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New Guidance Tackles VariousEmployer Mandate Issues

Published: January 12, 2016

IRS Notice 2015-87 provides further guidance on the application of various provisions of the Affordable Care Act ("ACA") that affect applicable large employers ("ALEs") under the Employer Penalty.

Unless otherwise provided, the guidance in Notice 2015-87 applies for plan years beginning on or after January 1, 2016, but employers may rely upon this guidance for all prior periods.

Notably, the guidance:

- Announces 2015 inflation adjustments to the "A" and "B" Penalties for calendar year (CY) 2015, $2,080/$3,120 and CY 2016, $2,160/$3,240 respectively.
- Clarifies how to calculate hours of service in certain situations when no duties are performed.
- Requires some non-educational organizations, like a staffing firm, to follow special rules applicable to educational organizations when placing individuals in an educational organization if a meaningful opportunity to provide services is not available throughout the entire year.

Inflation Adjustment To Employer Penalty (Q/A-13)

Background. Under the ACA, the amount of the Employer Penalty was established for a 2014 effective date with an annual inflation adjustment. However, the government delayed any assessments for one year (until 2015) and did not announce inflation adjustments for calendar years beginning after 2014.

New Guidance. The Notice provides the adjustments to the annual assessment for calendar years 2015 and 2016 as follows:

Calendar Year	"A" Penalty	"B" Penalty
2015	$2,080 (or $173.33/month)	$3,120 (or $260/month)
2016	$2,160 (or $180/month)	$3,240 (or $270/month)

Penalties are paid annually but assessed monthly. Future adjustments will be posted at www.irs.gov.

Example 1

An ALE with 200 FTEs does not offer coverage in calendar year 2015 and 2016. One FTE receives a subsidy in the marketplace to purchase health insurance coverage for all 12 months of the calendar year.

For 2015: $2,080 × (200 – 80 FTEs) = $249,600

For 2016: $2,160 × (200 – 30 FTEs) = $367,200

Example 2

An ALE with 200 FTEs offers unaffordable coverage to all FTEs. Instead of taking the employer's coverage, 50 FTEs receive a subsidy in the Marketplace to purchase health insurance coverage for all 12 months of the calendar year.

For 2015: $3,120 × 50 FTEs = $156,000

For 2016: $3,240 × 50 FTEs = $162,000

Hours Of Service (Q&A-14)

Background. An FTE is an employee who is employed an average of at least 30 hours of service per week (or 130 hours of service a month) with an ALE. An hour of service is defined as:

- each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer; and
- each hour for which an employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

With respect to hours where an employee is paid or entitled to payment when no duties are performed, the existing regulations reference an hours of service definition from Department of Labor regulations. However, the extent to which these regulations are incorporated for purposes of the employer mandate has been unclear.

New Guidance. The IRS intends to issue regulations that will adopt a "source of payment rule" for purposes of determining whether an hour of service must be credited when no duties are performed by the employee.

Specifically, if the employer contributes toward the payment, directly or indirectly then an hour of service must be counted. This is the case regardless of whether the payment is made by or due from the employer directly, or indirectly through, among others, a trust fund or insurer to which the employer contributes or pays premiums, and regardless of whether contributions made or due to the trust fund, insurer, or other entity are for the benefit of particular employees or are on behalf of a group of employees in the aggregate.

Moreover, hours of service are counted without limitation if there is a single continuous period where the employee performs no duties if the hours of service would otherwise qualify as hours of service under the Employer Penalty. There is a limited exception for educational organizations.

The guidance provides the following specific examples to consider when identifying hours of service.

An hour of service includes:
Disability payments (e.g., LTD or STD) when the benefit is included as taxable income to the employee and the recipient employee retains status as an employee of the employer.

An hour of service does not include:
Any hours after the individual terminates employment with the employer.
Payments made solely for the purpose of complying with workers' compensation.
Payments from a state or local government to the employee in the form of workers compensation wage replacement benefits provided the employee is not performing services for the employer.
Payments made solely for the purpose of complying with unemployment insurance laws.
Payments made solely for the purpose of complying with disability insurance laws.
Payments made to reimburse an employee for medical or medically-related expenses.
A disability payment (e.g., STD or LTD) where the employee paid for the coverage with after-tax contributions.

Rehire Rules For Educational Organizations (Q/A-16)

Background. Under the applicable measurement method, rehired employees may be treated as new hires if there is a break in service of at least 13 weeks. Educational organizations must use 26 weeks instead of 13 weeks.

Additionally, educational organizations that use the look back measurement method to identify full-time employees must credit hours of service (up to 501) for any employment break.

New Guidance. In light of concern that some educational organizations are attempting to avoid application of the 26-week rule and the employment break rule by, for example, using a third-party staffing agency for certain individuals providing service, the regulators propose amending the existing rules to extend application of these special rules in certain circumstances in which the services are being provided to one or more educational organizations, even if the employer is not an educational organization and even if the employee is not a teacher.

For example, the special rule would apply to an employer with respect to a bus driver who is primarily placed to provide bus driving services, or a cafeteria worker who is primarily placed to provide services in a cafeteria, at one or more educational organizations and who is not provided a meaningful opportunity to provide services during one or more months of the calendar year (for example, the summer recess period).

