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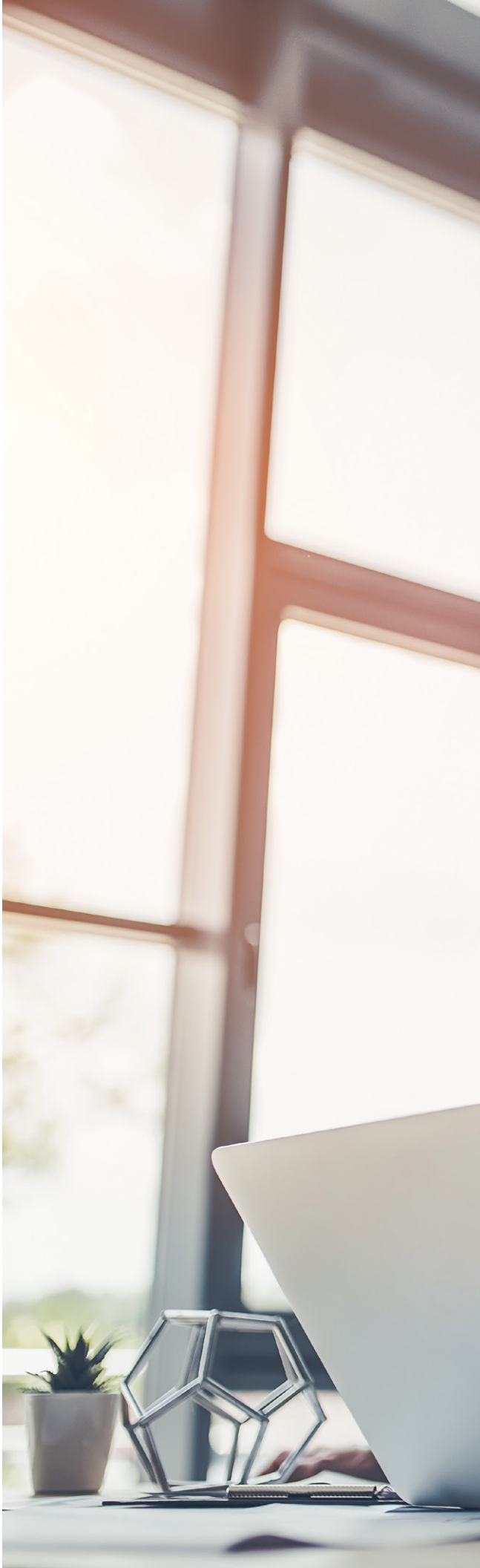
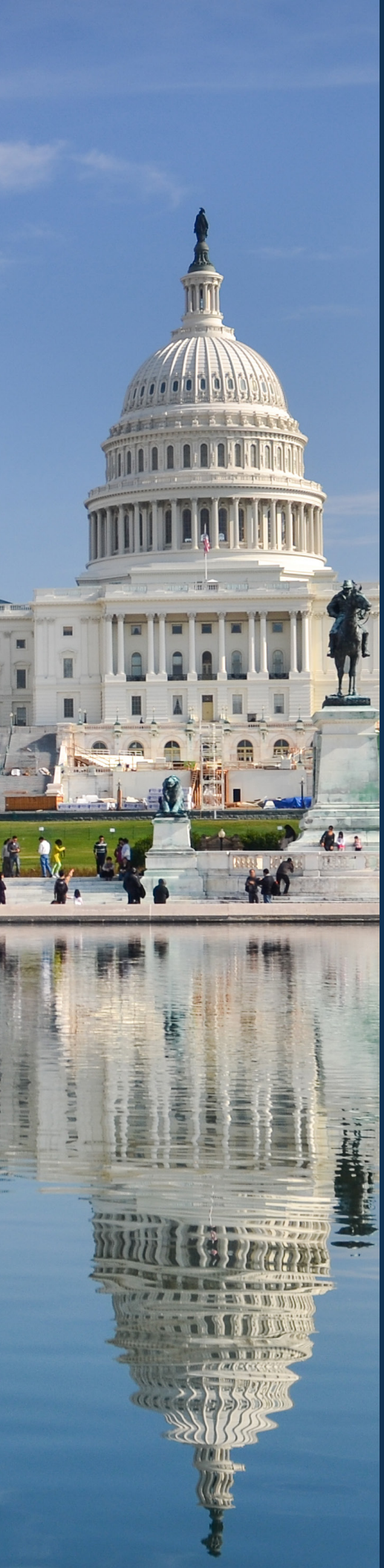
October

November

December





New Executive Order and Insight on the Employer Mandate

Published: October 13, 2017

President Trump signed an Executive Order ("EO") on October 12, 2017, directing various federal agencies to take regulatory action that will "increase health care choices for millions of Americans."

Along with the EO, the Administration issued a press release and some internal talking points that provide helpful insight into what the agencies are directed to review.

As it affects employer-sponsored plans:

- The Department of Labor ("DOL") is directed to consider expanding access to Association Health Plans ("AHPs") which could allow employers to form groups across state lines. Specifically, by taking a broader interpretation of ERISA, employers in the same line of business anywhere in the country could join together to offer healthcare coverage to their employees through the large group insurance market or through self-insurance, potentially accessing more coverage options at a lower cost. Such arrangements could be formed for the "express purpose" of offering group insurance (under current regulations, the sole purpose of any association plan cannot be the purchase of group insurance).
    - Within 60 days, the DOL shall consider proposing regulations or revising guidance consistent with the law, to expand access to health coverage by allowing more employers to form AHPs. The EO directs the agency to consider expanding the conditions that satisfy the "commonality-of-interest" requirements under the existing definition of an "employer" under ERISA 3(5).
    - The EO continues to support popular ACA mandates, including offering coverage to children to age 26, no annual or lifetime dollar limits, no cost-sharing for certain preventive care, and a general prohibition on preexisting condition exclusions and health status rating.

  - The EO specifically references using self-insurance as an option of AHPs. Because the current federal law permits association coverage to be governed under both state and federal rules, the EO raises issues in those states that either (1) prohibit creation of new self-insured association plans or (2) heavily regulate the ability to use self-insurance as an option under multiple employer welfare arrangement ("MEWA") rules.

- The Departments of the Treasury, Labor, and Health and Human Services ("the Departments") are to, within 60 days of the EO, consider proposing rules to expand coverage through low-cost short-term limited duration insurance ("STLDI"). It appears this coverage would be available in the individual market, primarily targeting individuals who are between jobs (as a lower cost alternative to COBRA), individuals in counties with only a single carrier option in the Marketplace, people with limited networks and those who missed annual Marketplace open enrollment but still want to purchase coverage. STLDI would not be subject to many of the insurance mandates under the ACA but would feature broad provider networks and high coverage limits.

- Within 120 days of the EO, the Departments are to consider additional changes that support more flexibility and increased usability of Health Reimbursement Arrangements ("HRAs"), including use with nongroup health insurance coverage.

What's Next?

An EO is a statement issued by the President to the federal agencies directing priorities and action on specific matters. Such policies generally do not have the effect of creating a new law or regulations.

The agencies will review the EO in context with the existing statutory and regulatory framework to determine how they can enact regulations or issue other guidance within the constraints of existing law. The Departments are likely to initially issue proposed regulations as the starting point for addressing the goals of the EO. However, the regulatory process is slow and its unlikely any final rules will be issued before 2018.

Specifically, with respect to AHPs, these arrangements are unique under ERISA as there is joint federal and state authority for governance. Creating a more flexible AHP marketplace, including crossing state lines, will bump up against various state insurance laws that may prohibit these types of transactions. Many states' insurance commissions and state governments have already announced their intent to challenge any federal overreach into a long-established tradition of state regulation of the insurance market.

In Other News: The Individual and Employer Mandates

The talking points contain a number of Q&As. Notably, when asked whether the Administration intends to enforce the Individual and Employer Mandate, the Administration responded as follows:

"The administration believes Congress should repeal the individual and employer mandates, and respective penalties enforced by the IRS on people who fail to purchase Washington-approved coverage and employers with at least 50 workers that fail to offer Washington-approved coverage. While HHS has the ability to define a hardship exception for the purpose of the individual mandate, the tax penalties are contained in the Internal Revenue Code and only Congress can change the law."

Therefore, it is notable to employers that, absent Congressional action, the Trump administration appears (at least based on these informal statements) willing to enforce the Employer Mandate.

