

# The Affordable Care Act's Reporting Requirements for Carriers and Employers January 2016

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In this volume, we have collected the 24 weekly blog posts that comprise the series entitled, "The Affordable Care Act's Reporting Requirements for Carriers and Employers." The series appeared in the Mintz Levin Employment Matters blog during the latter-half of 2015. Each of the posts addressed compliance issues affecting employers and state-licensed insurance carriers, with a particular though not exclusive focus on the law's reporting requirements. The issues discussed week-to-week were generally gleaned from newly issued guidance or developing client problems, questions or concerns. The issues addressed in these posts are generally of interest to carriers and employers and their respective advisors. We hope you find this volume useful.



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# Week 1:

# The Affordable Care Act's Reporting Requirements for Carriers and Employers

Posted By Alden Bianchi on July 20th, 2015

The Affordable Care Act (ACA) reporting rules that apply to health insurance carriers and to employers that sponsor group health plans are complicated and demanding. Proper compliance will require collecting, collating and organizing information month-by-month from disparate sources that will test the operability of even the most advanced software solutions. While some hold out hope for "simplification," we think this hope is naïve at best and reckless at worst. These rules are "a thing" that carriers and employers will need to deal with.

There is no shortage of commentary on two particular reporting requirements introduced by the ACA that affect group health plans. They are:

### Internal Revenue Code § 6055

Internal Revenue Code § 6055, which requires carriers and sponsors of self-funded group health plans to provide statements to individuals to whom they provide minimum essential coverage and to transmit copies to the IRS. ("Minimum essential coverage" is coverage that fulfills an individual's obligation to have health coverage under the ACA's individual mandate. In the context of employment, minimum essential coverage is generally provided under a group health plan that is either fully-insured or self-funded.) The first reports are due for 2015. Statements to covered individuals must be provided by January 31, 2016, with copies to the IRS together with a transmittal form by February 29, 2016 if filed on paper (March 31, 2016 if filed electronically).

The information to be provided to covered individuals is included on new IRS Form 1095-B, and transmitted to the IRS on new IRS Form 1094-B. Both the Code § 6055 reporting obligations, as well as those under Code § 6056 explained below, track the approach for reporting an employee's wages. Form W-2 includes the information to be provided to the employee, and Form W-3 is the form that the employer uses to transmit information to the IRS. Where the two regimes differ is in the level of complexity. Forms 1094-B and 1095-B, and their Code § 6056 analogs, Forms 1094-C and 1095-C, are exponentially more complicated.

The IRS has provided a helpful set of questions and answers explaining the Code § 6055 reporting requirements that is available here.

# Internal Revenue Code § 6056

Internal Revenue Code § 6056, which requires "applicable large employers" (i.e., employers with 50 or more full-time and full-time equivalent employees on business days during the previous calendar year) to furnish statements to (and transmit copies to the IRS along with certain transmittal information) each individual who was a full-time employee for at least one month, to disclose whether each such full-time employee and his or her spouse and/or dependents were offered health coverage, and, if so, to report the lowest cost of individual coverage available to the employee. In addition, the employer must report similar information with respect to part-time employees who are offered and who accept coverage. The first reports are due for 2015. Statements to covered individuals must be provided by January 31, 2016, with copies to the IRS together with a transmittal form by February 29, 2016 if filed on paper (March 31, 2016 if filed electronically).

An employer's status as an applicable large employer is determined based on all entities under common control. Each separate legal entity in the controlled group is referred to as an "applicable large employer member." Thus, an employer cannot divide itself up into multiple, smaller entities without changing the ownership structure and hope to evade the ACA's employer shared responsibility rules. While the rules governing common ownership can be daunting to apply, most employers are already familiar with them since similar rules have applied for decades to 401 (k) and other tax-qualified retirement plans. The reporting obligation under Code § 6056 applies at the level of the applicable large employer member. (Operating and business units that are not separate legal entities are not separate applicable large employer members.)

The information to be provided to covered individuals is generally included on new IRS Form 1095-C, and the transmittal to the IRS is on Form 1094-C. There is, however, an exception to the general rule in the case of a self-funded plan that is maintained by an applicable large employer. For these plans, the information that would ordinarily be included on Form 1095-B is instead reported in a separate section of Form 1095-C. Small employers (i.e., those with fewer than 50 full-time and full-time equivalent employees on business days during the previous calendar year) that sponsor self-funded plans report the offer of minimum essential coverage on Form 1095-B and transmit on Form 1094-B. They do not provide or file Form 1095-B or C.

The IRS has provided a helpful set of questions and answers explaining the Code § 6056 reporting requirements that is available here.

Penalties for non-compliance with either requirement are steep. Until recently, the penalty for failure to file an information return generally was \$100 for each return for which the failure occurs—i.e., per covered individual. And the total penalty

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imposed for all failures during a calendar year was capped at \$1,500,000. But the recently enacted <u>Trade Preferences Extension Act of 2015</u> increased these penalties to \$250 per day and an annual cap of \$3,000,000.

For a more thorough treatment of both the Code § 6055 and Code § 6056 reporting requirements please see <u>Information Reporting Under the Affordable Care Act: I.R.C. §6055 and §6056</u>, an article I recently wrote in the Bloomberg/BNA Tax Management Compensation Planning Journal.

Much of the commentary surrounding Code § 6055 and Code § 6056 dwells on and bemoans its complexity. Some hold out hope for simplification, either from Congress or from the IRS. We think this hope is misplaced. The complexity of the reporting rules appears to us to reflect the complexity of the underlying rules.

At the core of Form 1095-C are three questions (lines 14, 15 and 16) that solicit information about three disparate ACA provisions. Line 14 asks about offers of coverage relating to the ACA individual mandate (Code § 5000A); line 15 asks about the amount of the employee contribution for purposes of assessing an individual's eligibility for premium tax credits (Code § 36B); and line 16 relates to the applicable large employer's compliance with the employer shared responsibility rules (Code § 4980H). Moreover, compliance in each case is determined by month. The responses to the questions in lines 14 and 16 are in the form of indicator codes. There are nine separate codes for each, for a total of 18 different codes corresponding to 18 different compliance profiles, options, and situations. Perhaps these forms could be simplified if the information about the individual mandate and/or eligibility for premium tax credits was stripped out, but that would likely require yet another form.