In contrast, an employer that primarily places bus drivers or cafeteria workers at educational organizations would not apply the special rule to an employee if the individual was offered a meaningful opportunity to provide services during all months of the year (for example, in the case of a cafeteria worker, by working at a hospital cafeteria during the summer recess period of the educational organization at which the individual generally is placed).

This change will apply as of the effective date specified in the regulations (when issued), but in no event this be effective before the first plan year beginning after the date on which the proposed regulations are issued.

New Guidance Addresses Affordability and the Employer Penalty

Published: January 12, 2016

As background, applicable large employers ("ALEs") may be subject to the Employer Penalty if any full-time employee ("FTE") receives a subsidy to purchase Exchange coverage. There are two penalties, "A" and "B." The "B" Penalty can apply when the ALE offers at least 95% of FTEs and their dependent children minimum essential coverage ("MEC") but the coverage is not affordable, does not provide minimum value, or excludes 5% or fewer FTEs.

IRS Notice 2015-87 provides further guidance on the affordability component (and other topics to be summarized in future articles).

Unless otherwise provided, the guidance in Notice 2015-87 applies for plan years beginning on or after January 1, 2016, but employers may rely upon this guidance for all prior periods.

The concept of affordability is significant as it affects:

- whether an employer is subject to a "B" Penalty assessment; and
- how an employer reports the affordability of any group health plan coverage offered to full-time employees on Form 1095-C (Line 15) and the affordability safe harbor used for those who waive coverage (Line 16).

Inflation Adjustments To 9.5%

Background. The IRS provides three safe harbors the employer may use to establish affordable coverage in order to avoid the "B" Penalty. Under the safe harbors, an employer's offer of coverage is affordable with respect to an employee if the required contribution for self-only coverage in the lowest cost health plan that provides minimum value does not exceed 9.5% of:

- Form W-2 Safe Harbor. The employee's Form W–2 wages as determined at the end of the year.

- Rate of Pay Safe Harbor. the employee's rate of pay determined by multiplying 130 hours by the hourly rate of pay for an hourly employee, or by using monthly salary for non-hourly employees.

- FPL Safe Harbor. The monthly income for a single individual at 100% of the Federal Poverty Line ($93.18 per month for 2015).

New Guidance. In each of the safe harbors, the reference to 9.5% will be adjusted annually, consistent with the determination of affordable coverage for purposes of an individual's eligibility for subsidies. The rates for the first two years are as follows:

Calendar Year	Percentage (with adjustment)
2015	9.56%
2016	9.66%

Employers may rely upon the adjusted amounts for plan years beginning in 2015. Thus, the FPL safe harbor for 2015 is no more than $93.77 per month (slightly more than the unadjusted 2015 amount). The FPL for 2016 has not yet been issued.

These adjustments also apply with respect to the multiemployer plan interim relief, the requirement that employees be permitted to decline enrollment in coverage with a limited exception to affordable/minimum value coverage as determined under the FPL safe harbor, the definition of a Qualifying Offer for purposes of reporting on Line 14 of Form 1095-C (Code 1A), and use of alternative reporting methods for Qualifying Offers.

Flex Contributions And Affordability (Q/A-8)

Background. In some cases, employers provide flex contributions under a cafeteria plan. Employees can use these contributions toward the purchase of benefits.

New Guidance. Flex contributions reduce the amount of an employee's required contribution only if:

- the employee may not opt to receive the amount as a taxable benefit;

- the employee may use the amount to pay for MEC; and

- the employee may use the amount exclusively to pay for medical care (as defined under Code section 213).

This is referred to as a "health flex contribution."

Example 1

Employer offers employees coverage under a group health plan through a cafeteria plan. An employee electing self-only coverage under the health plan is required to contribute $200 per month toward the cost of coverage. Employer offers employer flex contributions of $600 for the plan year ($50 per month) that may only be applied toward the employee's share of contributions for the group health coverage or contributed to a health FSA.

The $600 employer flex contribution is a health flex contribution and reduces the employee's required contribution for the coverage. This affects the affordability determination for purposes of the employer mandate and applicable reporting. The $600 employer health flex contribution is taken into account as an employer contribution (and therefore reduces the employee's required contribution) regardless of whether the employee elects to apply the health flex contribution toward the employee contribution for the group health coverage or elects to contribute it to the health FSA.

The employee's required contribution for the group health coverage is $150 ($200 - $50) per month. Affordability is determined using $150 per month.

Example 2

Same facts as Example 1, but the employer flex contributions can be used for any benefit under the cafeteria plan (including benefits not related to health) but are not available as cash.

Because the $600 employer flex contribution is not used exclusively for medical care, it is not a health flex contribution and therefore does not reduce the employee's required contribution for the coverage. The employee's required contribution for the group health coverage is $200 per month. Affordability is determined using $200 per month.

Example 3

Same facts as example 2, but instead the flex contribution is available to pay for health benefits or to be taken as cash or other taxable compensation (and not available to pay for other types of benefits).

Same result as Example 2.

Transition Relief

For plan years beginning before January 1, 2017, a flex contribution that is not a health flex contribution (Examples 2 and 3 above) will be treated as reducing the amount of an employee's required contribution (affordability determined based on $150 as opposed to $200) provided:

- the employer offered the flex contribution arrangement (or a substantially similar flex contribution arrangement) for a plan year including December 16, 2015;
- a board, committee, or similar body or an authorized officer of the employer specifically adopted the flex contribution arrangement before December 16, 2015; or
- the employer provided written communications to employees on or before December 16, 2015 indicating that the flex contribution arrangement would be offered to employees at some time in the future.