Employer Action

Employers should:

- Be aware that we are likely to see new regulations addressing AHPs, HRAs, and STLDIs in the coming months. While changes to existing AHP and HRA rules are unlikely to affect 2018 plan years, such guidance may create challenges for 2019 and beyond.

- As the Administration signaled its intent to enforce the Employer Mandate:
  - Plan for compliance with the 2017 ACA reporting. The final Form 1094-C, Form 1095-C and Instructions are available.
  - Prepare to address any notices issued by the IRS regarding Employer Mandate assessments for the 2015 and 2016 calendar year.

Trump Halts Cost-Sharing Reductions

Published: October 13, 2017

Overview

On Thursday, October 12, 2017, the White House indicated that President Trump will end ACA cost-sharing reduction ("CSR") payments to insurance companies effective immediately. This was followed up by a White House statement indicating that the payments had lacked appropriations and therefore the government could not lawfully continue making them. While the impact to insurance companies and individuals who obtain subsidized coverage in the Marketplace is expected to be significant, the direct impact to employers and employer sponsored health plans is expected to be minimal.

CSR Payments Explained

Under the ACA, Congress authorized two types of subsidy payments to help Americans pay for and utilize health coverage in the Marketplace.

The first is premium subsidy assistance, which allows those with household incomes between 100% and 400% of the Federal Poverty Level (FPL) to obtain subsidies that reduce premiums costs for health coverage purchased in the Marketplace.

The second, and at issue here, is CSR payments, available to those who qualify for premium subsidy assistance and who have incomes between 100% and 250% of the FPL. CSR payments reduce the cost of deductibles, co-pays, and other means of cost sharing by directly reimbursing insurers for those costs. Roughly 7 million people are currently receiving CSR payments.

CSR Controversy

In 2014, House Republicans filed a lawsuit against then-HHS Secretary Burwell claiming that federal laws require every government expenditure to be tied to an annual or permanent funding source. This is known as appropriations. The lawsuit claimed that ACA legislation failed to include permanent appropriations for CSR payments. In May 2016, the US District Court for the District of Columbia agreed, and so absent annual approval, such payments are unlawful beginning in 2014. The judge ordered that such payments be immediately halted (enjoined), but stayed its decision (in effect, made it not applicable) pending appeal.

The government had been issuing CSR payments until today's announcement.

President Trump's Decision

The President announced that the government will no longer issue CSR payments and that such payments would be halted immediately (the Marketplace plan year runs through December 31). The immediate impact of this decision will affect insurance companies in the Marketplace, as presumably they will not be reimbursed for CSR payments for November and December 2017. Under the terms of Marketplace agreements, insurance companies can withdraw immediately if government payments or subsidies are halted. If this happens, many individuals could suddenly find themselves without coverage.

Additionally, for the 2018 calendar year, carriers will not receive CSR payments from the government. This will lead to higher costs and individuals choosing to forgo Marketplace coverage as it has become too expensive. In fact, many carriers filed their 2018 rates assuming the Government would pull funding for the CSR payments, leading to significant rate increases in the individual market.

Implications for Employers

The direct impact of this decision is minimal.

Applicable large employers ("ALE") - those with 50 or more full time equivalent employees - are subject to ACA employer shared responsibility "A" or "B" penalties for failure to offer affordable and/or minimal value coverage to full-time employees, if one or more of those employees obtain a subsidy or CSR in the exchange.

Even if CSRs are eliminated, since a prerequisite to an individual obtaining a CSR subsidy is to qualify for a premium reduction subsidy, there should be no change to an ALE's "A" or "B" penalty exposure since premium reduction subsidies are not impacted by this White House decision.

Further, since an ALE must make an offer of affordable and minimum value coverage in order to avoid "A" or "B" penalties, we do not anticipate a significant increase in employees forgoing coverage in the Marketplace and enrolling in employer sponsored plans (since those individuals would generally have been ineligible for Marketplace subsidies due to the employer's offer of affordable and MV coverage in the first place).

Additionally, if carriers exit the Marketplace or otherwise cancel plans in light of this change in policy, employers may see an increase in requests for special enrollment in their group health plans due to the loss of eligibility for Marketplace coverage.

The indirect implications are less clear. Stopping CSR payment will make individual insurance more expensive in the Marketplace. This may lead to carriers dropping out of the Marketplace, or if they remain, pricing plans beyond the reach of those individuals who previously benefited from CSR payments. This will likely result in an increase in the uninsured population. All payers in the health care system are affected by higher costs when there is a high uninsured population receiving uncompensated care.

Next Steps

The White House has indicated a desire to work with Congressional leaders to find a bipartisan fix for health reform. Since the collapse of health reform legislation late last month, there does not appear to be much appetite or political will to find a permanent solution. However, with the termination of CSR payments, it is possible a temporary or permanent fix could yet again be considered.

New Exemptions Affect Contraceptive Services

Published: October 18, 2017

On October 6, 2017, the U.S. Departments of Health and Human Services, Labor, and the Treasury (the Departments) released final, interim regulations allowing non-governmental employers, institutions of higher education, and individuals with religious or moral objections to cease coverage for some, or all, contraceptive services.

Background

All non-grandfathered health plans must cover certain preventive items and services without cost-sharing, including contraceptive services.

Religious employers and grandfathered medical plans are exempt from the contraceptive services mandate.

An accommodation (which is different from the blanket exemption) is available for certain non-profits with religious objections to providing contraceptive services and a certain closely held for-profit entities.

For this purpose, contraceptive services are defined to include contraception and contraceptive counseling, including all FDA-approved contraceptive methods, sterilization procedures and patient education and counseling.

New Regulations

As described below, the new regulations, effective October 6, 2017, largely expand exemptions to include more employers and extend to individuals. The regulations also revise the existing accommodations process making it optional, but still available.

Expanded exemptions – Employers

Non-governmental employers sponsoring a group health plan and objecting to providing some (or all) of the mandated contraceptive services based on seriously held religious beliefs or moral convictions may claim an exemption. The rules do not specifically define what constitutes a “sincerely held religious

belief" or "moral convictions." Instead, the Departments will look to such beliefs, principles or views that would have been adopted and documented in accordance with the laws of the state in which they are incorporated or organized.

The regulations provide the following non-exhaustive list of employers who may claim an exemption because they object to the provision of some, or all, contraceptive services based on **sincerely held religious beliefs**:

- A church, an integrated auxiliary of a church, a convention or association or churches or a religious order.
- A nonprofit organization.
- A closely-held for profit entity.
- A for-profit entity that is not closely held (this may include a publicly traded company).
- Any other non-governmental employer.
- An institution of higher education in its arrangement of student health insurance coverage.

With respect to the **moral convictions** exemption, the following are permissible objecting entities:

- A nonprofit organization.
- A for-profit entity that has no publicly traded ownership interest.
- An institution of higher education in its arrangement of student health insurance coverage.
- A health insurance issuer offering group or individual insurance coverage.

Exempt entities:

- May object to covering some, or all, mandated contraceptives services. For example, an entity may object to sterilization but not contraceptives. In that case the entity is exempt with respect to the items to which they object (sterilization), but not exempt with respect to the items for which there is no objection (contraceptives).
- Are not required to comply with the self-certification process (e.g., do not need to file notices or certifications of their exemption). Plan documents will need to be updated to reflect changes in coverage or design.
- May have previously claimed an accommodation and are now eligible for an exemption under these new rules.
- May, instead, choose to certify as an eligible organization which would remove the employer and the plan from responsibility and cost of contraceptive services while still providing participants and beneficiaries access to these services at no cost.

Expanded exemptions – Individuals

The individual exemption permits (but does not require) plan sponsors that do not specifically object to contraceptive coverage to offer coverage to their participants or beneficiaries who do object based on religious belief or moral conviction, while offering coverage that includes contraception to participants or subscribers who do not object. This exemption can apply with respect to individuals with coverage through a private employer or government sponsored group health plan.

The individual exemption cannot be used to force a plan (or its sponsor) or a carrier to provide coverage omitting contraception, or, with respect to health insurance coverage, to prevent the application of state law that requires coverage of such contraceptives or sterilization.

Practical Application

- **Effect on participants.** As exempt entities will exclude contraceptive services from their group health plan, female participants and beneficiaries will not be able to access these services from the group health plan and will either need to pay out-of-pocket or seek access through other resources.

- **Accommodations remain available.** The regulations leave intact the accommodations process for certain objecting employers to claim an accommodation versus an exemption. Under this process, the objecting employer can self-certify eligible employer status which documents their objection to providing some, or all, contraceptive services. The eligible organization provides this certification to the applicable carrier or TPA who then arranges access to the contraceptive services for participants and beneficiaries without cost sharing and at no additional cost to the employer or plan.

