALE Member Information – Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
		Yes	No				
23	All 12 Months	☐	☐			☐	
24	Jan	☐	☐			☐	
25	Feb	☐	☐			☐	
26	Mar	☐	☐			☐	
27	Apr	☐	☐			☐	
28	May	☐	☐			☐	
29	June	☐	☐			☐	
30	July	☐	☐			☐	
31	Aug	☐	☐			☐	
32	Sept	☐	☐			☐	
33	Oct	☐	☐			☐	
34	Nov	☐	☐			☐	
35	Dec	☐	☐			☐	

Form 1094-C (2014)

Column (a). If an employer offers MEC to at least 95% of FTEs and their children to age 26 for the entire CY, mark the "Yes" box in Line 23. If such coverage was not offered for the entire CY, mark "No" on Line 23 to reflect all 12 months.

If an offer of coverage to at least 95% of FTEs and their children was made for some, but not all, months of the CY mark either "Yes" or "No" in the appropriate check box for each month (Lines 24-35).

2015 70%/80 Relief. If an employer did not offer MEC to at least 95% of FTEs and their children to age 26 but is eligible for the 70%/80 transition relief, mark "Yes" in column (a) for each applicable month (or for the entire CY). Use code "B" in column (e).

Employees in a limited non-assessment period. For purposes of determining the 95% threshold (or 70% threshold for 2015) do not count employees in a limited non-assessment period.

4980H Transition Relief for Dependent Coverage. An employer may check "Yes" in column (a) if taking advantage of limited relief available when an offer of coverage to children was not made. For the 2014 and 2015 plan years, for an employee who was not offered dependent health coverage during the 2013 or 2014 plan years, an employer may treat, solely for purposes of section 4980H, an offer of health coverage to an FTE but not his or her dependents, as an offer of health coverage to the FTE and his or her dependents, if the employer takes steps during the 2014 or 2015 plan year (or both) to extend coverage under the plan to dependents not offered coverage during the 2013 or 2014 plan year (or both). An employer using this transition relief for a calendar year is not eligible to report using the Qualifying Offer Method (or the Qualifying Offer Transition Relief Method) for that CY (see appendix).

Column (b). Enter the number of FTEs for each month. Note this must be reported on a monthly basis (Lines 24-35). Do no count any employee who is in a limited non-assessment period. Do not use a single count for a 12-month period.

Column (c). Enter the total number of employees, including FTEs, non-FTEs and employees in a limited non-assessment period for each calendar month. An employer may choose one of the following days to determine this count per month and must use the same day for all months of the year:

- The first day of each month,
- The last day of each month,
- The first day of the first payroll period that starts during each month, or
- The last day of the first payroll period that starts during each month provided that for each month that last day falls within the calendar month in which the payroll period starts.