1095-C Reporting

While employers eligible for the limited relief described above may reduce the amount of the employee's required contribution for purposes of Form 1095-C reporting (Line 15) by the amount of a non-health flex contribution, they are not encouraged to do so, as it may affect the employee's eligibility for the premium tax credit.

If an employee's required contribution is reported in this manner (that is, without reduction for the amount of a non-health flex contribution) and the employer is contacted by the IRS concerning a potential "B" Penalty assessment relating to the employee's receipt of a premium tax credit, the employer will have an opportunity to respond and show that it is entitled to the relief contain in this Notice to the extent that the employee would not have been eligible for the premium tax credit if the required employee contribution had been reduced by the amount of the non-health flex contribution or to the extent that the employer would have qualified for an affordability safe harbor if the required employee contribution had been reduced by the amount of the non-health flex contribution.

Opt-Out Bonuses And Affordability (Q/A-9)

Background. Under a cafeteria plan, an employer may offer an employee a "cash option," a taxable amount that is available if the employee declines coverage under the employer's health plan (also referred to as an "opt-out bonus").

New Guidance. Treasury and IRS intend to issue regulations that treat an unconditional opt-out arrangement (that is, an arrangement providing for a payment conditioned solely on an employee declining coverage under an employer's health plan) in the same manner as a salary reduction for purposes of determining an employee's required contribution.

Example

An employer offers employees group health coverage through a cafeteria plan, requiring employees who elect self-only coverage to contribute $200 per month toward the cost of that coverage and offers an additional $100 per month in taxable wages to each employee who declines the coverage.

For purposes of affordability, the employee cost would be $300. This is because the offer of $100 in additional compensation has the economic effect of increasing the employee's contribution for the coverage. In this case, the employee contribution for the group health plan effectively would be $300 ($200 + $100) per month, because an employee electing coverage under the health plan must forgo $100 per month in compensation in addition to the $200 per month in salary reduction.

It is anticipated that proposed regulations will also address and request comments on the treatment of opt-out bonuses that are conditioned not only on the employee declining employer-sponsored coverage but also on satisfaction of additional conditions (such as the employee providing proof of having coverage provided by a spouse's employer or other coverage).

Effective Date/"B" Penalty/1095-C Reporting

Any required inclusion will generally apply only for periods after the issuance of final regulations, except in the case of a non-relief-eligible opt-out arrangement. This means an opt-out
bonus (other than a payment made under a non-relief-eligible opt-out arrangement):

- will not be treated as increasing an employee's required contribution for purposes of a "B" Penalty assessment; and
- employers are not required to increase the amount of an employee's required contribution by the amount of an opt-out bonus for purposes of Form 1095-C reporting (Line 15).

An arrangement will be considered a non-relief-eligible opt-out arrangement requiring the inclusion of an amount offered or provided under an unconditional opt-out arrangement, unless:

1. 1. the employer offered the opt-out arrangement (or a substantially similar opt-out arrangement) with respect to health coverage provided for a plan year including December 16, 2015;

2. 2. a board, committee, or similar body or an authorized officer of the employer specifically adopted the opt-out arrangement before December 16, 2015; or

3. 3. the employer had provided written communications to employees on or before December 16, 2015 indicating that the opt-out arrangement would be offered to employees at some time in the future.

Service Contract Act ("Sca") And Davis Bacon Act And Davis Bacon Related Acts ("Dbra) Fringe Benefits And Affordability (Q/A-10)

Background. The SCA and DBRA require that workers employed on certain federal contracts be paid prevailing wages and fringe benefits. Under the SCA and DBRA, an employer generally can satisfy its fringe benefit obligations by:

- providing a particular benefit or benefits, as determined by the employer, that have a sufficient dollar value; or
- providing the cash equivalent of benefits or some combination of cash and benefits; or
- allowing employees to choose among various benefits or among various benefits and cash.

If an employer chooses to provide fringe benefits under the SCA or DBRA by offering an employee the option to enroll in health coverage provided by the employer (including an option to decline that coverage) and the employee declines the coverage, that employer then generally is required to provide the employee with cash or other benefits of an equivalent value. An employer that chooses to satisfy its obligation to provide fringe benefits under the SCA or DBRA by offering an employee the option to enroll in health coverage provided by the employer (including an option to decline that coverage) generally would need to provide a significant additional subsidy to make the offer affordable. While the SCA and DBRA require employers to pay covered employees no less than prevailing wage and fringe benefit rates, this additional subsidy would result in certain employees receiving amounts significantly in excess of SCA and DBRA minimum rates.

New Guidance. Until the applicability date of any further guidance, and in any event for plan years beginning before January 1, 2017, employer fringe benefit payments (including flex credits or flex contributions) under the SCA or DBRA that are available to employees covered by the SCA or DBRA to pay for coverage under an eligible employer-sponsored plan (even if alternatively available to the employee in other benefits or cash) will be treated as reducing the employee's required contribution for participation in that eligible employer-sponsored plan for purposes of affordability, but only to the extent the amount of the payment does not exceed the amount required to satisfy the requirement to provide fringe benefit payments under the SCA or DBRA.