- **Plan documentation.** While entities claiming an exemption are not required to provide a special notice or certification, general ERISA rules apply with respect to material changes to coverage. This is further discussed in "Employer Action."

- **Moral conviction of health insurance carriers.** While expected to be unusual, an insurance carrier providing group health insurance coverage may be exempt due to the carrier's moral conviction. The plan remains subject to any requirement to provide coverage for contraceptive services unless the plan is otherwise exempt (due to religious belief or moral conviction). This can create coordination and compliance issues for non-exempt employer plan sponsors if group health plan coverage is purchased from an exempt insurer.

Employer Action

Employers wanting to avail themselves of this exception will need to:

- Amend their summary plan descriptions and any other plan documents, as necessary, for a prospective effective date:
  - A best practice would be to make a plan amendment in connection with annual enrollment (and not mid-year).
  - Immediate plan changes must be approved by carriers and likely will only be available to self-funded plans.
  - For insured plans:
    - Insurers may offer an exclusion of contraception to requesting employers.
    - Insurers can also claim exemption and not offer contraception to any employer in which case employers purchasing their plans will be out of compliance unless they too claim exemption.

    - State insurance law requiring coverage for certain contraceptive services are not preempted by this guidance and remain enforceable.

- Provide proper notice under existing rules. Under ERISA:
    - For health plans, a summary of material reduction should be distributed automatically to participants within 60 days of adoption of material reduction in services or benefits or at regular intervals of not more than 90 days. Although somewhat of a gray area, this should mean that employees hear about the change at least 60 days in advance. Although inadequate notice can result in penalties, it will rarely invalidate the change.
    - Review your SBC to determine if information on this document changes as a result of the exemption. If so, and if implemented mid-year 60-day prior notice is required and will satisfy the other requirements under ERISA.
    - For any ERISA-covered plan, it may be advisable to give written notice early under regular fiduciary duty principles.
    - Any description of exceptions, limitations, reductions, and other restrictions of plan benefits must be apparent in the SPD.

- Consider HR and PR challenges when revoking a benefit that has been available to female employees for free for a number of years. A thoughtful communication strategy will be important when making this type of change.

- Non-exempt entities should consider whether to make alternative coverage without contraceptive services available to participants and beneficiaries who qualify for an individual exemption. This will be administratively burdensome and may not necessarily be an available option from the carrier.

These rules are subject to change following the comment period which closes on December 5, 2017 but any significant changes appear to be unlikely.

Already, several states and interest groups have, or have expressed their intent to, initiated a lawsuit against the government challenging these rules. Employers claiming these exemptions should watch the legal developments as they may affect coverage.

2018 Cost of Living Adjustments

Published: October 23, 2017

On October 19, 2017, the IRS released cost of living adjustments for 2018 under various provisions of the Internal Revenue Code (the Code). Some of these adjustments may affect your employee benefit plans.

Cafeteria Plans

For plan years beginning in 2018, the dollar limitation under Section 125 for voluntary employee salary reductions for contributions to health flexible spending arrangements increases to **$2,650**.

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.

Qualified Transportation Fringe Benefits

For calendar year 2018, the monthly exclusion limitation for transportation in a commuter highway vehicle (vanpool) and any transit pass (under Code Section 132(f)(2)(A)) and the monthly exclusion limitation for qualified parking expenses (under Section 132(f)(2)(B)) increases to **$260**.

The Consolidated Appropriations Act of 2016 permanently changed the pre-tax transit and vanpool benefits to be at parity with parking benefits.

Requirement to Maintain Minimum Essential Coverage

For calendar year 2018, the applicable dollar amount used to determine the penalty under Section 5000A(c), for failure to maintain minimum essential coverage remains **$695**.

This is also referred to as the individual mandate under the ACA. Any assessed penalty tax is the greater of $695 or 2.5% of modified adjusted gross income in excess of the filing threshold and capped at the average premium amount for bronze coverage available on the health insurance exchange. The penalty is collected from an individual's tax refund due after filing their personal income tax return with the IRS.

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) again remains unchanged at **$120,000** for 2018.

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).

Key Employee

The dollar limitation under Code Section 416(i)(1)(A)(i) concerning the definition of a key employee for calendar year 2018 remains unchanged at **$175,000**.

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.

Non-Grandfathered Plan Cost-Sharing Limits

The 2018 maximum annual out-of-pocket limits for all non-grandfathered plans are $7,350 for individual coverage and **$14,700** 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.

Qualified Small Employer Health Reimbursement Arrangements

For tax years beginning in 2018, to qualify as a qualified small employer health reimbursement arrangement (QSEHRA) under § 9831(d), the arrangement must provide that the total amount of payments and reimbursements for any year cannot exceed **$5,050** ($10,250 for family coverage).

Health Savings Accounts

As announced in May 2017, the inflation adjustments for health savings accounts (HSAs) for 2018 were provided by the IRS in Rev. Proc. 2017-37.

Annual contribution limitation.

For calendar year 2018, the limitation on deductions for an individual with **self-only coverage** under a high deductible health plan is **$3,450**. For calendar year 2018, the limitation on deductions for an individual with **family coverage** under a high deductible health plan is **$6,900**.

High deductible health plan.

For calendar year 2018, a "high deductible health plan" is defined as a health plan with an **annual deductible that is not less than $1,350 for self-only coverage** or **$2,700 for family coverage**, and the **annual out-of-pocket expenses** (deductibles, co-payments, and other amounts, but not premiums) **do not exceed $6,650 for self-only coverage** or **$13,300 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.

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.

New York Stop-Loss Legislation Passed

Published: October 31, 2017

Governor Cuomo recently signed Assembly Bill A8264 into law, allowing employers having 1-100 employees to continue to purchase stop-loss coverage, catastrophic insurance and reinsurance coverage through December 31, 2019.

Background

The Affordable Care Act ("ACA") required a change of the small group market from 1-50 to 1-100 employees. The ACA was subsequently amended by the PACE Act, and the small group definition reverted to 1-50 employees. Prior to the PACE Act, New York had changed the definition of small group market to 1-100 employees, requiring legislative action to change the definition.

Stop-loss coverage, catastrophic insurance and reinsurance coverage are generally prohibited to be sold to employers in the small group market in the State of New York.

Prior to December 2015, the small group market was defined as an employer having 1-50 employees. After December 2015, an employer in the small group market became an employer with 1-100 employees. Prior Bills allowed an employer to purchase stop-loss, catastrophic insurance or reinsurance coverage until 2018 because the employer was in the large group market as of January 1,2015 or June 1, 2015. Employers that are part of a municipal cooperation or school do not have to be treated as small group market employers if a policy or coverage was in effect as of January 1, 2015 or June 1, 2015.

New Legislation

A8264 provides the review of the prohibited sale products within the small group market and extends the purchase of prohibited coverage until 2019. Under this legislation, an employer that was permitted to purchase stop-loss coverage, catastrophic insurance or reinsurance coverage because the employer was in the large group market as of January 1, 2015 or June 1, 2015 may continue to purchase such coverage until 2019.

It is important to note that the definition of small group market has not changed. In New York, a small group continues to be an employer with 1-100 employees.

A review of the law will be completed by spring 2018. We will keep you apprised of any changes.

For a copy of the Bill, visit:
https://www.nysenate.gov/legislation/bills/2017/a8264

IRS FAQs on 2015 Employer Penalty Payments

Published: November 8, 2017

Recently, the Internal Revenue Service ("IRS") issued additional FAQs regarding the Employer Shared Responsibility Payment (an assessment under the employer mandate).

Briefly, the FAQs:

- Describe a new Letter 226J that will be issued to Applicable Large Employers ("ALEs") if the IRS determined at least one full-time employee ("FTE") was enrolled in a qualified health plan for which a premium tax credit was allowed and the ALE did not offer the FTE affordable, minimum value coverage.
- Provide an opportunity and process for an ALE to follow and respond to Letter 226J before any penalty assessed and notice and demand for payment is made.
- Establish a specific notification timeframe (generally 30 days from the date of the letter) that an ALE will have to respond to the IRS regarding the proposed assessment. Failure to respond timely may result in the IRS assessing the penalty and issuing a notice and demand for payment with no further opportunity for the ALE to respond.
- Describe Notice CP 220J which will be used as formal notice and demand for payment of a penalty.
- Suggest that, for calendar year 2015, the first Letters 226J will be issued to ALEs in late 2017.