There is a silver lining here, if only a fleeting one. The IRS has announced that for 2015, it will apply a good faith compliance standard. No penalties will be imposed in the case of incomplete or inaccurate information if the reporting entity makes a good faith effort to comply. Of course, this less burdensome standard is not available to an employer that fails to file. But it's terrific news for employers that are endeavoring in earnest to comply. This relief is particularly welcome since many employers will be relying on third-party vendors who are just now developing their software solutions. No matter how expertly designed and executed, all reporting for 2015 will, in essence, be beta testing. No one has ever done this before for real.

# Week 2:

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Yikes! The Costs of Failing to Comply Just Doubled

Posted By Alden Bianchi on July 27th, 2015

The Affordable Care Act (ACA) imposes information reporting rules on providers of minimum essential coverage, e.g., insurance carriers and self-funded plans, and on applicable large employers, i.e., those employers that are subject to the ACA's employer shared responsibility rules. (For a description of the rules governing information reporting under the ACA, please see last week's post.) Internal Revenue Code sections 6721 and 6722 impose penalties for violations of the information reporting rules, including failing to timely file or for filing incorrect or incomplete information returns and/or payee statements. These provisions of the Code apply to a variety of information reporting requirements including Forms 1094-B, 1095-B, 1094-C, and 1095-C, which are the ACA reporting forms under Code sections 6055 and 6056. A new law, the Trade Preferences Extension Act of 2015, has doubled the size of the applicable penalties.

### **Background**

A penalty is imposed under Code section 6721 in the case of a provider of minimum essential coverage under Code section 6055 that fails to file timely information returns, fails to include all the required information, or includes incorrect information on the return. A penalty is also imposed under Code section 6722 in the case of a provider that fails to furnish timely the statement, fails to include all the required information, or includes incorrect information on the statement. Thus, for each affected employee, there are two possible violations. Code section 6724 provides rules under which penalties may be waived upon a showing of reasonable cause. Relief under this provision is at the discretion of the Service, however. It is unlikely to be available to any employer who ignores the reporting requirements.

Similar penalties are imposed on applicable large employers for failing to timely file information returns or furnish timely the statements, respectively, required by Code section 6056. Again, there are two possible violations for each affected employee. As in the case of Code section 6055, Code section 6724 provides rules under which penalties may be waived upon a showing of reasonable cause.

Under both sets of rules, the penalties for non-compliance were, until recently, \$100 for each return for which the failure occurs—i.e., per covered individual, with an annual cap of \$1,500,000. Thus, the penalty in the case of the failure to both furnish statements and file the required return was \$200 per affected employee up to a maximum of \$3,000,000. (These penalties are reduced somewhat where the failures are corrected within a short period of time.)

# The Trade Preferences Extension Act of 2015

The Trade Preferences Extension Act of 2015 extends a trade agreement with certain sub-Saharan African partners and prevents trade partners from undercutting United States businesses with artificially low prices. The law also includes Trade Ad-

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justment Assistance help for workers and companies affected by trade policies. One of the law's revenue offsets includes a provision that increases penalties for incorrect information returns, including those required by the ACA, to \$250 per day (from \$100 per day) with an annual cap of \$3,000,000 (up from \$1,500,000). Thus, for example, if an applicable large employer fails to file an information return and fails to furnish timely the statement to a single employee, the penalty is \$500.

# The "good faith compliance" transition rule

In the final regulations issued under Code sections 6055 and 6056, the IRS provided relief that is intended to allow "additional time to develop appropriate procedures for collection of data and compliance with the new reporting requirements." Specifically, the IRS has announced that it will not impose penalties under Code sections 6721 and 6722 on issuers of minimum essential coverage (Forms 1094-B and 1095-B) or applicable large employers (Forms 1094-C and 1095-C) that can show that "they have made good faith efforts to comply with the information reporting requirements." **The relief is available, however, only where compliance is timely.** 

The significance of the good faith standard should not be underestimated. It means that carriers and employers that endeavor in good faith to comply will not be subject to penalties if their efforts fall short. Carriers and employers that fail to file on time may still be eligible for penalty relief under Code section 6724 (explained above), but only if the IRS determines that the standards for reasonable cause are satisfied. Thus, late filers will have a more difficult time getting penalties waived or abated.

### Conclusion

The Code section 6055 and 6056 filing requirements are complicated. It will be difficult, particularly for 2015 (the first year for which reporting is required) to get it right on all counts. This is especially true since the software that is being created to assist carriers and employers to comply is currently untested. The 2015 good faith compliance transition rule provides room for error. It does so, however, only for carriers and employers that are paying attention and who file on time.

For a thorough treatment of the Code § 6055 and Code § 6056 reporting requirements please see <u>Information Reporting Under the Affordable Care Act: I.R.C. §6055 and §6056</u>

# Week 3:

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: The Basics

Posted By Alden Bianchi on August 4th, 2015

The purpose of IRS Form 1095-C is to furnish information to the IRS about an applicable large employer's compliance with the Affordable Care Act's (ACA) employer shared responsibility rules. The form also solicits information that the IRS will use to track both compliance by employees and their dependents with the Act's individual mandate and their eligibility for premium tax subsidies. Much of the required data is provided in responses to lines 14, 15 and 16 (Part II) of the form. An understanding of what is reported in these three lines and how they interact, therefore, is essential to an understanding of Internal Revenue Code § 6056, which Form 1095-C supports.