Example

Employer offers employees subject to the SCA or DBRA coverage under a group health plan through a cafeteria plan, which the employees may choose to accept or reject. Under the terms of the offer, an employee may elect to receive self-only coverage under the plan at no cost, or may alternatively decline coverage under the health plan and receive a taxable payment of $700 per month. For the employee, $700 per month does not exceed the amount required to satisfy the fringe benefit requirements under the SCA or DBRA.

Until the applicability date of any further guidance (and in any event for plan years beginning before January 1, 2017), the required employee contribution for the group health plan for an employee who is subject to the SCA or DBRA is $0 for purposes of the "B" Penalty and reporting on Form 1095-C.

1095-C Reporting

Employers are encouraged to treat these fringe benefit payments as not reducing the employee's required contribution for purposes of reporting on Form 1095-C (thus reflect $700 as opposed to $0 on the Form 1095-C, Line 15).

If an employee's required contribution is reported without reduction for the amount of the fringe benefit payment and the employer is contacted by the IRS concerning a potential "B" Penalty, the employer will have an opportunity to respond and show that it is entitled to the relief contained in the Notice to the extent that the employee would not have been eligible for the premium tax credit if the required employee contribution had been reduced by the amount of the fringe benefit payment or to the extent that the employer would have qualified for an affordability safe harbor if the required employee contribution had been reduced by the amount of the fringe benefit payment.

Treasury and IRS continue to consider other methods for reporting the amount of the required contribution for employees subject to the SCA or DBRA, including the possible use of indicator codes. However, any new methods will not require implementation for reporting on plan years beginning before January 1, 2017.

Implications For Some Employees (Q/A-11)

Certain individuals may be affected by Q/A-8 through 10 because employers are permitted to report a lower amount as the employee's required contribution on the Form 1095-C. Specifically, employees who (1) enrolled in coverage through the Marketplace, (2) did not receive the benefit of advance payments of the premium tax credit, and (3) have household income is in the range for premium tax credit eligibility (100% - 400% FPL), may need additional information from their employers regarding their required employee contribution to determine eligibility for the premium tax credit.

Employers that use the available relief are encouraged to notify employees that they may obtain accurate information about their required contribution taking into account the modifications provided to the employer through the Notice using the employer contact telephone number provided to the employee on Form 1095-C. If the modified required contribution is not affordable and the employee is otherwise entitled to the premium tax credit, the employee may claim it on Form 8692, Premium Tax Credit, which is filed with the employee's annual income tax return (regardless of the required contribution or qualifying offer information reported on that employee's Form 1095-C).

Congress Enacts 2-Year Delay of Cadillac Tax

Published: January 13, 2016

On December 18, President Obama signed bipartisan legislation for a year-end spending and tax package. As part of the package, Congress enacted a two-year delay of the ACA Excise Tax ("Cadillac Plan Tax") provision. As such, the tax now goes 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.

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).

The legislation made the following additional ACA-related changes:

- Permits a tax deduction of any Cadillac Plan tax assessment (whereas the original version of the law did not permit a tax deduction);
- 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; and
- Extends parity between mass transit and parking benefits under Code section 132(f).

New Qualified Transit and Parking Guidance

Published: January 22, 2016

The Consolidated Appropriations Act, 2016 (the "Act") permanently changed the pre-tax transit benefits to be at parity with parking benefits. As a result, the Act retroactively increased the 2015 transit benefits from $130 to $250. For 2016, the transit and parking pre-tax benefits are $255.

On January 12th, the IRS issued Notice 2016-06, which provides alternative correction procedures for employers related to the 2015 pre-tax transit increase. Employers are required to correct Forms 941 and W-2 by amounts in excess of $130, whether provided by the employer or through a compensation reduction arrangement.

- For example, if an employer provided an employee with a transit pass worth $200, but taxed the employee $70 ($200-$130), then the employer is required to correct the 941 and the W-2 to reflect the $70 as tax free benefits.

- As another example, if an employee enrolled in a compensation reduction arrangement and purchased a $200 transit pass, $130 pre-tax and $70 post tax, the employer is required to correct the Form 941 and the employee's W-2 to treat the $70 as pre-tax.

Ordinarily, an employer is required to make corrections to the Forms 941 and W-2 by filing Forms 941-X for each quarter and the Form W-2C. However, Notice 2016-06 provides the following procedures to reduce administrative burden:

1. Repay or reimburse employees for over-collected FICA Tax (including any additional Medicare tax) for all four quarters of 2015;

2. The reimbursement or repayment must be completed prior to filing the Form 941 by the employer;

c. Taxable Medicare Wages and Tips on Line 5C;
d. Taxable Wages and Tips subject to additional Medicare Tax on Line 5D.

If the employer takes advantage of the administrative procedures outlined in the Notice, the employer will not have to file a Form 941-X or Forms W-2c (the Forms ordinarily filed to make corrections).

If an employer has not repaid or reimbursed employees for over-collected FICA Tax, then the employer must follow the ordinary correction procedures, meaning filing amended returns for each quarter and amended W-2s (Forms 941-X and W-2c, respectively).

Finally, the Notice also clarifies the following additional items:

- An employer is not required to provide additional transit benefits to its employees for 2015;

- An employee is not permitted to retroactively increase the 2015 salary reduction to take advantage of the increase provided by the Act;

- An employee is not permitted to have a salary reduction in excess of $255 for 2016 to compensate for the 2015 increase; and

- There continues to be a limitation on providing cash reimbursements for transit passes when transit passes are readily available for direct distribution by the employer to the employee.