This update to the existing FAQs on the employer-shared responsibility requirement offers the first real guidance on the process of notification and assessment of any employer mandate penalties.

The IRS appears ready to move forward with this notification and assessment process given the failure of ACA repeal and absent other rulemaking, guidance, or legislation that further delays enforcement of the mandate.

Recently, however, new legislation has been introduced in the House and Senate that would suspend the employer mandate for the period before January 1, 2018. Whether Republican leadership can secure enough votes to pass another attempt at a party-line repeal remains uncertain.

The following provides additional details, including an explanation of the various letters and notices that an ALE may receive as part of this process. Copies or samples of these letters are not currently available on the IRS website.

Background

Beginning in 2015, ALEs may be subject to an assessable payment (referred to as a "penalty") if any FTE receives a premium tax-credit (a "subsidy") to purchase health insurance through the Marketplace. There are two possible penalties ("A" and "B"). The penalty that may apply will depend on the circumstances of the ALE.

While ALEs are generally defined as employers with at least 50 FTEs (including full-time equivalent employees and employees under common ownership) in the preceding calendar year, for 2015 only (and plan years that begin 2015) the IRS provided helpful relief generally excluding ALEs with 50-99 FTEs from penalty assessments, subject to specific rules.

The 2015 Penalties

- **"A" Penalty – "No Coverage" Penalty.** This penalty applies when an ALE does not offer at least 70% of FTEs and their dependent children minimum essential coverage and at least one FTE receives a subsidy in the Marketplace to purchase qualified health plan coverage.
  - The penalty is $173.33/month (or $2,080/year) multiplied by the total number of FTEs – 80.

- **"B" Penalty – "Offer Coverage Penalty".** This penalty applies when an ALE offers at least 70% of FTEs and their dependent children minimum essential coverage but the coverage is not affordable, does not provide minimum value or excludes 30% or fewer FTEs and one (or more) of those FTEs receive a subsidy in the Marketplace.
  - The penalty is the lesser of:
    - $260/month (or $3,120/year) multiplied by the total number of FTEs who receive a subsidy; or
    - The "A" penalty.

The above rules are somewhat different for years after 2015 and are not addressed in this summary.

MAKING A SHARED RESPONSIBILITY PAYMENT (FAQS 55 – 58)

Q1: How does an employer know that it owes an employer shared responsibility payment?

The IRS will use Letter 226J to describe the general procedures it will use to propose and assess an employer penalty. Letter 226J will be issued to an ALE if the IRS determines that, for at least one month in the year, one or more of the ALE's FTEs was enrolled in a qualified health plan (i.e. individual Marketplace plan) for which a premium tax credit was allowed (and the ALE did not qualify for an affordability safe harbor or other relief for the employee).

Letter 226J will include:

- a brief explanation of the employer mandate (Code Section 4980(H));
- an employer shared responsibility payment summary table itemizing the proposed payment by month and indicating for each month if the liability is an "A" penalty or a "B" penalty, or neither;
- an explanation of the employer shared responsibility payment summary table;
- an employer shared responsibility response form, Form 14764, "ESRP Response";
- an employee PTC list, Form 14765, "Employee Premium Tax Credit (PTC) List" which lists, by month, the ALE's assessable FTEs, and the indicator codes, if any, the ALE reported on lines 14 and 16 of each assessable FTE's Form 1095-C;
- a description of the actions the ALE should take if it agrees or disagrees with the proposed employer shared responsibility payment in Letter 226J; and
- a description of the actions the IRS will take if the ALE does not respond timely to Letter 226J.

Employers that receive a Letter 226J must respond by the date shown on the letter (usually within 30 days from the date of the letter). The Letter 226J will include contact information of a specific IRS employee that the ALE may contact with questions.

Q2: Does an employer that receives a Letter 226J proposing an employer shared responsibility payment have an opportunity to respond to the IRS about the proposed payment, including requesting a pre-assessment conference with the IRS Office of Appeals?

Yes.

ALEs will have an opportunity to respond to Letter 226J before any penalty is assessed and notice and demand for payment is made. Letter 226J contains instructions for how the ALE should respond in writing, either agreeing with the proposed employer shared responsibility payment or disagreeing with part (or all) of the proposed amount.

- The IRS will acknowledge the ALE's response to Letter 226J with an appropriate version of Letter 227 (a series of five different letters that, in general, acknowledge the ALE's response to Letter 226J and describe further actions the ALE may need to take).
- If, after receipt of Letter 227, the ALE disagrees with the proposed or revised employer shared responsibility payment, the ALE may request a pre-assessment conference with the IRS Office of Appeals. The ALE should follow the instructions provided in Letter 227 and Publication 5, Your Appeal Rights and How To Prepare a Protest if You Don't Agree for requesting a conference. A conference should be requested in writing by the response date shown on Letter 227 (generally will be 30 days from the date of Letter 227).

If the ALE fails to respond to either Letter 226J or Letter 227, the IRS will assess the amount of the proposed employer shared responsibility payment and issue a notice and demand for payment, regardless of actual liability.

Q3: How does an employer make an employer shared responsibility payment?

If, after correspondence between the ALE and the IRS or a conference with the IRS Office of Appeals, the IRS or IRS Office of Appeals determines that an ALE is liable for an employer shared responsibility payment, the IRS will assess the employer shared responsibility payment and issue a notice and demand for payment, Notice CP 220J.

Notice CP 220J will include a summary of the employer shared responsibility payment and will reflect payments made, credits applied, and the balance due, if any. That notice will instruct the ALE how to make payment.

ALEs will not be required to include the employer shared responsibility payment on any tax return that they file or to make payment before notice and demand for payment. For payment options, such as entering into an installment agreement, refer to Publication 594, The IRS Collection Process.

Q4: When does the IRS plan to begin notifying employers of potential employer shared responsibility payments?

For the 2015 calendar year, the IRS plans to issue Letter 226J informing ALEs of their potential liability for an employer shared responsibility payment, if any, in late 2017.

The FAQs do not address when notification regarding assessments in calendar year 2016 and 2017 will happen. Further guidance expected.

Employer Action

ALEs should:

- For now, keep an eye out for the new Letter 226J in the mail. Be mindful of the timeline to respond to the notice.
- Ensure they have records reflecting offers of coverage to identified FTEs for CY 2015. This will include copies of the Forms 1094-C and 1095-C that they filed. These Forms will be helpful when reviewing any IRS notice in determining whether an assessment is correct.
- Contact their tax advisor for assistance if they receive the letter and have questions. Please note that we cannot represent clients in this process.

Guidance Issued on QSEHRAs

Published: November 21, 2017

The IRS recently issued Notice 2017-67 which provides guidance related to the administration of Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs).

Background

Under the Affordable Care Act, a health reimbursement arrangement (HRA) must be integrated with a group health plan (as it could not meet the market reform provisions on its own) and was not able to reimburse employees for individual premiums. However, on December 13, 2016, President Obama signed into law the "21st Century Cures Act" which established QSEHRAs (a special standalone HRA).

According to the 21st Century Cures Act, a QSEHRA is an arrangement that meets the following criteria:

1. The arrangement is funded solely by an eligible employer (less than 50 full-time employees (including full-time equivalent employees) in the preceding calendar year not offering a group health plan to any of its employees);

2. The arrangement provides, after the eligible employee provides proof of coverage, for the payment or reimbursement of the medical expenses incurred by the employee or the employee's family members;

3. The amount of payments and reimbursements described above cannot exceed certain thresholds ($5,050 self-only/$10,250 for family coverage for 2018); and

4. The arrangement is generally provided on the same terms to all eligible employees of the eligible employer.

On October 17, 2017, President Trump issued an Executive Order directing federal agencies to revise guidance to increase the usability of HRAs, expand employers' ability to offer HRAs to their employees, and allow HRAs to be used in conjunction with non-group coverage. The authors of Notice 2017-67 claim that the guidance therein addresses each of those objectives.