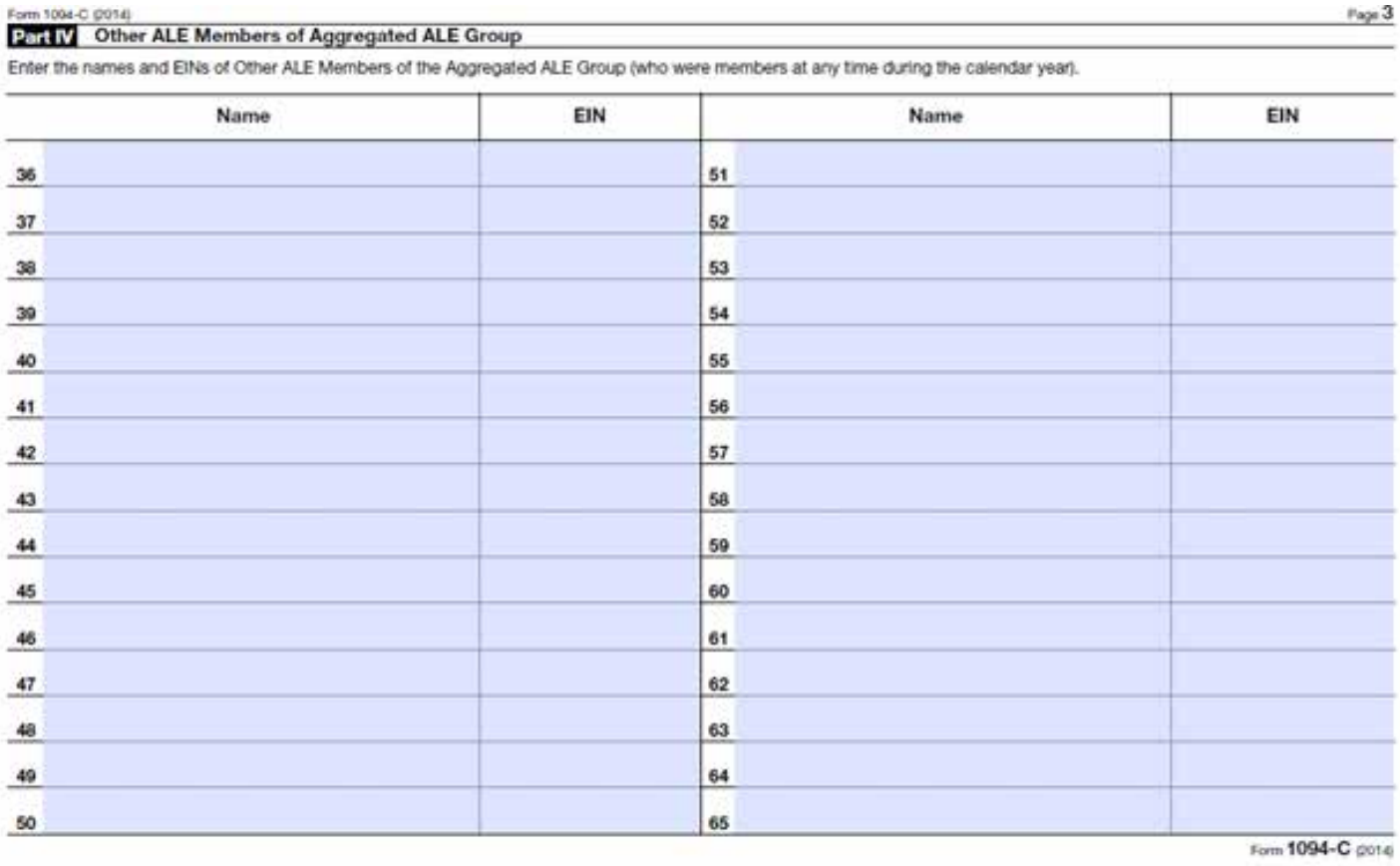
While unlikely, if the total number of employees was the same for every month of the entire CY, enter that number in column (c), Line 23. Otherwise reflect the count for each month in column (c), Lines 24-35.

Column (d). If the employer is part of a controlled group (Line 21, Part II should be checked), then reflect each month the employer was a member of the controlled group in column (d). If part of a controlled group for all 12 months of the calendar year, use the box in Line 23. The employer will also need to complete Part IV. If the employer is not a part of a controlled group, leave column (d) blank.

Column (e). If the employer marked Line 22, box "C", the employer must certify eligibility for the medium sized employer relief by entering code "A" in column (e). If the employer is eligible for the 70%/80, then use code "B" in column (e).

Do not complete any of Part III if the 1094-C is not the authoritative transmittal.

PART VI — Do not complete any of Part IV if the 1094-C is not the authoritative transmittal



Form 1094-C (2014) Page 3

Part IV Other ALE Members of Aggregated ALE Group

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

	Name	EIN		Name	EIN
36			51		
37			52		
38			53		
39			54		
40			55		
41			56		
42			57		
43			58		
44			59		
45			60		
46			61		
47			62		
48			63		
49			64		
50			65		

Form 1094-C (2014)

Lines 36-65. If part of a controlled group (aggregated ALE) list the name and EIN of other employers in the controlled group (aggregated ALE).

Do not complete Part IV if the employer is not part of a controlled group (aggregated ALE).