For further information and details, please see IRS Notice 2016-6,

http://www.irs.gov/pub/irs-drop/n-16-06.pdf.

For implementation, please call your payroll service provider directly and discuss the Notice.

New Guidance Addresses Account-Based Plans

Published: January 25, 2016

IRS Notice 2015-87 provides further guidance on health flexible spending accounts ("health FSAs") and health reimbursement arrangements ("HRAs") (and other topics summarized in past articles).

Health FSAs And Carryovers

Background. An employer, at its option, may amend its health FSA to allow employees to roll over up to $500 of unused contributions to the immediately following plan year, provided the plan does not allow for a grace period.

New Guidance.

1. Unused amounts carried over from the prior year are subject to COBRA.

2. Unused amounts carried over from the prior year cannot be included in the COBRA premium.

Example

An employer maintains a calendar year health FSA. During open enrollment, an employee elected to reduce his salary by $2,500 for the year. In addition, the employee carries over $500 in unused benefits from the prior year. Thus, the maximum benefit that the employee can become entitled to receive under the health FSA for the entire year is $3,000. The employee terminates employment on May 31. As of that date, the employee had submitted $1,100 of reimbursable expenses under the health FSA.

Conclusion: If the employee elects COBRA, the maximum benefit that the employee could become entitled to receive for the remainder of the year is $1,900 ($3,000 minus $1,100).

The COBRA premium for a health FSA with a carryover is based solely on the sum of the employee's salary reduction election for the year (and any employer contribution) plus the allowed 2% administration fee.

Example

An employee elects salary reduction with respect to a health FSA of $2,000. The employer provides a matching contribution of $1,000. In addition, the employee carries over $500 in unused benefits from the prior year. The employee experiences a qualifying event that is a termination of employment on May 31.

Conclusion: The maximum amount the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the year is 102% of 1/12 of the applicable premium of $3,000 ($2,000 of employee salary reduction election plus $1,000 of employer contributions) times the number of months remaining in the year after the qualifying event. The $500 of benefits carried over from the prior year is not included in the applicable premium.

3. A health FSA must allow carryovers for COBRA continuees, subject to the same terms applicable to similarly situated non-COBRA participants.

Example

An employer maintains a calendar year health FSA. During open enrollment, an employee may elect to reduce salary by $2,500 for the year. In addition, the plan allows a carryover of up to $500 in unused benefits remaining at the end of the plan year. An employee elects salary reduction of $2,500 for the year. The employee terminates employment on May 31. As of that date, the employee had submitted $400 of reimbursable expenses under the health FSA. The employee elects COBRA continuation coverage and pays the required premiums for the rest of the year. As a qualified beneficiary, the former employee submits additional reimbursable payments in the amount of $1,600. At the end of the plan year, there is $500 of unused benefits remaining.

Conclusion: The qualified beneficiary is allowed to continue to submit expenses under the same terms as similarly situated non-COBRA beneficiaries in the next year, for up to $500 in reimbursable expenses. The maximum amount that can be required as an applicable premium for the carryover amount for periods after the end of the plan year is $0. The maximum period the carryover is required to be made available is the period of COBRA continuation coverage. In this case, the period is 18 months and terminates at the end of November of the next year. Thus, the health FSA need not reimburse any expense incurred after that November.

Note in the example above that if there were no carryover, this individual's health FSA benefits would have ended on December 31.

Due to the carryover, this individual has access to $500 for reimbursable expenses with no additional COBRA premium charged. While this does not appear to provide the individual the right to a new COBRA election effective January 1, it does mean that employers and third party administrators ("TPAs") need to continue to monitor these accounts until the entire COBRA period expires which may increase administration costs to the plan.

4. A health FSA may condition the ability to carry over unused amounts on participation in the health FSA in the next year (and even if the ability to participate in that next year requires a minimum salary reduction election to the health FSA for that next year).

Example

Employer sponsors a cafeteria plan offering a health FSA that permits up to $500 of unused health FSA amounts to be carried over to the next year, but only if the employee participates in the health FSA during that next year. To participate in the health FSA, an employee must contribute a minimum of $60 ($5 per calendar month). As of December 31, 2016, Employee A and Employee B each have $25 remaining in their health FSA. Employee A elects to participate in the health FSA for 2017, making a $600 salary reduction election. Employee B elects not to participate in the health FSA for 2015. Employee A has $25 carried over to the health FSA for 2017, resulting in $625 available in the health FSA. Employee B forfeits the $25 as of December 31, 2016 and has no funds available in the health FSA thereafter.

Conclusion: This arrangement is permissible.

5. A health FSA may limit the ability to carry over unused amounts to a maximum period. Thus, if an individual carried over $30 and did not elect any additional amounts for the next year, the health FSA may require forfeiture of any amount remaining at the end of that next year.

HRAs

Background. Employers can only offer HRAs that are integrated with a group health plan.

New Guidance.

1. An HRA cannot reimburse the medical expenses of an employee's spouse and/or dependents unless they are enrolled in the employer's group health plan. This is effective the first day of the 2016 plan year. However, an HRA that otherwise would be integrated based on the terms of the plan as of December 16, 2015 does not need to comply until the first day of the 2017 plan year.