# **Background**

As we reported in the <u>first post</u> of this series, the ACA's employer shared responsibility rules require applicable large employers to furnish statements (and transmit copies to the IRS along with certain transmittal information) to each individual who was a full-time employee for at least one month during the year. Employers must disclose whether each full-time employee and his or her spouse and/or dependents were offered health coverage, and, if so, report the lowest cost of individual coverage available to the employee. Similar information must also be reported with respect to part-time employees who are offered and who accept coverage. (For a comprehensive treatment of these and related requirements please see <u>Information Reporting Under the Affordable Care Act: I.R.C. §6055 and §6056.)</u>

### Form 1095-C Part I

The information to be provided to covered individuals is included on new <u>Form 1095-C</u>. Part I of the form (consisting of lines 1 through 13) asks for information about the employee and the reporting entity. The Act's employer shared responsibility rules apply to applicable large employers, which may consist of multiple legal entities under common control (e.g., a parent company and a series of wholly-owned subsidiaries). Final regulations implementing Code § 6056 impose reporting obligations on each legal entity in the controlled group, which the regulations refer to as the "applicable large employer member" (or "ALE Member"). Thus, each ALE Member will be responsible for its own transmittals on Form 1094-C.

# Form 1095-C Part II

Form 1095-C Part II includes lines 14, 15 and 16. In each instance, the requested information is reported month-by-month. There is an option in each case, however, to apply a single response covering all 12 months where the information is the same for all 12 months.

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### • Line 14

Line 14 asks about the coverage, if any, offered to the employee and his or her spouse and/or dependents. The employer's response is made in the form of a code, which are set out and defined in the instructions to the Form 1095-C (available here).

## The ACA's employer shared responsibility rules establish two layers of penalties.

Under the first, an employer has the choice to either offer health insurance coverage to substantially all of its full-time employees or to pay a potentially large fine. This penalty is imposed under Code § 4980H(a), with which line 14 is unconcerned. Information about compliance with Code § 4980H(a) is instead provided in Part III of Form 1094-C. The second layer of penalty, under Code § 4980H(b), does concern line 14 and arises in instances in which an employer has made an offer of coverage sufficient to comply with Code § 4980H(a) but the coverage is either unaffordable or fails to provide minimum value. (A plan that provides minimum value is roughly synonymous with a major medical plan.) It is anticipated that the Code § 4980H(b) penalty will be much less than the penalty imposed under Code § 4980H(a).

A preventive-services-only plan is an example of a plan that fails to provide minimum value. An offer of such a plan qualifies as an offer of coverage for Code § 4980H(a) purposes. It does not prevent exposure to penalties under Code § 4980H(b), however. An offer of a preventive-services-only plan would be reported on line 14 using code 1F ("Minimum essential coverage NOT providing minimum value offered to employee, or employee and spouse or dependent(s), or employee, spouse and dependents").

If the employer offers a minimum value plan that includes the option to include spouses and dependents, the offer would be reported using code 1A ("Minimum essential coverage providing minimum value offered...") or 1E ("Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse"), as appropriate.

An employer need not offer coverage to a spouse in order to avoid Code § 4980H penalties. But a spouse that is included in the employer's offer may, as a consequence, be rendered ineligible for premium subsidies from a public exchange, i.e., "firewalled" as explained below. Here, information that is unnecessary for Code § 4980H purposes is being used to assess compliance with Code § 36B, which relates to premium subsidies.

For purposes of responding to line 14, an employer is deemed to offer health coverage for a month only if it offers health coverage that would provide coverage for every day of that calendar month. Thus, in the case of an employee terminated mid-month, the line 14 reporting code is code 1H (No offer of coverage). This might appear contrary to the final Code § 4980H regulations under which an employer is treated as having offered the employee health coverage for the month if the employee would have been offered health coverage for the entire month had he or she been employed for the entire month. This apparent inconsistency is accommodated in line 16 (explained below).

The rule in Part II, line 14 reporting (requiring coverage to be provided for every day of the calendar month) stands in marked contrast to other reporting. Form 1095-C, Part III applies to sponsors of self-funded plans. (Sponsors of fully-insured plans do not fill out Part III.) For Part III purposes, an employer reports an individual as having coverage under the plan for the calendar month if the individual was covered for any day of the calendar month. The difference is that Part III reports offers of minimum essential coverage that would ordinarily appear on Form 1094-C and reports compliance with the ACA's individual mandate. For individual mandate purposes, coverage on any day of the month is sufficient to escape a penalty under Code § 5000A.

### Line 15

Line 15 requires the employer to provide the employee's share of the lowest cost monthly premium for self-only coverage under an employer-sponsored group health plan that provides "Minimum Value." The IRS wants to know this because a low- or moderate-income employee who might otherwise qualify for subsidized coverage from a public exchange or marketplace is rendered ineligible if he or she has an offer of employer coverage that provides minimum value and that is affordable. (Such an employee is sometimes said to be "firewalled" from receiving a premium subsidy.) Line 15 enables the IRS to determine whether coverage is affordable and, as a consequence, whether the employee is firewalled. In combination with line 14, it also enables the IRS to determine whether a spouse or dependent is also firewalled.

# • Line 16

Line 16 asks for a safe harbor or other code that would excuse the ALE Member from making an offer of coverage. An ALE Member is not necessarily exposed to Code § 4980H(b) penalties in each instance in which it fails to make an offer of coverage to a full-time employee and his or her dependents. The final regulations under Code § 4980H(b) set out a series of instances in which an employer will not incur a penalty despite failing to offer coverage. These instances are referred to as "limited non-assessment periods." (Please see our previous post on the subject of limited non-assessment periods). In instances in which there is no offer of coverage in a particular month, line 16 provides the employer with the opportunity to explain why it is not subject to a penalty. For example, in the line 14 example above relating to mid-month terminations, the line 14 reporting of "no offer of coverage" would be balanced by the code 2B ("[E]mployee 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..."). Another common example involves waiting periods,

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for which the appropriate code is 2D ("Employee in a section 4980H(b) Limited Non-Assessment Period").