New Guidance

Notice 2017-67, structured as 79 Questions and Answers (Q&As), explains several specifics related to QSEHRAs. Here are some of the highlights:

- Eligible employer (Q&As 1-7):
  - The 50-employee threshold and whether the employer offers a health plan takes into account the entire controlled group.
  - An employer that goes over this threshold is not an eligible employer as of January 1st of the year it becomes an applicable large employer in accordance with ACA rules.
  - An employer will fail to be an eligible employer for any month during which it offers a group health plan, allows continued access to amounts accumulated from a prior HRA or carried over in an FSA.
  - Offering a health plan to former employees or contributing to employees' HSAs (including allowing HSA contributions through a cafeteria plan) will not prevent an employer from being an eligible employer.
- Eligible employee (Q&As 8-11):
  - A QSEHRA may only be provided to employees (not former employees, retirees, or non-employee owners).
  - If a previously ineligible employee becomes an eligible employee, coverage must be provided by the next day.
  - Participation in the QSEHRA cannot be waived.
- Same terms requirement (Q&As 12-26): A QSEHRA must be operated on a uniform and consistent basis with respect to all eligible employees.
  - A permitted design includes one that offers the same dollar amount benefit whether self-only or family coverage is elected.
  - It is also permitted to structure a plan to reimburse up to the self-only and family statutory limits or up to an equal percentage thereof without referring to a baseline policy.
- Statutory dollar limits (Q&As 27-34):
  - Statutory dollar limits for non-calendar year or short plan year QSEHRAs are prorated based upon the number of months in the applicable calendar year. The same prorating would apply as to a newly eligible employee added mid-year.
  - A carryover is permitted, but only if the annual amount available to the employee does not exceed the threshold for that year, taking into account the carryover.
- Written notice requirement (Q&As 35-39): An eligible employer that provides a QSEHRA during 2017 or 2018 must furnish the initial notice to eligible employees by the later of February 19, 2018 or 90 days before the first day of the plan year.
- MEC requirement (Q&A 40): Reimbursements through the QSEHRA are taxable for any month that minimum essential coverage (MEC) is not maintained.
- Proof of MEC requirement (Q&As 41-43): A QSEHRA may only provide reimbursements after proof of coverage is provided. Such proof, which must be provided annually, can be third-party documentation (i.e., an insurance card) accompanied by an attestation or an attestation accompanied by the date coverage began and the name of the provider. If this proof is not provided, a reimbursement cannot be made, even on a taxable basis. A model attestation is provided as an Appendix to the Notice.

- Substantiation requirement (Q&As 44-45): The eligible employee will follow substantiation requirements if it complies with the FSA substantiation requirements.

- Reimbursement of medical expenses (Q&As 46-56):

  - A QSEHRA cannot provide a cash-out of unused permitted benefits at the end of the year.

  - It cannot impose a deductible or other cost-sharing requirement.

  - It cannot reimburse amounts incurred before QSEHRA coverage begins.

  - A QSEHRA can reimburse over-the-counter drugs without a prescription.

- Reporting requirement (Q&As 57-64): Any benefit provided through the QSEHRA must be reported on the employee's Form W-2.

- Coordination with the Premium Tax Credit (Q&As 65-71): If an employee is provided QSEHRA coverage for a coverage month, the premium tax credit allowable is reduced by 1/12 of the permitted benefit under the QSEHRA for the year.

- Failure to satisfy the requirements to be a QSEHRA (Q&As 72-74): Plans that operate as QSEHRAs but fail to satisfy the requirements to be QSEHRAs will result in all amounts paid under the plan being includable in each employee's gross income and wages.

- Interaction with HSA requirements (Q&As 75-78): A QSEHRA that is structured to only reimburse premiums will not jeopardize HSA-eligibility.

- Effective date (Q&A 79): The guidance provided in Notice 2017-67 is effective for plan years beginning on or after November 20, 2017 (but can be relied on by plans established before that date). Nevertheless, if an eligible employer has established a QSEHRA and operated it consistent with the statutory provisions (but not with this guidance), the employer may continue to operate it in such a manner until the last day of the plan year that began in 2017.

For Notice 2017-67, visit:
https://www.irs.gov/pub/irs-drop/n-17-67.pdf

Received Letter 226J

Now What?

Published: December 15, 2017

The IRS issued Letter 226J to certain Applicable Large Employers ("ALEs"). This letter describes the proposed Employer Shared Responsibility Payment ("ESRP") owed for calendar year 2015.

Letter 226J provides specific information on the ESRP and instructions for responding to the proposed assessment. The IRS will issue a Notice and Demand for payment of the proposed assessment (as the final amount) if the ALE fails to timely respond to Letter 226J. If an employer disagrees with the assessment, timely responding via Form 14764 and including a statement explaining the objections and any back up documentation is crucial.

ALEs that receive these letters should carefully review them. It will be important to have 2015 Forms 1094-C and 1095-C available as you work through the information. Other materials may be relevant as well, including documentation regarding employee eligibility, affordability and minimum value of employer-sponsored coverage and/or copies of employee waiver forms.

This summary is intended to explain the information contained in Letter 226J and to provide general guidance on these requirements.

Background

Beginning in 2015, ALEs may be subject to an ESRP (also referred to as a "penalty") if any ACA full-time employee ("ACA FTE") receives a premium tax-credit ("PTC") to purchase health insurance through the Marketplace. There are two possible penalties ("A" and "B"). The penalty that may apply will depend on the circumstances of the ALE. A more detailed discussion of ESRP calculation and assessments is available later in this summary.

"A" Penalty - "No Coverage" Penalty

- This penalty applies when an ALE does not offer at least 95% (70% for 2015) of ACA FTEs and their dependent children minimum essential coverage ("MEC") and at least one ACA FTE receives a subsidy in the Marketplace to purchase qualified health plan coverage.

- For 2015, the penalty is $173.33/month (or $2,080/year) multiplied by the total number of ACA FTEs – 80.

"B" Penalty - "Offer Coverage" Penalty

- This penalty applies when an ALE offers at least 95% of ACA FTEs and their dependent children MEC but the coverage is not affordable, does not provide minimum value or excludes 5% (30% for 2015) or fewer ACA FTEs and one (or more) of those ACA FTEs receive a subsidy in the Marketplace.

- For 2015, the penalty is the lesser of:

    - $260/month (or $3,120 annually) multiplied by each ACA FTE who receives a subsidy in the Marketplace to purchase health insurance coverage; or

    - the "A" penalty.

Transition relief may be available to certain employers for calendar year 2015 (and for non-calendar year 2015 plans that ended in 2016).

- Subject to certain rules, ALEs with 50-99 full-time employees are not subject to ESRP (however, these ALEs were required to report information to the IRS on Forms 1094-C and 1095-C).

- ALEs with at least 100 ACA FTEs avoid the "A" penalty if an offer of coverage was made to at least 70% of ACA FTEs (and their dependents). Additionally, if subject to the "A" penalty (e.g., offered coverage to 50% of ACA FTEs), the ALE may exclude the first 80 ACA FTEs (as opposed to 30) when calculating the assessment.

- Non-calendar year plans were not subject to any penalty assessment until the first day of the 2015 plan year assuming, at that time, there was an offer of affordable and minimum value coverage to all ACA FTEs (and their dependents).

Beginning with calendar year 2015 (and each calendar year thereafter), ALEs are responsible for providing certain information to ACA FTEs and the IRS regarding offers of health insurance coverage. ALEs use Forms 1094-C and 1095-C to meet this requirement. Information contained in those Forms is used to determine eligibility for individual premium tax credits as well as the application of an ESRP.

For every calendar year, Forms 1095-C are provided to ACA FTEs (generally by January 31 of the following year) and Forms 1094-C and 1095-C provided to the IRS (generally March 31 of the following year unless filing fewer than 250 Forms, then February 28). This is the case regardless of an employer's plan year.

Letter 226J

The first page of the letter provides a general overview of the Employer Shared Responsibility rules and contains some important information:

- Tax year to which the letter applies, generally 2015.

- The date of the letter. This is important as the ALE must respond within 30 days. Many of the letters were issued mid-November 2017.

- A contact name, phone number and fax number for a person at the IRS responsible for the specific letter.

- The response date. This date is important. It is 30 days from the date the letter is issued. Many of the responses will be due in mid-December 2017. Keep in mind that in order to consider that appeal of an assessment, the IRS must receive the response by this date (not just mailed on this date).

- The proposed penalty assessment. This dollar amount is determined based on records the ALE submitted to the IRS (i.e., Form 1094-C and Forms 1095-C for 2015) and the information submitted by the ACA FTEs on their individual tax returns for 2015.

Letter 226J is a package of information relevant to the proposed assessment and includes:

- An ESRP Summary Table itemizing the proposed ESRP by month.
- Form 14764 – the ESRP Response Form.
- Form 14765 – the Employee PTC Listing.
- An envelope for submitting response to the IRS.