2. May an HRA or similar employer-funded health care arrangement be used to purchase individual market coverage after the employee covered by the HRA ceases to be covered by other integrated group health plan coverage without causing the HRA to fail to comply with the market reforms?
   - No for the typical HRA; an HRA covering two or more current employees fails to be integrated with another group health plan if the amounts credited to the HRA may be used to purchase individual market coverage.
   - Yes if the HRA covers fewer than two participants who are current employees (such as one covering only retirees or other former employees) as the HRA qualifies as an "excepted benefit."

A participant with available funds from an HRA for any month is not eligible for a premium tax credit for that month as he is deemed to be enrolled in minimum essential coverage.

For more information, visit:
https://www.irs.gov/pub/irs-drop/n-15-87.pdf.

2016 Federal Poverty Guidelines

Published: February 2, 2016

Background

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 Federal Poverty Line ("FPL") is relevant to this penalty in two ways:

1. **Affordability Safe Harbor:** 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% (as indexed) of a monthly amount determined as the FPL for a single individual for the applicable calendar year, divided by 12.

2. **Subsidy Eligibility:** An individual is only eligible for a subsidy in the Exchange if he or she is within 100-400% of the FPL and is not offered affordable, minimum value group coverage.

Indexed Amounts

The following are the 2016 HHS poverty guidelines:

2016 Poverty Guidelines For The 48 Contiguous States And The District Of Columbia

Persons in family/household	Poverty guideline
1	$11,880
2	$16,020
3	$20,160
4	$24,300
5	$28,440
6	$32,580
7	$36,730
8	$40,890

For families/households with more than 8 persons, add $4,160 for each additional person.

2016 Poverty Guidelines For Alaska

Persons in family/household	Poverty guideline
1	$14,840
2	$20,020
3	$25,200
4	$30,380
5	$35,560
6	$40,740
7	$45,920
8	$51,120

For families/households with more than 8 persons, add $5,200 for each additional person.

2016 Poverty Guidelines For Hawaii

Persons in family/household	Poverty guideline
1	$13,670
2	$18,430
3	$23,190
4	$27,950
5	$32,710
6	$37,470
7	$42,230
8	$47,010

For families/households with more than 8 persons, add $4,780 for each additional person.

Affordability Safe Harbor and Subsidy Eligibility 2016 Results

So as to provide employers with adequate time to establish premium amounts in advance of the plan's open enrollment period, a plan can use any of the poverty guidelines in effect within 6 months before the first day of the plan year. These new thresholds were announced in January 2016.

Based on 2016 levels:

- For affordability safe harbor purposes, the applicable FPL is the FPL for the state in which the employee is employed. The FPL is $11,880 for a single individual for every state (and Washington D.C.) except Alaska3 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 $95.63 (9.66% of $11,880/12) or less, the employer meets the FPL safe harbor.

- For subsidy eligibility purposes, the applicable FPL is the FPL for the state in which the employee resides. 100 – 400% of the FPL is $11,880 - $47,520 for a single individual and $24,300 - $97,200 for a family of four for every state (and Washington D.C.), except Alaska or Hawaii.

Medicare Part D

Reminder to Notify CMS

Published: February 25, 2016

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/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosureForm.html.

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, 2016) must complete this reporting no later than February 29, 2016.

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 (800) 633-4227.

HHS Finalizes Health Plan Out-of-Pocket Limits for 2017

Published: March 8, 2016

On March 1, 2016, the Department of Health and Human Services (HHS) released cost-sharing parameters setting the 2017 maximum annual out-of-pocket limits on non-grandfathered health plans at **$7,150** for self-only coverage and **$14,300** for coverage other than self-only. These limits take effect for the first plan year on or after January 1, 2017.

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 family coverage.

As a reminder, the 2016 maximum annual out-of-pocket limits for all non-grandfathered plans are **$6,850** for self-only coverage and **$13,700** for coverage other than self-only.

California Insurance Legislation

Published: March 9, 2016

California enacted legislation affecting group health plans. Generally, these requirements apply if the employer purchases health coverage from a health plan or health insurer regulated by California (generally, insured health plan coverage). Self-insured health plans subject to ERISA and policies written in other states (and not regulated by California) are not subject to these requirements. Discuss with carriers for further information.

Unless otherwise noted, these requirements were effective January 1, 2016.

Minimum Value Plans (AB 248)

California prohibits insurance carriers from offering, amending or renewing a large group non-grandfathered health plan that does not meet at least 60% minimum value. This requirement does not apply to grandfathered plans and limited wrap around coverage.

For a copy of the legislation, visit:

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB248.

Cost Sharing Requirements (AB 1305)

California aligns state insurance rules to mirror federal requirements under the Affordable Care Act ("ACA") with respect to maximum out-of-pocket spending on essential health benefits ("EHBs"). Specifically, for plan years beginning on or after January 1, 2016, cost sharing limits must not exceed $13,700 for family coverage and such coverage must include an individual out-of-pocket limit of no more than $6,850.

California goes even further than the requirements under the ACA and imposes requirements on health plan deductibles.

- **Small group (1-100 employees) -** For plan years beginning on or after January 1, 2016, insured small employer group health plans in California must embed an individual deductible in the family coverage that is not greater than the limit for individual coverage. For example, a small group health plan has a $1,000 deductible for self-only coverage and a $2,000 deductible for family coverage. The family coverage must include an individual deductible of $1,000 so that once an individual incurs claims to reach the $1,000 individual deductible in the family coverage that individual's benefits are paid according to the terms of plan even though the family deductible of $2,000 is not fully satisfied. Carriers may apply for a one-year delay in the effective date.