Do not complete any of Part IV if the 1094-C is not the authoritative transmittal.

Form 1095-C

Overview

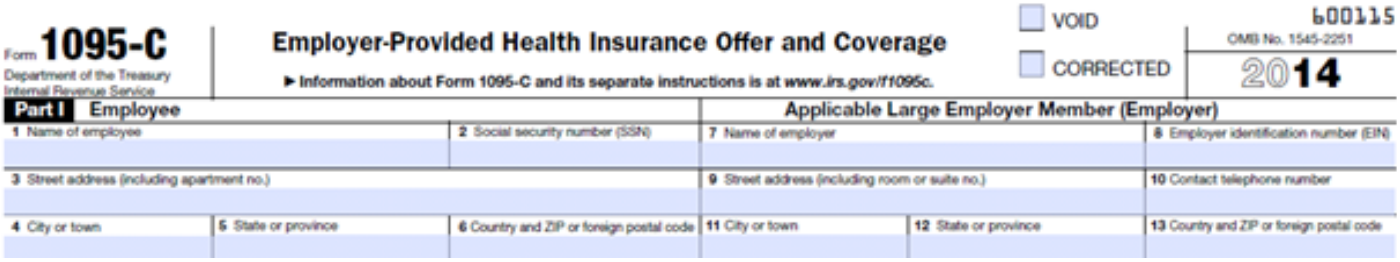
All ALEs must complete one Form 1095-C for each FTE. This means that each FTE who was an FTE for at least one month of the calendar year must receive a Form 1095-C with respect to the calendar year. Form 1095-C is used to report information about each FTE for purposes of the employer mandate. It is also used to determine an employee's eligibility for a premium tax credit in the Marketplace.

Employers that offer self-insured health plan coverage will also use Form 1095-C to report information regarding MEC to the IRS and to covered individuals under the employer-sponsored self-insured plan. This demonstrates that a covered individual is not liable for a shared responsibility payment under the individual mandate for the months the individual (and/or a spouse and dependants) are covered by the self-insured health plan.

As described earlier, Forms 1095-C are transmitted to the IRS by the employer using Form 1094-C. In addition, the employer must provide a copy to each FTE and any covered employee/individual in a self-insured health plan. Alternative statements to issuing the Form 1095-C to the employee are permitted, subject to specific rules described in the appendix. Generally, most employers will furnish the Form 1095-C as opposed to an alternative statement.

How to Complete Form 1095-C

PART I



Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at www.irs.gov/f1095c.

☐ VOID
☐ CORRECTED

600115
OMB No. 1545-2251
2014

Part I Employee			Applicable Large Employer Member (Employer)		
1 Name of employee	2 Social security number (SSN)		7 Name of employer		8 Employer identification number (EIN)
3 Street address (including apartment no.)			9 Street address (including room or suite no.)		10 Contact telephone number
4 City or town	5 State or province	6 Country and ZIP or foreign postal code	11 City or town	12 State or province	13 Country and ZIP or foreign postal code

Lines 1-7. Lines 1-6. Enter the name of the employee, the employee's social security number (SSN), and complete address.

Lines 7-13. Enter the employer's name, EIN, address, a contact person's phone number (who to call about the information reported on the form). This information should be the same as what is reported in Part I of Form 1094-C.

PART I

Part II Employee Offer and Coverage

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage		$	$	$	$	$	$	$	$	$	$	$	$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)													

Line 14. Offer of Coverage. This line reflects the employer's offer of coverage, if any, for each month of the CY through the use of the Series 1 Codes. If the same Code applies for all 12 months, enter the applicable Code in the

"All 12 Months" section. A Series 1 Code must be entered for each month of the CY (January – December), even if the employee was not an FTE for one or more calendar months. Enter the Code identifying the type of health coverage actually offered by the employer to the employee, if any. A list of codes follows.