In the weeks that follow, we will consider how Form 1095-C, Part II would be completed for some common situations involving progressively different and more challenging facts. We will also consider issues involving third party offers of coverage (including coverage provided by staffing firms, PEOs, multi-employer plans and MEWAs), COBRA, and reporting in the case of mid-year mergers, acquisitions, and other corporate reorganizations.

# Week 4:

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Highlights from the Draft 2015 Instructions for Forms 1094-C and 1095-C

Posted By Alden Bianchi on August 10th, 2015

The IRS recently issued <u>draft 2015 Instructions for Forms 1094-C and 1095-C</u> ("2015 Instructions"). These are the forms that employers with 50 or more full-time employees (including full-time equivalent employees) in the previous year—i.e., Applicable Large Employers ("ALEs")—use to report their compliance with the Affordable Care Act's ("ACA") rules governing employer shared responsibility. Where an ALE consists of more than one commonly controlled entity, reporting is required at the level of the controlled group member (or "ALE Member"). The employer shared responsibility rules are codified in § 4980H of the Internal Revenue Code ("Code"), and the corresponding reporting requirements are set out in Code § 6056.

The draft 2015 Instructions do not deviate radically from the 2014 Instructions. They do, however, contain some important clarifications. This post examines the highlights. (For a comprehensive treatment of the ACA reporting-related requirements please see Information Reporting Under the Affordable Care Act: I.R.C. § 6055 and § 6056.)

## (1) Extensions and Waivers

The Code § 6056 compliance deadline is fast approaching. While this reporting requirement mirrors the reporting and transmittal of wages scheme of Forms W-2 and W-3, respectfully, the reporting rules under Code § 6056 are exponentially more complicated. Moreover, while wage reporting relies on data from payroll, reporting under Code § 6056 requires ALE Members to access and collate information from multiple sources, including payroll, HRIS, COBRA administration, and leave-of-absence administration.

It gets worse. As we reported in the <u>second installment</u> of this series, the IRS has announced that it will not impose penalties where ALE Members can show that "they have made good faith efforts to comply with the information reporting requirements." The relief is available, however, only where compliance is timely. (Other relief is available in the case of untimely compliance, but is less generous and less certain.) Thus timeliness is of the essence.

The 2015 Instructions clarify that:

"You can get an automatic 30-day extension of time to file by completing Form 8809, Application for Extension of Time To File Information Returns... However, you must file Form 8809 by the due date of the returns in order to get the 30-day extension. Under certain hardship conditions you may apply for an additional 30-day extension. See the instructions for Form 8809 for more information."

Similar relief is provided in the case of requests for extensions of time to furnish statements to recipients.

# (2) Increased Penalties

As we <u>reported previously</u>, the Trade Preferences Extension Act of 2015 includes a provision that increases penalties for incorrect information returns, including those required by the ACA, to \$250 per day (from \$100 per day) with an annual cap of \$3,000,000 (up from \$1,500,000). The 2015 Instructions reflect this change.

### (3) Clarification of 98% Offer Method

Eligibility for the "98% Offer Method" as an alternative to the general method requires an employer to certify that the employer offered affordable health coverage providing minimum value to at least 98% of its employees "for whom it is filing a Form 1095-C employee statement, and offered minimum essential coverage to those employees' dependents." The benefit of this method is that the employer is not required to identify which employees (for whom it is filing) were full-time employees.

There has apparently been some confusion about how to apply the 98% Offer Method relating to how one treats an employee in a limited non-assessment period. For example, assume ALE Member offers affordable minimum value coverage to all of its employees, full-time and part-time, and to their dependents in each month from January 2015 to July 2015. On August 15, ALE Member hires 5 new full-time employees to whom coverage is offered as of December 1, 2015 following the plan's waiting period (or "limited non-assessment period" in the parlance of the Code § 4980H final regulations). Is the 98% Offer Method available in this instance? That is, does this ALE Member offer coverage to 98% of its employees from August to November? The 2015 Instructions answer this question in the affirmative, saying:

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"To be eligible to use the 98% Offer Method, an employer must certify that taking into account all months during which the individuals were employees of the employer and were not in a Limited Non-Assessment Period, the employer offered, affordable health coverage providing minimum value to at least 98% of its employees for whom it is filing a Form 1095-C employee statement, and offered minimum essential coverage to those employees' dependents."

To drive the point home, the 2015 Instructions offer the following example of an arrangement that complies with the 98% Offer Method:

"Employer has 325 employees. Of those 325 employees, Employer identifies 25 employees as not possibly being full-time employees because they are scheduled to work 10 hours per week and are not eligible for additional hours. Of the remaining 300 employees, 295 are offered affordable minimum value coverage for all periods during which they are employed other than any applicable waiting period (which qualifies as a Limited Non-Assessment Period). Employer files a Form 1095-C for each of the 300 employees (excluding the 25 employees that it identified as not possibly being full-time employees). Employer may use the 98% Offer Method because it makes an affordable offer of coverage that provides minimum value to at least 98% of the employees for whom Employer files a Form 1095-C. Using this method, Employer does not identify whether each of the 300 employees is a full-time employee. However, Employer must still file a Form 1095-C for all of its full-time employees..."

# (4) "Plan Start Month" Indicator Box

On Form 1095-C, there is a new box, entitled "Plan Start Month," that is optional for 2015. This box is required to take account of a difference in the manner in which affordability is determined for purposes of an individual's eligibility for premium tax credits versus affordability for purposes of Code § 4980H. The issue is explained in a <u>previous post</u>. For purposes of determining an individual's eligibility for premium tax credits, the indexing of the ACA's original 9.5% affordability threshold is done on the basis of the plan year, not the calendar year (see IRS Revenue Procedure 2014-37, § 5.02). Thus, the IRS needs to know the plan year for purposes of enforcing the premium tax credit rules.

## (5) Multiemployer Plan Relief

The 2014 Instructions direct ALE Members to not enter a code in Part II, line 14 of Form 1095-C (offers of coverage) for health coverage that is not actually offered. Line 14 must instead reflect the coverage actually offered to the employee. The multiemployer safe harbor provided under the Code § 4980H final regulations, though available for purposes of Form 1094-C, Part III, column (a) (relating to whether the employer offered minimum essential coverage to at least 70% of its full-time employees (95% after 2015)) does not apply here.