- **Large group (101 or more employees) -** This same requirement will take effect for large group insurance contracts on January 1, 2017.

With respect to qualified High Deductible Health Plans ("HDHP"), carriers must take care to appropriately align state requirements with federal rules governing HDHPs. California generally prohibits deductibles in the small group health plan market that exceed $2,000 for single coverage and $4,000 for family coverage. Effective January 1, 2016, the indexing factor for these thresholds has changed. Specifically, a health plan that includes an embedded individual deductible in family coverage that is below the minimum family deductible required for qualified HDHP coverage ($2,600 for 2016) is not HSA qualified. The law requires the carrier to use the greater of the family HDHP minimum deductible or the deductible for individual coverage under the plan contract. Presumably, this will create a mechanism for carriers to continue to offer HSA-compatible health plans.

For a copy of the legislation, visit:

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160AB1305.

Supreme Court Finds State Reporting Law Is Preempted by ERISA

Published: March 10, 2016

On March 1, 2016, the Supreme Court decided in a 6-2 vote that a Vermont reporting law did not apply to ERISA-covered plans, which includes most benefit plans.

The Issue

Vermont established an "all payer claims database" which requires insurers, third party administrators ("TPAs") of self-funded plans, providers, and government agencies to report data on health care costs, prices, quality, and use of services to the state to examine health care utilization, expenditures, and performance. Seventeen states, including New York and Connecticut, also have or are developing all payer claims databases (although reporting is on a voluntary basis in some states).

Liberty Mutual has a self-funded plan for its employees with about 80,000 members across the U.S. Liberty Mutual directed its TPA to refuse to submit its data to Vermont. Vermont issued a subpoena ordering the TPA to transmit the files. The penalty for the TPA's noncompliance was $2,000 per day and suspension to operate in Vermont for up to 6 months.

Having in its contract with the TPA a hold harmless clause for judgments related to Liberty Mutual's failure to comply with any laws, Liberty Mutual filed suit in district court, seeking a declaration of preemption.

Preemption Arguments

- **Interference with plan administration.** ERISA Sec. 514 states that ERISA preempts any and all state laws that relate to employee benefit plans. Under ERISA, state laws should not interfere with the uniformity of plan administration. Employers are frustrated by multi-jurisdictional mandates that impose conflicting administrative obligations, subjecting them to administrative costs and wide-ranging liability.

- **Fiduciary responsibility and privacy.** Liberty Mutual argued that it was concerned about protecting the privacy of individuals' medical records per its fiduciary duties under ERISA.

Arguments against Preemption

- **Different objectives.** Vermont argued that its reporting scheme had objectives that differed from those of ERISA, which focus on (1) the financial solvency of plans and (2) fiduciary duties to protect participants (so that ERISA did not preempt the Vermont law).

What Happened?

The Court found that Vermont's all payer claims database does not apply to plans subject to ERISA. In the majority opinion, the Court identified reporting as a principal and essential feature of ERISA and plan administration. Vermont's requirement that ERISA plans report detailed information about the administration of benefits amounts to a direct regulation by the state of a fundamental ERISA function. As such, the Court ruled in favor of Liberty Mutual as such state laws are inconsistent with the central design of ERISA – to provide a single uniform national scheme without interference from the laws of the states. Justice Breyer suggested that the DOL could develop a similar reporting requirement to satisfy the states' needs. The privacy argument was not addressed.

Can Employers Disregard all State Laws Related to Benefits?

Not advisable. As employers subject to ERISA are well aware, there are many burdensome state laws that have been found to apply to their plans or have not been challenged in court.

Additionally, ERISA does not preempt state insurance laws that apply to carriers of ERISA-covered insured plans.

Employers wanting to disregard similar state laws related to benefits should consult counsel.

Form 1095-C Notification Reminder and Frequently Asked Questions

Published: March 15, 2016

As a reminder, important deadlines for most employers* are as follows:

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

Generally, if Forms 1094-C and/or 1095-C are incorrect and incomplete, a penalty may apply if not corrected by the due date and the employer cannot show reasonable cause. Briefly, the amount of penalties can range from $50/form with a $500,000 maximum penalty/year to $250/form with a maximum penalty of $3M/year.

* Applies to:

1. large employers (had 50 or more full-time employees (including full-time equivalent employees) on business days in 2014); and
2. small employers with self-funded medical plans.

New York City Transit Benefit Mandate

Published: March 16, 2016

As you know, beginning January 2016, a New York City employer with 20 or more Full Time Employees (FTEs) is required to provide its employees with a pre-tax qualified transportation benefit program up to the limit permitted by Federal Law. Currently, the Internal Revenue Service permits a pre-tax transit benefit of up to $255 for 2016. The Act does not include the pre-tax parking benefits.

The Affordable Transit Act (the Act) was signed into law in the fall of 2014 by New York City Mayor Bill de Blasio. The Act defines a FTE the same as the Affordable Care Act, or as an employee that works at least 30 hours per week. In addition, the Act specifically excludes government employers, employers not required to pay federal, state and city payroll taxes, and employees covered by a Collective Bargaining Agreement (CBA).