Series 1 Codes - Offer of Coverage and Line 15

1A	Qualifying Offer. MEC providing minimum value (MV) offered to FTE with employee contribution for self-only coverage equal to or less than 9.5% mainland single federal poverty line ($93.18 for 2015) and at least MEC offered to spouse and dependent(s).	■ This code may be used to report for specific months for which a Qualifying Offer was made, even if the employee did not receive a Qualifying Offer for all 12 months of the CY. ■ Leave Line 15 blank.
1B	MEC providing MV offered to employee only.	■ Enter the amount of the lowest cost, self-only coverage in Line 15.
1C	MEC providing MV offered to employee and at least MEC offered to dependent(s) (not spouse).	■ Enter the amount of the lowest cost, self-only coverage in Line 15.
1D	MEC providing MV offered to employee and at least MEC offered to spouse (not dependent(s)).	■ Enter the amount of the lowest cost, self-only coverage in Line 15.
1E	MEC providing MV offered to employee and at least MEC offered to dependent(s) and spouse.	■ This is likely a commonly used Code. ■ Enter the amount of the lowest cost, self-only coverage in Line 15.
1F	MEC NOT providing MV offered to employee, or employee and spouse or dependent(s), or employee, spouse and dependents.	■ This is likely a commonly used Code. ■ Enter the amount of the lowest cost, self-only coverage in Line 15.
1G	MEC NOT providing MV offered to employee, or employee and spouse or dependent(s), or employee, spouse and dependents.	■ Applicable for part time employees enrolled in self-insured plans. ■ Use this Code to report covered employees who are NOT full-time and/or non-employees offered coverage under the self-insured plan (e.g., retiree, COBRA qualified beneficiary) ■ Leave Line 15 blank
1H	No offer of coverage (employee not offered any health coverage or employee offered coverage that is not MEC).	■ Employers that do not offer health insurance coverage or offer coverage that is not MEC (e.g., only a dental plan). ■ Leave Line 15 blank.
1I	Qualifying Offer Transition Relief 2015. Employee (and spouse or dependents) received either: (1) no offer of coverage, (2) an offer that is not a qualifying offer, or (3) a qualifying offer for less than 12 months.	■ See Appendix. ■ Leave Line 15 blank.

Line 15. **Affordability.** Line 15 must be completed if Codes 1B, 1C, 1D or 1E are used in Line 14. Otherwise, leave blank. Enter the amount of the employee's share of the lowest cost premium for self-only, minimum value coverage. If no employee contribution is required for the lowest cost MV plan (i.e., it's 100% employer paid), enter "0.00". If the employee's share is the same for all 12 months of the CY, use the "all 12 Months" box. The amount reflected in Line 15 may not necessarily be the amount the employee is actually paying for coverage.

For example, the employer offers two health plans. The employee's share of the lowest cost premium for self-only, minimum value coverage is $100/month. This FTE elects a benefit option that is $200/month. For this FTE, the amount reflected in Line 15 is $100, even though the FTE is paying $200/month for coverage.

Line 16. **Safe Harbor.** The Series 2 Codes are used to report one or more months during the calendar year where the employer may not be subject to a penalty under the employer mandate either due to the employee's actual enrollment in MEC or certain relief. For each FTE (and any covered employee/individual in a self-insured plan), the employer will need to identify any Series 2 Code that may be applicable. In some cases multiple Series 2 Codes may be applicable, and an ordering rule applies (illustrated below). If no Series 2 Codes apply for a month, leave the box blank.