Getting enrollment and disenrollment information from the multiemployer plan to the employer requires a level of cooperation heretofore rarely encountered in the multiemployer plan environment. And even if the multiemployer plan is willing to provide the information, the HIPAA privacy rules may prevent them from doing do. Enrollment and disenrollment information has something of a tortured history under HIPAA. It is protected health information or "PHI," except when it isn't. Overgeneralizing, enrollment and disenrollment is not PHI in the hands of an employer, but it is PHI in the hands of a plan/covered entity. While making this call is not always easy, in the multiemployer plan context it's pretty simple: The information is in the plan's hands, so it is in all likelihood PHI. (The extent to which this result is counterintuitive is beyond the scope of this post.) Nor do there appear to be any available exemptions under which the multiemployer plan could obtain this information, short of getting signed authorizations from each and every plan participant and beneficiary.

Recognizing the reporting challenges that employers and multiemployer plans face, the 2015 Instructions provide transition relief. For reporting offers of coverage involving multiemployer arrangements for 2015, an ALE Member is directed to:

"[E]nter code 1H on line 14 for any month for which the employer enters code 2E on line 16 (indicating that the employer was required to contribute to a multiemployer plan on behalf of the employee for that month and therefore is eligible for multiemployer interim rule relief)."

Thus, under this transition rule, Code 1H may be entered without regard to whether the employee was eligible to enroll in coverage under the multiemployer plan. This solution had previously been proposed by a handful of software vendors who are developing expert systems to assist with compliance. This relief is both welcome and necessary.

# (6) Offers of COBRA Coverage

Following the recent revisions to its FAQs relating to reporting under Code § 6506 (see Q&As 16, 17 and 18), the 2015 Instructions provide rules for handling offers of COBRA coverage. Generally, an offer of COBRA coverage that is made to a former employee upon termination of employment is reported as an offer of coverage only if the former employee enrolls in the coverage. If the former employee does not enroll in the coverage (even if a spouse or dependent of the former employee independently enrolls in the coverage), the ALE Member is directed to use code 1H (no offer of coverage) for any month for which the offer of COBRA continuation coverage applies.

# (7) Smoothing of Employee Premiums

Where minimum value coverage is offered, an employer using the general reporting method reports on Form 1095-C, line 15 "the amount of the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that is offered to the employee." The 2015 Instructions clarify that, for purposes of determining the monthly employee contribution, "an employer may divide the total employee share of the premium for the plan year by the number

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of months in the plan year to determine the monthly employee contribution for the plan year." The 2015 Instructions offer the following example:

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

### (8) ALE Determination Transition Rule

The 2015 Instructions include an express reference to a transition rule set out in Section XV.D.3 of the preamble to the Code § 4980H final regulations. For 2015, an employer may determine its status as an ALE by reference to a period of at least six consecutive months during 2014 rather than the entire 2014 calendar year.

# (9) Breaks in Service/Leaves of Absence

The treatment of unpaid leaves of absence received little attention in the Code § 4980H final regulations other than in the relatively narrow context of special unpaid leaves. The 2015 Instructions change that by enunciating the following broad principle:

"In certain circumstances, an employee may have a break in service (including a break in service due to a termination of employment) during which the individual does not earn hours of service, but upon beginning to earn hours of service again the employer must treat the individual as a continuing employee rather than a new hire for purposes of certain rules under the section 4980H regulations."

We addressed the underlying issues in a <u>previous post</u>. Consistent with the Code § 4980H final regulations, the 2015 Instructions emphasize that "[t]hese rules do not impact whether the individual was an employee during the break in service, so the individual should only be treated as an employee during the break in service for purposes of reporting if the individual remained an employee during that period (and had not terminated employment with the employer)." Thus, for example, an employee on unpaid leave during the break in service would be treated as an employee for reporting purposes during the break in service, while a former employee whose employment had been terminated during the break in service would not.

# Week 5:

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Reporting of Health Reimbursement Arrangements under Code § 6055 (Spoiler Alert: You Are Not Going to Like This One)

Posted By Alden Bianchi on August 19th, 2015

As <u>we reported last week</u>, the IRS recently issued <u>draft 2015 Instructions for Forms 1094-C</u> and 1095-C. These instructions are of interest to applicable large employers who must report their compliance with the Affordable Care Act's (ACA) rules governing employer shared responsibility. At the same time, the IRS also issued <u>draft 2015 Instructions for Forms 1094-B and 1095-B</u> ("Draft 2015 Instructions"). Forms 1094-B and 1095-B are used to report certain information to the IRS and to taxpayers about individuals who are covered by minimum essential coverage and therefore are not liable for the individual shared responsibility payment. The Draft 2015 Instructions contain an unpleasant clarification on the subject of Health Reimbursement Arrangements, saying essentially that an employer that maintains an insured group plan and a self-funded Health Reimbursement Arrangement (HRA) must separately report the HRA coverage.

### **Background**

The ACA added Internal Revenue Code § 6055, which requires information reporting by any entity that provides "minimum essential coverage" or "MEC." Providers of MEC must file an information return with the IRS and provide a written statement to each individual listed on the return. The information reported under Code § 6055 allows taxpayers to establish (and the IRS to verify) (i) that they had minimum essential coverage and (ii) their months of enrollment, during a calendar year.

The Code § 6055 reporting obligation in the case of a fully-insured plan rests with the health insurance issuer or carrier. In the case of a self-funded plan, the obligation is generally with the employer/plan sponsor. There is an exception in the final regulations under which no reporting is required for "minimum essential coverage that provides benefits in addition or as a supplement to a health plan or arrangement" but only "if the primary and supplemental coverages have the same plan sponsor" or the "coverage supplements government-sponsored coverage" (e.g., Medicare).