If the ALE **AGREES** with the proposed ESRP:

- Complete, sign and date Form 14764, ESRP Response and return it to the IRS by the response date shown on the first page of the letter.
- Include the payment amount via check or money order. If the ALE is enrolled in the Electronic Federal Tax Payment System ("EFTPS"), payment may be made electronically.
- If the entire ESRP is not paid, a Notice and Demand (essentially, a bill) for the remaining balance will be issued.
- For additional payment options, see Publication 594 or call the telephone number on the issued bill.
- Failure to pay the bill will result in a collections process and interest assessed.

If the ALE **DISAGREES** with the proposed ESRP:

- Complete, sign and date Form 14764, ESRP Response and return it to the IRS so that it is received by the response date on the first page of the letter.
- Include a signed statement as to why you disagree with part, or all, of the proposed ESRP. Documentation may be included to support the statement.
    - Make sure the statement describes corrections, if any, that you want made to the information reported on Forms 1094-C and 1095-C. Do not file a corrected 1094-C with the IRS to reflect these changes.
    - Make changes, if any, on the Employee PTC Listing using the indicator codes in the Instructions to Form 1094-C and 1095-C for the applicable tax year (i.e., 2015). Do not file corrected 1095-Cs to report changes. It is unclear whether you will also need to correct prior returns or if the IRS will correct via this process. Further guidance is needed.
    Include the revised Employee PTC Listing, if necessary, and any additional documentation supporting the requested changes with the Form 14764, ESRP Response, and signed statement

Employee PTC Listing – Form 14765

Letter 226J includes Form 14765- Employee PTC Listing and provides a snapshot of Form 1095-C for the calendar year 2015. Briefly, this listing

- identifies individuals the IRS believe to be ACA FTEs of the ALE; and
- received a PTC in any month of calendar year 2015.

The IRS identifies individuals as ACA FTEs receiving the PTC, thus triggering the ESRP. Using Form 14765, the IRS lists out the affected individuals and months of the calendar year. Individuals and months that are not highlighted are triggering the assessment. You will want to carefully review the list and determine whether any corrections to the information is needed. Corrections are made using the 2015 indicator codes applicable to Form 1095-C. We have included these for your reference in Appendix B, along with links to the 2015 instructions and forms.

Corrections are not needed for any month that is highlighted. The following example illustrates the Form 14765 Employee PTC listing.

Employee Name	SSN (last 4 digits)	All 12 months Indicator Codes (Form 1095-C, lines 14 and 16 combined)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Additional Information Attached
Mary Smith	2233	First row as filled	1H/	1H/	1H/	1H/	1H/	1H/	1H/	1H/	1H/	1H/	1H/	1H/	
Mary Smith		Second row for corrections	1H/2A	1H/2A	1H/2A	1H/2D	1H/2D	1H/2D	1H/2D	1H/2D	1H/2D	1H/2D	1H/2D	1H/2D	X
John Doe	4455	First row as filled	No PTC	No PTC	No PTC	No PTC	No PTC	No PTC	No PTC	1H/	1H/	1H/	1H/	1H/	
John Doe		Second row for corrections													
Tim Jones	6677	First row as filled	1H/	1H/	1H/	1H/2A	1H/2A	1H/2A	1H/	1H/	1H/	1H/	1H/	1H/	
Tim Jones		Second row for corrections													

The grey highlights mean no penalty is assessed for these months.

Months not highlighted grey reflect an ESRP. Review Forms 1095-C to determine whether this is correct. If incorrect revise the applicable Codes in the second row. If including additional information in support of the correction check the additional information box.

Above is an example of corrections for "Mary Smith" in **red**. In this case, Mary wasn't hired until March 25th and she was a new hire variable employee. Because the employer uses a 12-month initial measurement period, the employer is correcting the Form to reflect 2A (not employed) for Jan – Mar and then 2D for April – Dec to reflect that she is in a limited non-assessment period and therefore not subject to a penalty. The additional information box is checked as this employer is submitting documentation that Mary is not an ACA FTE during 2015.

Employee Information and Calculation

This section describes how the IRS determined the ESRP assessment for 2015. Specifically,

- The ESRP applies and is calculated on a monthly basis and each month is a taxable period.
- The ALE may be liable for an ESRP for any month of calendar year 2015 under either Section 4980H (a) or (b) if it:
    - Did not offer MEC to at least 70% of its ACA FTEs (and their dependents) and at least one ACA FTE received a PTC (4980H(a) assessment or "A" penalty).
    - Did offer MEC to at least 70% of ACA FTEs and their dependents and at least one ACA FTE received a PTC because (1) the coverage was unaffordable, (2) the coverage did not provide minimum value or (3) the ACA FTE was not offered the coverage. (4980(b) assessment or "B" penalty).
- The ESRP is not deductible for income tax purposes.

A summary table shows how the IRS came up with any assessment ("A" or "B") for each month of the calendar year. For any month, an ALE may owe:

- no ESRP, or
- an ESRP under 4980H(a) ("A"), or
- an ESRP under 4980H(b) ("B").

An ALE cannot be assessed both an A and B penalty in the same month.

How to Read the ESRP Summary Table

- Column "a" shows whether (for each month of the calendar year, as listed) the employer made an offer of MEC to at least 70% of the ACA FTEs and their dependents. The response will be "Yes" or "No."

Important Note
Many Summary Tables have shown "No" in column "a" even though the ALE made an offer of coverage to at least 70% of ACA FTEs (therefore should be "Yes"). ALEs will need to address this error in the statement submitted with the ESRP Response. Do not try to correct the error through the correction process for Form 1094-C.

- Column "b" reflects the number of ACA FTEs the ALE reported on the Form 1094-C. If "Yes" in any month, this means the employer made an offer of coverage to at least 70% of ACA FTEs.
    - If the ALE failed to report the number of ACA FTEs on the Form 1094-C Part III for the calendar year, the IRS uses the number of Forms 1095-C the ALE identified as submitting on Form 1094-C, Part II Line 20.
    - If the ALE failed to report the number of ACA FTEs on the Form 1094-C Part III for any month (or months) of the calendar year (e.g., left November blank), the IRS uses the ACA FTE count for the month with the greatest number of ACA FTEs reported.

Practical Tip
Make sure you have your Form 1094-C from the 2015 reporting handy as you go through this letter for accuracy. It will also help you identify whether you may have missed certain information on some (or all) of the months of the calendar year.

- Column "c" reflects the number of ACA FTEs that the employer is allowed to subtract from the "A" penalty calculation. If the employer qualified for transition relief, this number is 80. Otherwise it is 30. In order to claim relief, the ALE should have checked Box "C" on Form 1094-C Part II Line 22 and entered "B" on the Form 1094-C Part III Column "e."

Important Note
Most ALEs will be able to use "80." In some instances, we have seen the IRS use "30" as opposed to "80." This may be due to mistakes on the Form 1094-C and can be addressed in the statement included with the ESRP Response (Form 14764). Do not try to correct the Form 1094-C as the response to Letter 226J.

- Columns "d" and "e" provide the number of ACA FTEs the IRS identified as receiving a PTC for at least one month of the calendar year. Letter 226J describes these as "assessable full-time employees" (or "ACA FTEs"). Essentially, it is their receipt of the PTC that triggered the proposed assessment on the ALE. Details on each of the identified "assessable full-time employees" can be found on the Employee PTC Listing (Form 14765). Only one of the columns ("d" or "e") will be completed for a month as the employer cannot be subject to both the "A" and "B" penalty in the same month. Column "f" identifies whether it is the "A" penalty (4980H(a)) or the "B" penalty (4980H(b)) that applies to some (or all) of 2015.
- Column "g" provides the proposed ESRP for each month of 2015 with a total annual proposed assessment captured at the bottom of the table. This number should match what is included as the ESRP on the first page of Letter 226J.

Assessment of "A" or "B" Penalty

"A" penalty. The 4980H(a) ESRP applies for a month when:

- Column "a" MEC coverage offer indicator (offered to at least 70% of ACA FTEs and their dependents) is marked "No"; and

- Column “d” has at least one (1) for that same month (reflecting at least one ACA FTE received a PTC).

The 4980H(a) assessment is calculated by taking the number in column “b” (the IRS ACA FTE count for the month) and subtracting column “c” (number of ACA FTEs the ALE can back out of its total for purposes of “A” penalty calculation). The resulting number is then multiplied by 173.33 ($2,080/12) to arrive at the monthly ESRP.