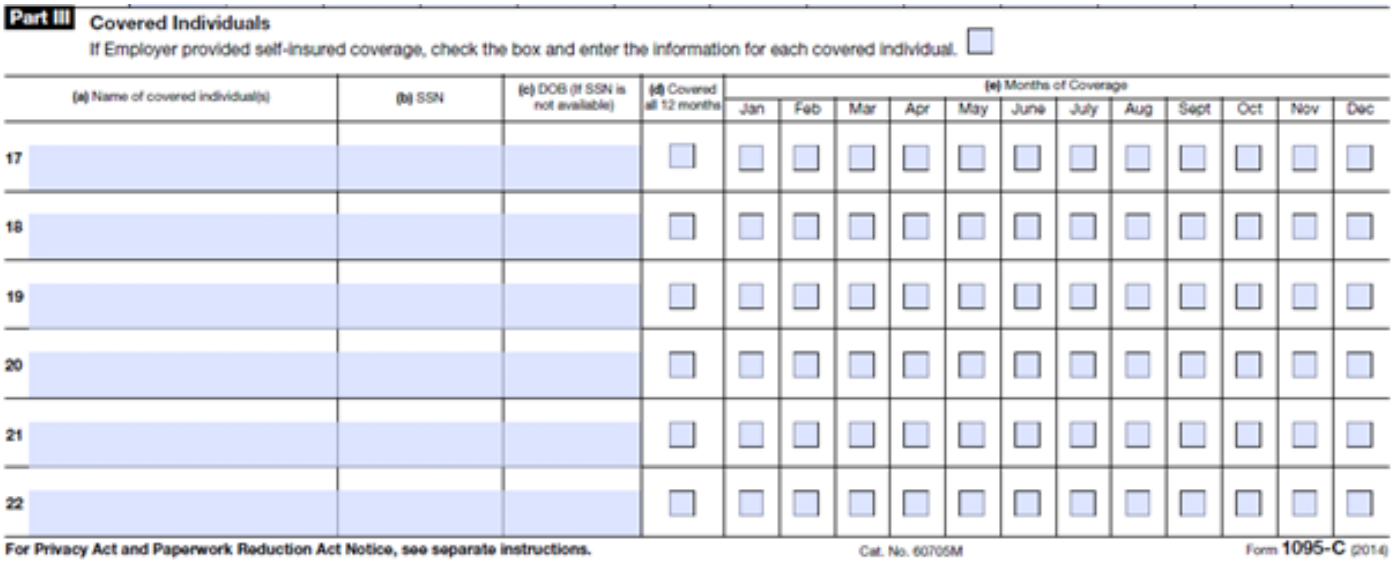
Series 2 Codes - Offer of Coverage and Line 16

2A	**Employee not employed during the month.** Enter code 2A if the employee was not employed on any day of the calendar month.	■ Do not use code 2A for a month if the individual was an employee of the employer on any day of the calendar month. ■ Do not use code 2A for the month during which an employee terminates employment with the employer.
2B	**Employee not an FTE.** Enter code 2B if the employee is not an FTE for the month AND did not enroll in MEC, if offered for the month.[11]	■ Also use this code for January 2015 if the employee was offered health coverage no later than the first day of the first payroll period that begins in January 2015 and the coverage offered was affordable and provided minimum value.
2C	**Employee enrolled in coverage offered.** Enter code 2C for any month in which the employee enrolled in health coverage offered by the employer for each day of the month, regardless of whether any other code in Code Series 2 might also apply.	■ Code 2C trumps any other Series 2 Code that may be relevant. ■ This is also used for any covered employee/individual in a self-insured health plan.
2D	**Employee in a limited non-assessment period.** Enter code 2D for any month during which an employee is in a Limited Non-Assessment Period. This includes an Initial Measurement Period (IMP) and associated Initial Administrative Period, the first calendar month of employment if the employee is not hired on the first day of the month, the period following change in status from non-FTE to FTE during an IMP and/or the waiting period.	■ Do not use 2B (not an FTE).
2E	**Multiemployer interim rule relief.** Enter code 2E for any month for which the multiemployer interim guidance applies for that employee.	■ Do not use 2D if the employer can use Code 2E.
2F	**Form W-2 safe harbor.** Enter code 2F if the employer used the Form W-2 safe harbor to determine affordability for this employee for the year.	■ Do not use if employee enrolled in the coverage offered (2C). ■ If an employer uses this safe harbor for an employee, it must be used for all months of the calendar year for which the employee is offered health coverage. ■ Do not use if 2E can be used (multiemployer relief).

11 Use code 2B if the employee is an FTE for the month and whose offer of coverage (or coverage if the employee was enrolled) ended before the last day of the month solely because the employee terminated employment during the month (so that the offer of coverage or coverage would have continued if the employee had not terminated employment during the month).