# **Reporting Status of HRAs**

The preamble to the proposed regulations had the following to say about reporting for HRAs:

A commenter asked whether an employer and an issuer must coordinate section 6055 reporting for an employer sponsored

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group health plan that consists of an insured high-deductible health plan (HDHP) and additional health benefits provided through a contribution to a health savings account. Health savings accounts are not minimum essential coverage, and therefore section 6055 reporting is not required for them. Additionally, the proposed regulations provide that reporting is not required for arrangements such as health reimbursement arrangements that supplement minimum essential coverage. 78 Fed. Reg. p. 54,990 (Sept. 9, 2013) (Emphasis added).

The preamble to the final regulations appeared to be in accord:

The proposed regulations provided that reporting is not required for arrangements that provide benefits in addition or as a supplement to a health plan or arrangement that constitutes minimum essential coverage. The preamble to the proposed regulations identified health reimbursement arrangements as supplemental coverage to which this rule may apply... The final regulations clarify that minimum essential coverage that supplements a primary plan of the same plan sponsor or that supplements government-sponsored coverage (such as Medicare) are supplemental coverage not subject to reporting. 79 Fed. Reg. 13, 221 (Mar. 10, 2014) (Emphasis added).

This clarification is reflected in a set of IRS-authored Code § 6055 Q&As, Q&A 14, which reads:

Must a health coverage provider report under section 6055 for arrangements that provide benefits in addition or as a supplement to an arrangement that is minimum essential coverage?

If the additional or supplemental benefits are not minimum essential coverage (for example, if they are excepted benefits like coverage at an on-site medical clinic), no reporting is required for the additional or supplemental benefits. In addition, no reporting is required under section 6055 for additional or supplemental benefits that are minimum essential coverage if the primary and supplemental coverages have the same plan sponsor or the coverage supplements government-sponsored coverage such as Medicare.

But it was not until the Draft 2015 Instructions for Forms 1094-B and 1095-B that the full import of the clarification in the final regulations became apparent. Here is what the Draft 2015 Instructions have to say:

### Supplemental Coverage

Providers aren't required to report the following minimum essential coverage that is supplemental to other minimum essential coverage.

- Coverage that supplements a government-sponsored program, such as Medicare or TRICARE supplemental coverage.
- Coverage of an individual in more than one plan or program provided by the same plan sponsor (the plan sponsor is required to report only one type of minimum essential coverage).

Coverage isn't provided by the same plan sponsor if they aren't reported by the same reporting entity. Thus, an insured group health plan and a self-insured health reimbursement arrangement covering the employees of the same employer aren't supplemental. (Emphasis added).

What this means, of course, is that small employers with fully-insured plans that maintain HRAs will be required to issue Form 1095-Bs to covered employees and transmit copies to the IRS on Form 1094-B. This is so despite that the carrier will issue the Form 1095-Bs with respect to the fully-insured coverage. Small employers with self-funded plans will issue Form 1095-Bs and transmit copies on Form 1094-B only for the major medical coverage. For these employers, the HRA is supplemental.

Large employers with fully-insured arrangements, who would not otherwise complete Part III of Form 1095-C, will need to do so if they also maintain an HRA. Large employers with self-funded arrangements that include an HRA will issue Form 1095-Cs with Parts I, II and III completed as they would even if there was no HRA. The transmittal in each case would be on Form 1094-C

But what does it mean for the coverage to not be "provided by the same plan sponsor?" Isn't the employer the "plan sponsor" of an insured plan as well as a self-funded plan? The reference to being "reported by the same reporting entity" is new in the Draft 2015 Instructions. The language does not appear in the final regulations. To treat HRAs in the manner envisioned by the Draft 2015 Instructions, the insurer must be the plan sponsor of a fully-insured plan. The final regulations refer to the health insurance issuer or carriers and to plan sponsors. At no point do they conflate the two.

Most HRAs are "integrated" with group health plan coverage—i.e., they are only available when offered and elected alongside group health plan coverage. (We discussed integrated vs. non-integrated HRAs here.) Integrated HRAs merely supplement other group health plan coverage; non-integrated HRAs, in contrast, result in a separate offer of minimum essential coverage. Might it not be better to require reporting of HRA coverage only where the HRA is not integrated (such as a retiree-only HRA)?

## **Reporting of Other Supplemental Coverage**

The preamble to the final Code § 6055 regulations clarifies that "reporting is not required for arrangements that provide benefits in addition or as a supplement to a health plan or arrangement that constitutes minimum essential coverage." Nor is reporting required for coverage that is not minimum essential coverage. Thus, for example, no reporting is required for health savings accounts, which are not minimum essential coverage.

What is—or at least should be—clear is that the term "supplemental" in the context of "other supplemental coverage" does

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not mean "supplemental coverage" as that term is used in Public Health Service Act § 2791, ERISA § 733, and Code § 9832 establishing HIPAA excepted benefits. These parallel statutory provisions establish four categories of excepted benefits, the last of which is "supplemental" excepted benefits. Supplemental benefits for HIPAA purposes are those provided under a separate policy, certificate, or contract of insurance and that consist of coverage supplemental to Medicare, coverage supplemental to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) or to Tricare, or similar coverage that is supplemental to coverage provided under a group health plan. HIPAA excepted benefits are not minimum essential coverage so they do not trigger a reporting obligation.

But if "other supplemental coverage" is unrelated to HIPAA supplemental benefits, then what is it? For example, if an employer offers a fully insured major medical plan but provides prescription drug coverage under a self-funded carve-out, must the prescription drug coverage be separately reported? Based on the Draft 2015 Instructions, the answer appears to be yes, irrespective of whether it rises to the level of other supplemental coverage.