“B” penalty. The 4980H(b) ESRP applies for a month when:

- Column “a” (offered to at least 70% of ACA FTEs and their dependents) is marked “Yes”; and
- Column “e” has at least one (1) for that same month (reflecting at least one ACA FTE received a PTC).

The 4980H(b) assessment for a month is calculated by taking the number in column “e” (the number of ACA FTEs who receive a PTC) and multiplying it by $260 ($3,120/12).

Form 14764 – ESRP Response

Regardless of whether you agree or disagree with the proposed assessment, ALEs should timely respond to Letter 226J. There is a phone number to call on the ESRP Response form in the event you need additional time to respond.

An ALE that disagrees with the proposed assessment must submit the following:

- Form 14764 – ESRP Response,
- Signed statement, and
- Any supporting documentation.

An ALE that agrees with the proposed assessment must submit the following:

- Form 14764, and
- Payment.

To complete Form 14764, the ALE needs the following information.

Contact Information

- Your name
- Address
- Primary and secondary phone numbers and the best time to call

Agreement or Disagreement with the ESRP

- **Agree with the assessment.** If you agree with the proposed assessment, check the box reflecting the agreement, print and sign your name and include the date.
- **Disagree with the assessment.** If you disagree with part (or all) of the proposed assessment, check the box reflecting partial/total disagreement with the proposed assessment.

Payment

This includes full or partial payment options if agreeing to the proposed penalties. Payment can be made by check, money order or, if participating, electronically through EFTPS.

- Include the employer ID number (EIN), the tax year (2015) and ESRP on the payment and any correspondence.
- Make check or money order payable to the United States Treasury.

If you are not making a payment, for example because you disagree with the assessment, check the box indicating no payment.

Authorization - Optional

The ALE may authorize additional individuals to assist the ALE with this process. ALEs must designate any authorized individual in the ESRP Response. This may be another

person at the company, legal counsel or a tax adviser. Please do not list us or a member of your service team as we cannot interface directly with the IRS on your behalf.

Sign the authorization in order for the IRS to discuss and provide information to the designated person.

Importance of Responding

If the employer **does not respond** by the date identified on the first page of the letter, a Notice and Demand will be sent for the ESRP that has been proposed and will be assessed. The ESRP will be subject to IRS lien and levy enforcement actions and interest will accrue from the date of the Notice and Demand until the ESRP is paid in full.

Sample Statement Letter

We have crafted a sample statement letter that can be used as a starting point for drafting a response disagreeing with the proposed ESRP. The statement includes some examples of why an ALE would disagree with the ESRP. These examples are not exhaustive. ALEs that disagree with the ESRP will need to include a statement explaining the reason for the disagreement along with a completed Form 14765 and any supporting documentation in a response to the IRS. See Appendix A for the sample.

Appendix A: Sample Statement – ESRP Response

The following is a sample response statement that may be used as a starting point to respond to the IRS when disagreeing with an ESRP assessment. This is just a sample and does not take into account the particular facts and circumstances of the employer's offer of coverage (or lack thereof). Employers must carefully review the details of the assessment and determine the reasons for disagreement. Areas that are highlighted reflect where the employer information is needed. Our comments provide insight on where information may be found and/or examples. The examples provided in this summary are not exhaustive and there may be situations not described in this letter which apply to a particular employer. Employers should carefully review any Letters 226J and work with legal and tax advisors to respond to the IRS in a timely manner.

Company Letterhead

(Insert Month, Day, Year)

Comment
Should be no later than the Response Date on Letter 226J.

Department of Treasury
Internal Revenue Service
Group 2219
7300 Turfway Road, Suite 410
Florence, KY 41042

Re: *(Employer Name:)*
(Employee ID Number)
(Contact ID Number)

Comment
Located on the first page of Letter 226J.

Employer Response to Proposed ESRP

To Whom It May Concern:

This letter is being sent in response to Letter 226J dated (*insert date of the letter)* for Tax Year 2015.

Comment
Located on the first page of Letter 226J.

(Employer Name) **disagrees** with the proposed Employer Shared Responsibility Payment in the amount of *(insert assessment amount)* outlined in the ESRP Summary Table and submit this appeal.

Comment
ESRP payment amount is located on the first page of the Letter 226J and in the ESRP summary table.

(Name of Employer)

Comment
The following are examples of why an employer may disagree with the ESRP. An employer's specific reason for disagreement will be based particular facts and circumstances unique to the employer. There may be more than one reason for the disagreement. Employers will need to carefully draft a response disagreeing with the proposed assessment that reflects the employer's particular circumstances. The examples provided here are general in nature and may not apply to a specific situation.

- *Calendar Year Plan.* Did offer minimum essential coverage to at least 70% of [Employer]'s full-time employees (and their dependents) for all twelve months in accordance with IRC Section 4980h(a).

- *Non-Calendar Year Plan.* Did offer minimum essential coverage to at least 70% of [Employer]'s full-time employees (and their dependents) from *insert first day of non-calendar year plan (e.g., April 1)*, 2015 through December 31, 2015 in accordance with Section 4980H(a) and qualified for non-calendar year plan transition relief.

- *Calendar Year Plans.* Did offer minimum essential coverage to at least 70% of [Employer]'s full-time employees (and their dependents) for all twelve months and the offer of coverage was minimum value and affordable as determined by the [W-2 safe harbor, rate of pay safe harbor or Federal Poverty Level safe harbor] in accordance with Section 4980H(b).

- *Non-Calendar Year plans*. Did offer minimum essential coverage to at least 70% of [Employer]'s full-time employees (and their dependents) from *insert first day of non-calendar year plan (e.g., April 1)*, 2015 through December 31, 2015.

- *Error on Form 1094-C*. Reviewed Form 1094-C filed for Tax Year 2015 and determined that Part III, Column A inaccurately states that minimum essential coverage was not offered to at least 70% of our full-time employees for all twelve months [*or from _____ 2015 through _____ 2015*] ***and/or*** Part III, Column (a), (b), (c), or (e) was/were inadvertently left blank. Please correct Form 1094-C, Part III as follows: *insert requested corrections*.

- *Error(s) on Forms 1095-C*. Reviewed the filed Forms 1095-C and determined that Part II, Line 14/16 [reflects an incorrect code or was incomplete and/or did not identify the correct safe harbor]. I have updated the Employee Premium Tax Credit (PTC) Listing on Form 14765 to reflect the correct codes.

- *Medium-sized employer relief*. Reviewed Form 1094-C filed for Tax Year 2015 and determined that [Employer] was eligible for transition relief from penalties as we employed fewer than 100 full-time employees (including full-time equivalents) in calendar year 2014 and otherwise satisfied applicable requirements for relief. Form 1094-C Part II, Line 22, Box C ***and/or*** Part III column (e) *was/were inadvertently left blank (or other error)*. Please correct Form 1094-C, Part III as follows: *insert requested corrections.*

In support of this signed statement, please find enclosed the following:

1. Completed Form 14764, ESRP Response

2. [Revised Form 14765, Employee Premium Tax Credit (PTC) Listing]

3. Supporting documentation

Comment.
Use this space to describe the supporting documentation that is included with the response. They type of supporting documentation will vary based on the facts and circumstances of the appeal. Following are some examples but is not exhaustive.

- Enrollment/waiver form – to show that an offer of coverage was made and/or accepted

- SBC – to show that the plan meets minimum value

- Plan Documents (SPD/Certificate of Coverage/Booklet) – to show who is eligible for the plan and when benefit coverage begins for new employees

- Contribution documentation (if not included on the enrollment form) – to show the amount the employee would pay for coverage such as an open enrollment guide

- If the employer used the Rate of Pay or W-2 Affordability Safe Harbor, include either of the following: Copy of the employee's pay stub or the previous year's Form W-2]

Sincerely,

[Name of contact person with title]
[Name of Employer]

Appendix B: 2015 Form 1095-C Codes

SERIES 1 CODES: Specify the type of coverage, if any, offered to an employee, the employee's spouse, and the employee's dependents.

1A	Qualifying Offer. Minimum essential coverage providing minimum value offered to full-time employee with employee contribution for self-only coverage equal to or less than 9.56% mainland single federal poverty line (For 2015, $93.77 or less) and at least minimum essential coverage offered to spouse and dependent(s).
1B	Minimum essential coverage providing minimum value offered to employee only.
1C	Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) (not spouse).
1D	Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to spouse (not dependent(s)).
1E	Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse.
1F	Minimum essential coverage NOT providing minimum value offered to employee; employee and spouse or dependent(s); or employee, spouse and dependents.
1G	Offer of coverage to employee who was not a full-time employee for any month of the calendar year (which may include one or more months in which the individual was not an employee) and who enrolled in self-insured coverage for one or more months of the calendar year.
1H	No offer of coverage (employee not offered any health coverage or employee offered coverage that is not minimum essential coverage, which may include one or more months in which the individual was not an employee)
1I	Qualifying Offer Transition Relief 2015: Employee (and spouse or dependents) received no offer of coverage; received an offer that is not a qualifying offer; or received a qualifying offer for less than 12 months.