2G	**FPL Safe Harbor.** Enter code 2G if the employer used the FPL safe harbor to determine affordability for this employee for any month of the CY.	■ Do not use if employee enrolled in the coverage offered (2C). ■ Do not use if 2E can be used (multiemployer relief).
2H	**Rate of pay safe harbor.** Enter code 2H if the employer used the rate of pay safe harbor to determine affordability for this employee for any month of the CY.	■ Do not use if employee enrolled in the coverage offered (2C). ■ Do not use if 2E can be used (multiemployer relief).
2I	**Non-calendar year transition relief applies to this employee.**	■ Applies only for non-calendar year plans that qualify for this relief. ■ Applies only with respect to the months during the CY prior to the start of the plan year (e.g., June 1 plan year, 2I may be used to report relief for January – May).

PART III



Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual. ☐

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form 1095-C (2014)

Complete Part III ONLY if the employer offers a self-insured group health plan in which the employee or other individual is enrolled. If the employer completes Part III it must indicate self-insured coverage by checking the box at the top of the section. Employers sponsoring an insured arrangement will leave this section blank as the carrier is responsible.

This part must be completed by an employer offering self-insured health plan coverage for any individual who was an employee for one (or more) calendar month(s) of the year and who enrolled in the coverage **regardless** of full-time status. In addition, if non-employees are covered by the self-insured plan, an employer may use Form 1095-C (as opposed to Forms 1094-B and 1095-B) to report MEC for these individuals. This may include certain retirees or COBRA qualified beneficiaries or non-employee members of the board of directors who have coverage under the self-insured health plan.[12] Note, the employer must still complete Parts I and II with respect to these individuals. Use Code 1G in Line 14 to reflect the offer of coverage for a non-employee or a part-time employee.

12 If self-insured coverage is offered to these non-employees, there are additional compliance considerations that should be reviewed, including potential MEWA and tax implications of offering coverage to non-employee board of director members, potential for uncovered claims if not appropriately contracted for in the stop loss agreement, assurance that the plan terms permit such coverage and potential for 105(h) discrimination violations in the event that such coverage is extended only to former highly compensated employees.

Lines 17-22. Complete the name and social security number of each covered individual (e.g., employee, spouse and children). For individuals other than the employee listed in Part I, a tax identification number may be provided. If SSN is not available, a date of birth (DOB) may be used if a reasonable effort to collect the SSN is made.[13] Check the applicable boxes to reflect the months the individuals are enrolled in the self-insured health plan during the CY.

Filing and Distributing the Forms

FORM 1094-C

Forms 1094-C and all Forms 1095-C are filed with the IRS by February 28 if filing on paper (or March 31 if filing electronically) of the year following the calendar year to which the return relates. If the regular due date falls on a Saturday, Sunday, or legal holiday, file by the next business day. A business day is any day that is not a Saturday, Sunday, or legal holiday.

For CY 2015, these Forms are **due to the IRS by February 29, 2016 (as the 28th is a Sunday), or March 31, 2016 if filing electronically.**

Form 1094-C and Form 1095-C are subject to the requirements to file returns electronically. Filers of 250 or more information returns must file the returns electronically. The 250-or-more requirement applies separately to each type of return and separately to each type of corrected return.

FORM 1095-C

The requirement to furnish Form 1095-C to an employee is satisfied if the form is properly addressed and mailed on or before the due date. If the regular due date falls on a Saturday, Sunday, or legal holiday, file by the next business day. A business day is any day that is not a Saturday, Sunday, or legal holiday.

Generally, Forms 1095-C are due to employees by January 31 of the year following the calendar year to which the return relates.

For CY 2015, the 1095-C is **due to employees by February 1, 2016 (as January 31 is a Sunday).**

Unless an alternative furnishing method is available (see *Appendix*), the employer will provide a copy of the Form 1095-C to each FTE (i.e., an FTE for at least one month during the calendar year). In addition, if the health plan is self-insured, the employer must provide a copy to each individual who had coverage for at least one month during the calendar year.

Statements must be furnished on paper by mail, unless the recipient affirmatively consents to receive the statement in an electronic format. If mailed, the statement must be sent to the employee's last known permanent address, or if no permanent address is known, to the employee's temporary address.