# Week 6:

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Reporting Group Health Plan Opt-Out Arrangements Under Code § 6055

Posted By Alden Bianchi on August 24th, 2015

Under a common strategy for controlling group health care plan costs, employers sometimes adopt arrangements under which an employee is offered cash as an incentive to waive coverage. These arrangements are colloquially referred to as "opt-out plans" or "opt-out arrangements." Amounts offered under opt-out arrangements—we will call them "opt-out credits"—are in some instances paid as unrestricted, taxable cash. Other opt-out arrangements might impose a requirement that, to qualify for the opt-out credit, the employee must have other group health plan coverage. And still others might offer only a choice between group health plan participation and an opt-out credit that consists of a contribution to the employee's health flexible spending account. This post examines how opt-out credits affect an applicable large employer's determination of affordability for purposes of complying with the Affordable Care Act's (ACA) employer shared responsibility rules, and it explains how opt-out credits are reported.

### **Background**

Whether coverage is "affordable" plays a role in the ACA regulatory scheme in three instances:

## • The individual mandate

Under the ACA's individual mandate, U.S. citizens and green card holders must have "minimum essential coverage" or pay a tax penalty. "Minimum essential coverage" includes coverage under certain government-sponsored programs (e.g., Medicare and Medicaid), eligible employer-sponsored plans, individual market coverage, grandfathered group health plans, and other coverage, as recognized by regulation. An individual may be exempt from the penalty for failing to maintain minimum essential coverage, however, if available health care coverage is unaffordable based on the individual's income. Specifically, the exemption applies in any month in which an individual's contribution for health care coverage for the month exceeds 8% of his or her household income.

## • Eligibility for premium tax subsidies and cost sharing reductions

Certain low- and moderate-income taxpayers are entitled to claim a premium assistance tax credit and cost sharing reductions to assist them to obtain health insurance through a qualified health plan offered in a public insurance exchange or marketplace. The premium assistance tax credit is available for individuals who: (i) have a household income for the taxable year between 100% and 400% of the federal poverty line (FPL) for the individual's family size; (ii) may not be claimed as a dependent by another taxpayer; and (iii) if married, file a joint return. Where an individual is offered coverage by his or her employer, premium tax credits and cost sharing reductions are denied if the offered coverage is both affordable and provides minimum value. Where this occurs, the employee is said to be "firewalled," i.e., though otherwise eligible for a premium tax credit, he or she is nevertheless rendered ineligible.

### • Employer shared responsibility

Under the ACA employer shared responsibility rules, applicable large employers (generally employers with 50 or more full-time and full-time equivalent employees) must make an offer of coverage to substantially all of their full-time employees or face the possibility of having to make assessable payments to the government (i.e., non-deductible excise tax penalties). Applicable large employers that make the requisite offer of coverage are able to avoid any exposure for assessable payments, however, if the offer of coverage is both affordable and provides minimum value. ("Minimum value" coverage is generally synonymous with major medical coverage.) Coverage is affordable if an employee's share of the premium for employer-provided coverage would cost the employee 9.5% or less of his or her annual household income. Because employers generally

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will not know their employees' household incomes, employers can take advantage of one or more of the three affordability safe harbors. If an employer meets the requirements of any of these safe harbors, the offer of coverage will be deemed affordable for purposes of the employer shared responsibility provisions regardless of whether it was affordable to the employee for purposes of the premium tax credit. The three affordability safe harbors are the Form W-2 wages safe harbor, the rate of pay safe harbor, and the FPL safe harbor. These safe harbors are all optional.

# **Opt-out Credits and Affordability**

On November 26, 2014 the Treasury Department and the IRS issued <u>final regulations</u> implementing the individual mandate. Among other things, these regulations provide rules for determining affordability where an employer offers opt-out flex credits. It provides:

(E) Employer contributions to cafeteria plans. Amounts made available for the current plan year under a cafeteria plan, within the meaning of section 125, are taken into account in determining an employee's or a related individual's required contribution if: (1) The employee may not opt to receive the amount as a taxable benefit; (2) The employee may use the amount to pay for minimum essential coverage; and (3) The employee may use the amount exclusively to pay for medical care, within the meaning of section 213. [Treas. Reg. § 1.5000A-3(e)(3)(ii)(E)]

Under this regulation, an opt-out credit may be taken into account for determining affordability for purposes of the ACA individual mandate only if the employee does not have the option to elect cash, and the credit may be used to purchase minimum essential coverage. Based on comments in the preamble to these final regulations (79 Fed. Reg. p. 70,466, 3rd column), the regulators anticipate that a similar rule will be adopted for employer shared responsibility purposes. Moreover, in their informal comments at industry and bar association meetings, Treasury and IRS representatives (expressing their own views and not that of the agency they represent) have consistently made it clear that the approach taken in the final individual responsibility regulations applies with equal force in the employer context.

The approach adopted by the final individual mandate regulations adds to the employee's cost of coverage the opt-out amount that the employee would have to forgo in order to obtain the coverage. Applying this rule in the context of the employer shared responsibility rules makes coverage offered alongside an opt-out arrangement far less affordable. This has a substantive impact on the employer's exposure, and it also impacts reporting on Form 1095-C.

### Reporting the opt-out payment

To grasp the consequences of the rule described above, consider the following two examples:

Example 1: Employer provides a \$1,500 opt-out payment that may only go the health FSA if the employee waives coverage.

**NOTE:** This benefit might be attractive to an employee who has other coverage under the plan of a spouse. Care must be taken, however, to ensure that the health FSA is structured as an excepted benefit. Failure to do so will trigger ACA violations relating to annual and lifetime limits and first-dollar preventive services. (For an explanation of these issues, please see our <u>previous post</u> on the subject.)

Example 2: Employer provides a \$1,500 opt-out payment that is paid in cash if the employee waives coverage.

Assume that in both cases, the employee premium for the employer's group health plan is \$50 per month or \$600 per year. Both offers are affordable under the FPL safe harbor. (Under the FPL safe harbor, if the cost of coverage is \$92.38 per month or less, coverage is deemed affordable.)

**NOTE:** If the opt-out arrangement reimburses an employee upon proof of other coverage, the arrangement would be an employer payment plan even if the employer includes the amount in taxable income. The other coverage in this instance would have to be limited to other group health plan coverage. (For an explanation of these issues, please see our <u>previous post</u> on the subject.)