Penalties

Employers required to comply with the Act, but which fail to implement a transit program will be subject to penalties between $100-$250. An employer that fails to comply with the Act may receive a Notice of Non-Compliance. If so, the employer has a 90 day period to correct the violation without penalties. However, if the employer fails to correct the violation within the 90 day period, the employer will be subject to a $250 penalty for each 30-day period of non-compliance. Finally, employers have a 180 day grace period to comply with the Act, meaning employers **will not be subject to any penalties** until **July 1, 2016.**

Recordkeeping Requirement

Employers must keep records that demonstrate that each eligible FTE was offered the opportunity to use pre-tax income to purchase transit benefits and indicate whether the employee accepted or declined the offer. Employers may maintain these records electronically. Finally, the law requires employers to keep records for two years. Employers may use the form available on the Department of Consumer Affairs website to document compliance (See the “Common Questions” Section for link).

Benefit to Employers

Although the Act will require additional administration and associated costs, its pre-tax feature will also benefit employers because payroll costs may decrease. As a result, the employer may pay less in payroll taxes by excluding certain income paid to its employees.

Common Questions

Q1: Who must comply?

- A New York City Employer w/ 20+ employees
- A New York City Employer is an employer that is registered to do business in NYC and therefore, has employees working in NYC
- NYC includes 5 boroughs – Manhattan, Queens, Brooklyn, Staten Island, and the Bronx.

Q2: Do I count part time or full time employees?

An employee is defined as an employee working 30+ hours a week – the same as the Affordable Care Act (ACA)

Q3: Do I count employees working outside of NYC?

No, only employees working in NYC.

Q4: Do I count employees working outside of NYC?

Yes, the count is the number of employees working in NYC, regardless of where he/she resides.

Q5: Are there any Employers that are EXEMPT?

- Yes.
  - Employers whose employees are subject to a Collective Bargaining Agreement (CBA)
  - Government Entities – Federal Government, State Governments, and Local Governments
  - Employers exempt from Federal, State, and City payroll taxes.

Q6: Do I count part time or full time employees?

- Pre-tax transit benefits, up to the IRS limit – currently $255
- The employer does not have to offer parking pre-tax benefits, but can.

Q7: Can I send employees to the Department of Consumer Affairs to obtain benefits if I do not want to provide benefits?

No, the employer is responsible for providing the benefits.

Q8: There are administrative costs associated with establishing this program for my employees, can I charge the cost of administration to employees?

No, the employer is responsible for implementing this program.

Q9: How do I show compliance?

- Retention of any and all documents that show the employer offered commuter benefits.
- A sample form is available at: http://www1.nyc.gov/assets/dca/downloads/pdf/about/CommuterBenefits-EmployerComplianceForm.pdf

Q10: If I don't comply, what are the penalties?

$100-$250 for each 30-day period of non-compliance, beginning July 1, 2016

Q11: If I don't comply, will I be given a grace period to comply?

Yes, once an employer has received a non-compliance notice, the employer will have a period of 90 days to correct the violation without penalties.

Q12: Ok, I understand, I am ready to comply; Do you have a list of vendors?

Yes, for a list of vendors and contact information, visit:
http://www1.nyc.gov/site/dca/about/commuter-benefits-FAQs.page#7

Q13: Can I self administer this program?

- No.
  - Although the New York City Ordinance does not require the employer to have a vendor in place and technically permits self-administration, Federal Law disqualifies a transit reimbursement as a pre-tax benefit beginning January 1, 2016.
  - As such, an employer is no longer permitted to provide qualified transportation fringe benefits in the form of cash reimbursements in geographic areas where terminal restricted debit cards are readily available (Rev. Ruling 2014-32).
  - New York City has terminal restricted debit cards and therefore, transit reimbursements would no longer qualify as excluded tax income – meaning the employer cannot deduct the reimbursement pre-tax.

Q14: I offered the transit benefit to an employee who waived coverage initially, but now wants to join, can I let him/her?

Yes, an employee can waive initially and join at a later date.

New SBC Template Implementation Announced

Published: March 21, 2016

The Departments of Labor ("DOL"), the Internal Revenue Service ("IRS"), and Health and Human Services ("HHS") (collectively, "the Departments") announced through Affordable Care Act ("ACA") FAQ 30 that the new Summary of Benefits and Coverage ("SBC") template and associated documents, published by the Departments on February 26, 2016, should be used for the open enrollment period that begins on or after April 1, 2017.

As background, the ACA requires an SBC 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.

As stated in FAQ 30, the Departments intend to review the comments and finalize the new SBC template and associated documents expeditiously (the comment period closes March 28, 2016). The Departments intend that health plans and issuers that maintain an annual open enrollment period will be required to use the new SBC template and associated documents beginning on the first day of the first open enrollment period that begins on or after April 1, 2017 with respect to coverage for plan years (or, in the individual market, policy years) beginning on or after that date. For plans and issuers that do not use an annual open enrollment period, the new SBC template and associated documents would be required beginning on the first day of the first plan year (or, in the individual market, policy year) that begins on or after April 1, 2017.

For further information, see FAQ 30:
http://www.dol.gov/ebsa/faqs/faq-aca30.html

Also, see the SBC regulations and templates available on the DOL's EBSA site at:
http://www.dol.gov/ebsa/healthreform/regulations/summaryofbenefits.html

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