Consent to furnish statement electronically. An employer is required to obtain affirmative consent to furnish a statement electronically. This requirement ensures that statements are furnished electronically only to individuals who are able to access them. An individual may consent on paper or electronically, such as by email. If consent is on paper, the individual must confirm the consent electronically. A statement may be furnished electronically by email or by informing the individual how to access the statement on the employer's website. Consent to receive a Form W-2 electronically does not transfer to Form 1095-C delivery. A separate consent identifying the Form 1095-C is needed.

13 To demonstrate a reasonable effort, the employer must satisfy the following steps:
- Initial solicitation at the time the relationship with the covered individual(s) is established (e.g., upon hire or initial enrollment);
- If unsuccessful, an annual solicitation must be made by Dec. 31 of the same year;
- If still unsuccessful, a second solicitation is required by Dec. 31 of the following year;
- If still unsuccessful, no penalties applied if a DOB is used in lieu of a SSN.

Use of a truncated SSN is permitted for Forms 1095-C that are provided to covered individuals. However, truncated SSNs are not permitted on Forms 1095-C submitted to the IRS.

PENALTIES FOR NONCOMPLIANCE WITH THESE INFORMATION REPORTING REQUIREMENTS

Generally, if Forms 1094-C and/or Forms 1095-C are incorrect and incomplete, a penalty may apply if not corrected by the due date and the employer cannot show reasonable cause. The penalties are the same as under the rules for Forms W-2. Briefly, the amount of penalties can range from $30/form with a $250,000 maximum penalty/year to $100/form with a maximum penalty of $1.5M/year (these are referred to as the 6721 and 6722 penalties).

Limited Relief for CY 2015

- The IRS will not impose penalties on large employers that can show that they have made good faith efforts to comply with the information reporting requirements. Specifically, relief is provided from penalties described above for returns and statements filed and furnished in 2016 to report offers of coverage in 2015 for incorrect or incomplete information reported on the return or statement. However, no relief is provided if the large employer cannot show a good faith effort to comply with the information reporting requirements or that fail to timely file an information return or furnish a statement.
- However, consistent with existing information reporting rules, ALE members that fail to timely meet the requirements still may be eligible for penalty relief if the IRS determines that the standards for reasonable cause under section 6724 are satisfied.

CY 2016 and Thereafter

The penalty under section 6721 may apply to an ALE member that fails to file timely information returns, fails to include all the required information, or includes incorrect information on the return. The penalty under section 6722 may apply to an ALE member that fails to furnish timely the statement, fails to include all the required information, or includes incorrect information on the statement. The waiver of penalty and special rules under section 6724 and the applicable regulations, including abatement of information return penalties for reasonable cause, may apply to certain failures under section 6721 or 6722. Discuss penalties with tax advisors.

ADDITIONAL INFORMATION

Third party assistance.

Reporting arrangements between a large employer and carriers or other parties (e.g., TPA, payroll provider) are not prohibited. However, entering into a reporting arrangement does not transfer a large employer's potential liability under section 4980H and does not transfer the potential liability for failure of the employer to file returns and furnish statements under section 6056. If a person who prepares returns or statements required under section 6056 is a tax return preparer, that person will be subject to the requirements generally applicable to tax return preparers.

Employers under Common Control (multiple ALE members)

Each large employer under a controlled group is responsible for reporting under section 6056. Generally, each large employer must file separate section 6056 returns providing that employer's EIN. If more than one third party is facilitating reporting for an large employer in the controlled group, there must be only one Authoritative Transmittal (noted on Form 1094-C) reporting aggregate employer-level data for all FTEs of that large employer. Additionally, there must be only one section Form 1095-C for each FTE with respect to employment with that ALE member.

14 In addition, large employers that fail to timely meet the requirements still may be eligible for penalty relief if the IRS determines that the standards for reasonable cause.