SERIES 2 CODES: Safe Harbor

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 a full-time employee. Enter code 2B if the employee is not a full-time employee for the month and did not enroll in minimum essential coverage, if offered for the month. Enter code 2B also if the employee is a full-time employee 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).
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 (other than code 2E) might also apply (for example, the code for a section 4980H affordability safe harbor). Do not enter 2C in line 16 if code 1G is entered in the All 12 Months Box in line 14 because the employee was not a full-time employee for any months of the calendar year. Do not enter code 2C in line 16 for any month in which a terminated employee is enrolled in COBRA continuation coverage (enter code 2A).
2D	Employee in a section 4980H(b) Limited Non-Assessment Period. Enter code 2D for any month during which an employee is in a Limited Non-Assessment Period for section 4980H(b) (e.g., waiting periods, initial measurement period, etc.).
2E	Multiemployer interim rule relief. Enter code 2E for any month for which the multiemployer arrangement interim guidance applies for that employee, regardless of whether any other code in Code Series 2 (including code 2C) might also apply.

2F	Section 4980H affordability Form W-2 safe harbor
2G	Section 4980H affordability federal poverty line safe harbor.
2H	Section 4980H affordability rate of pay safe harbor.
2I	Non-calendar year transition relief applies to this employee. Enter code 2I if non-calendar year transition relief for section 4980H(b) applies to this employee for the month.

Final forms and instructions for 2015 are available here:

- Instructions: https://www.irs.gov/pub/irs-prior/i109495c--2015.pdf
- Form 1094-C: https://www.irs.gov/pub/irs-prior/f1094c--2015.pdf
- Form 1095-C: https://www.irs.gov/pub/irs-prior/f1095c--2015.pdf

Extension of Deadline for 2017 Forms 1095-C

Published: December 28, 2017

On December 22, 2017, the IRS issued Notice 2018-06, which provides a limited extension of time for employers to provide 2017 Forms 1095-C to individuals. It also extends good-faith transition relief from certain penalties for the 2017 reporting year. The deadline to provide Forms 1094-C and 1095-C to the IRS was not extended.

Q1: What was Extended?

2017 Forms 1095-C statements must be furnished to individuals by **March 2, 2018** (rather than January 31, 2018).

This extension of time also applies to carriers providing Forms 1095-B to individuals in insured plans.

Q2: Were the deadlines for reporting to the IRS extended?

No.

The 2017 Form 1094-C and all supporting Forms 1095-C (collectively, "the return") is due to the IRS by April 2, 2018 if filing electronically (or February 28, 2018 if filing by paper). These deadlines **were not extended** as part of the relief announced in Notice 2018-06. Per the Notice, the government determined there was no similar need for additional time for employers to file these Forms with the IRS.

As a reminder, employers that file at least 250 Forms 1095-C must file electronically. The IRS encourages all filers to submit returns electronically.

Q3: Is there penalty relief?

Yes

Notice 2018-06 extends transition relief from penalties to reporting entities that have made good-faith efforts to comply with the information reporting requirements for the 2017 reporting year, both for furnishing the Form 1095-C to individuals and for filing with the IRS. Specifically, this relief applies to missing or inaccurate taxpayer identification numbers and dates of birth, as well as other information required on the return or statement.

No relief is available if the reporting entity does not make a good-faith effort to comply with the regulations or for a failure to file a return or furnish a statement by the applicable due dates.

This relief does not absolve an employer from correcting an incorrect Form if so instructed by the IRS.

Q4: What if the submissions are late?

Employers that do not comply with these 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.

Q5: What if employees do not have Forms 1096-C (or Forms 1095-B from the carrier) before they file their tax returns?

Some taxpayers may not receive their Form 1095-C (or 1095-B from the carrier) by the time they are ready to file their personal tax return for 2016. Taxpayers do not need to wait until they receive their Form 1095-C (or 1095-B) to file their annual tax return, and may rely on other information from their employer (or carrier) for purpose of filing individual taxes. Individuals need not send this information to the IRS when filing their returns but should keep it with their tax records.

Q6: Will the IRS offer this relief for 2018 reporting?

According to the Notice, the IRS does not anticipate extending this transition relief, either with respect to the due date for furnishing the Form 1095-C to individuals and good-faith relief from certain penalties, to 2018 reporting.

Congress Passes Tax Reform Bill

Published: December 28, 2017

On December 20, 2017, the House and Senate sent President Trump the Tax Cuts and Jobs Act for signature. The House of Representatives passed their version of the bill on November 16, 2017 while the Senate passed their version on December 2, 2017. Because the versions were not identical, a Tax-Bill Conference Committee was formed from members of the Senate and the House of Representatives to negotiate the text of the combined bill. After the finalized text was approved and released by the committee, the House and Senate each passed the combined bill (which happened on December 20th in the House and December 19th in the Senate) before it was sent to the White House.

Included in the law are a few employer-provided health and welfare-related provisions that can be summarized as follows:

- **Individual Mandate.** The law sets the Individual Mandate penalty to $0 starting in 2019. As a reminder, the Individual Mandate is the part of the Affordable Care Act that institutes a penalty on individuals that do not maintain health coverage during the year.

- **Medical Expense Deduction.** The law expands the medical expense deduction for 2017 and 2018 for qualified expenses exceeding 7.5% of adjusted gross income (from 10% under current law). In 2019, the deduction will increase to expenses in excess of 10% of adjusted gross income.

- **Transportation Benefits.** The law eliminates the employer's deduction for qualified transportation fringe benefits. In addition, except as necessary for ensuring the safety of an employee, the law would eliminate any deduction for providing transportation or any payment or reimbursement for commuting to work. This provision is effective for amounts paid or incurred after 2017. It appears qualified transportation fringe benefits remain excludable from the employee's income. It is the employer's ability to deduct the employer's cost for providing these benefits that is changed.

- Bicycle Commuter Benefits. Suspends the exclusion from an employee's gross income and wages for qualified bicycle commuting benefits. Under existing law, employers may provide employees up to $20 per qualifying bicycle commuting month on a tax-free basis. Effective January 1, 2018, any payment or reimbursement by the employer for bicycle commuting expenses will be subject to ordinary income tax and considered wages. The suspension will sunset after December 31, 2025.

- **Employer Tax Credit for FMLA Leave.** Finally, for 2018 and 2019 only, the law creates a tax credit for employers that pay employees while on FMLA leave. Vacation leave, personal leave, or other medical or sick leave do not count for this purpose. The credit is generally 12.5% of the amount of wages paid to qualifying employees (although it increases by .25% for every percentage point an employee's FMLA wages exceed 50% of their normal wages).
  - A qualifying employer is one who:
    - Allows all qualifying FT employees at least two weeks of annual paid FMLA leave (and a pro-rata amount for non-FT employees); and
    - Has a leave program providing for at least 50% of normal wages.
  - A qualifying employee is one who:
    - Has been employed for at least one year; and
    - Who had compensation in the previous year below 60% of the highly compensated threshold. The highly compensated threshold in 2018 is $120,000, meaning the compensation to be a qualifying employee for purposes of the credit is $72,000 for 2018.

Notably, the law **does not:**

- Repeal or otherwise change the employer mandate and applicable Form 1094-C and 1095-C reporting.

- Eliminate tax code provisions associated with dependent care flexible spending accounts and adoption assistance programs (under the original House bill, these were repealed).

- Address the high cost plan excise tax (i.e., the Cadillac Plan Tax) set to take effect on January 1, 2020.

- Reinstate Federal funding for cost-sharing payments to certain individuals buying individual and family coverage in the Marketplace.

Please note that this is not a full review of the law, but focuses solely on provisions that employers should be aware of in relation to the health and welfare benefits they provide.

The IRS will began reviewing the revised Code and issuing regulations and guidance to address the changes in the future. As guidance relates to health and welfare benefits, we will keep you apprised of relevant changes.

For the current text, visit:
https://www.congress.gov/congressional-report/115th-congress/house-report/466/1.

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