Appendix A

Form 1094-C Part II, Line 22 (A), (B) and (D)


22 Certifications of Eligibility (select all that apply):

A. Qualifying Offer Method B. Qualifying Offer Method Transition Relief C. Section 4980H Transition Relief D. 98% Offer Method

The guidance provides three methods that will slightly reduce these reporting requirements and, in some cases, provide an alternative to furnishing the Form 1095-C to the employee. These options DO NOT eliminate the employer's responsibility to complete and file Forms 1094-C and 1095-C with the IRS.

QUALIFYING OFFER METHOD – BOX A

An employer may use this method when a qualifying offer if made to one or more FTEs for all months during the CY (January – December). An offer is considered a qualifying offer if:

- The offer is made for all 12 months of the CY,
- The employee contribution for self-only coverage that meets MV does not exceed$93.18/month, and
- There is an offer of MEC to a spouse and dependents, if applicable.

The furnishing method described below only applies to FTEs who received the qualifying offer for all 12 months of the CY.

What relief does this method actually provide?

- Do not report the self-only employee premium cost for the lowest cost MV plan on Line 15 of 1095-C. Instead use Code 1A in Line 14 of 1095-C.
- Instead of providing participants the 1095-C, an employer may furnish a "qualifying offer statement" that includes:
  - Employer name, address, EIN,
  - A contact name, and phone number at which the employee may receive more information about the offer of coverage and the information on the Form 1095-C filed with the IRS for that employees.
  - A statement indicating that, for all 12 months of the CY, the employee and his/her spouse, and dependents, if any, received a qualifying offer and therefore are not eligible for premium tax credit.
  - A statement directing the employee to see Pub. 974, Premium Tax Credit (PTC), for more information on eligibility for the premium tax credit.

Important note for employers with self-insured health plans. If the employer sponsors a self-insured plan, the alternative "qualifying offer statement" described above CANNOT be used for any employee who is covered by the self-insured health plan. These employees must receive a Form 1095-C.

QUALIFYING OFFER METHOD TRANSITION RELIEF – BOX B

Qualifying Offer Method Transition Relief is available for CY 2015 only. To use this method, an employer must certify that a qualifying offer of coverage (as described above) was made to at least 95% of FTEs.

What relief does this method actually provide?

- Do not report the self-only employee premium cost for the lowest cost MV plan on Line 15 of 1095-C. Instead, in Line 14 of Form 1095-C, use Code 1A for any months for which the employee received a qualifying offer or 1I for any month for which the employee did not receive the qualifying offer.
- Provide each FTE who received the qualifying offer for all 12 months of the CY with either a copy of their 1095-C, or the "qualifying offer statement" previously described.
- Solely for 2015, for any employee of an employer eligible for the Qualifying Offer Method Transition Relief who does not receive a qualifying offer for all 12 calendar months, including employees who receive no offer, the employer may, in lieu of providing the employee with a copy of Form 1095-C, furnish a statement containing the following information.
    - Employer name, address, EIN,
    - A contact name and phone number at which the employee may receive more information about the offer of coverage and the information on the Form 1095-C filed with the IRS for that employees.
    - A statement indicating that the employee, his or her spouse and dependents, if any, may be eligible for a premium tax credit for one or more months of 2015.
    - A statement directing the employee to see Pub. 974, Premium Tax Credit (PTC), for more information on eligibility for the premium tax credit.

Important note for employers with self-insured health plans. If the employer sponsors a self-insured plan, the alternative "qualifying offer statement" described above CANNOT be used for any employee who is covered by the self-insured health plan. These employees must receive a Form 1095-C.

98% METHOD – BOX D

To use this method, an employer must certify that it offered, for all months of the CY, affordable coverage providing minimum value to at least 98% of its employees for whom it is filing a 1095-C and offered MEC to those employees' dependents. The employer is not required to identify which of the employees for whom it is filing were FTEs, but the employer is still required to file Forms 1095-C on behalf of all of its FTEs (and any employees/individuals covered by a self-insured plan). Health coverage is deemed affordable if the employer meets one of the available safe harbors (W-2, FPL, rate of pay).

What relief does this method actually provide?

- No need to complete the FTE count on 1094-C, Part III, column (b).