In <u>Example 1</u>, the employee cost of health coverage is \$50.00 per month. Thus, the employer will enter \$50 on Form 1095-C, line 15 and enter Code 2G ("4980H affordability federal poverty line safe harbor") on line 16. That a code is entered on line 16 indicates that the employee is firewalled and that the employer will not incur a penalty under Code § 4980H(b).

In <u>Example 2</u>, the employee cost of health coverage is \$175.00 per month. This amount consists of the \$50 employee cost plus \$125 per month lost opportunity cost (i.e., the \$1,500 annual opt-out credit divided by 12). Since the employer is using the FPL safe harbor, which assumes that each employee earns the FPL amount, line 16 would be left blank, thereby signaling that a penalty may be due.

Special thanks to Frank Palmieri, Esq. Palmieri & Eisenberg, for providing the examples used in this post.

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# Week 7:

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Mergers and Acquisitions

Posted By Alden Bianchi on August 31st, 2015

When it comes to mergers and acquisitions involving at least one applicable large employer (ALE), the substantive rules governing employer shared responsibility (under Internal Revenue Code § 4980H) and the corresponding reporting rules (under Internal Revenue Code § 6056) share at least one thing in common: we don't yet know how they work. This leaves parties to corporate deals with some challenging questions: How should acquired employees be treated? Does the form of the transaction matter? Do "successor employer" rules of the sort found in the COBRA final regulations apply? Are the parties free to apportion exposure? What presumptions might be invoked if the matter of Affordable Care Act (ACA) compliance is not addressed? What exactly was Tom Brady's role in "deflate gate"?

A recent program sponsored by the American Bar Association Center for Continuing Legal Education on the subject of the ACA reporting rules included a discussion of the reporting aspects of mergers and acquisitions in which Treasury Department and IRS representatives participated. Because the official position of the government may only be enunciated in formal written guidance, the opinions voiced by the government representatives were not binding. They were, rather, their own informal views. The program nevertheless provided some useful hints as to how mergers and acquisitions would be treated for ACA purposes.

## Background—what we do know

That the ACA's employer shared responsibility rules will play a role in mergers and acquisitions is clear from the statute. Code § 4980H(c)(2)(C)(iii) provides that, for purposes of determining whether an employer is an ALE, any reference to an employer includes a reference to any predecessor of the employer. In addition, in the case of an asset deal, a purchaser may become responsible for certain of the seller's tax, benefits and employment liabilities under the successor employer doctrine, this despite that the asset purchase agreement expressly excludes these liabilities by its terms.

# Predecessor and successor employers

Here is what the final regulations under Code § 4980H have to say about predecessor and successor employers:

# "Predecessor employer. [Reserved]" Treas. Reg. § 54.4980H-1(a)(36).

The preamble to the final regulation is modestly more forthcoming. It reads, in relevant part:

"As with the proposed regulations, the final regulations reserve with respect to specific rules for identifying a predecessor employer (or the corresponding successor employer). The Treasury Department and the IRS continue to consider development of rules for identifying a predecessor employer (or the corresponding successor employer), and until further guidance is issued, taxpayers may rely upon a reasonable, good faith interpretation of the statutory provision on predecessor (and successor) employers for purposes of the applicable large employer determination. For this purpose, use of the rules developed in the employment tax context for determining when wages paid by a predecessor employer may be considered as having been paid by the successor employer (see § 31.3121(a)(1)–1(b)) is deemed reasonable." 79 Fed. Reg. p. 8,548 (Feb. 12.2014)

Under the successor employer rules set out in Treas. Reg. § 31.3121(a)(1)–1(b), where an employee works for more than one employer during the calendar year, the combined amount of wages subject to the employee portion of the Social Security tax is capped at the Social Security wage base. There is no exception permitting an employer to reduce or eliminate withholding the Social Security tax from the employee's wages when the employee receives wages from a second employer or multiple employers during the calendar year, even when the employee has reached the Social Security wage base taking into account wages paid by another employer or a combination of employers. There is rather a mechanism for claiming a refund on the employee's individual income tax return.

An exception applies in the case of an asset sale. For purposes of determining whether a successor employer has reached the Social Security wage base, the successor employer is allowed to take credit for the wages that a predecessor employer paid to an employee during the calendar year if the following conditions are satisfied:

- The successor acquired substantially all the property used in a trade or business or used in a separate unit of a trade or business, of the predecessor;
- The employee was employed in the trade or business of the predecessor immediately prior to the acquisition and is employed by the successor in its trade or business immediately after the acquisition; and
- The wages were paid during the calendar year in which the acquisition occurred and prior to the acquisition.

# The successor employer doctrine

In the benefits context, the best known instance of the successor employer doctrine arises under COBRA. In an asset sale, where the seller or a related entity continues to maintain a health plan, terminating employees who lose health coverage

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are entitled to be offered COBRA, even if hired by the buyer and offered coverage under the buyer's plan. If neither the seller nor any related entity has a group health plan following an asset sale, and the buyer continues the business operations associated with the purchased assets without interruption or substantial change, the buyer is considered a successor employer and responsible for COBRA coverage.

# The Final Code § 4980H regulations and Notice 2014-49

The final Code § 4980H regulations include extensive and complex rules that apply to an employee who experiences a change in employment status, from a position for which the look-back measurement method is used, to a position for which the monthly measurement method is used (or vice versa). But the final regulations did not address whether, or under what conditions, an employer that uses a measurement method for a category of employees may subsequently change that measurement method. Instead, the preamble to the final regulations makes the following promise:

"The Treasury Department and the IRS anticipate that the rules with respect to a transfer from a position to which one look-back measurement method applies to a position to which another look-back measurement method applies will require complex rules because the methods may differ not only in the length of the applicable measurement and stability periods, but also the starting dates of the measurement periods... To provide for these rules in the most comprehensible format, as well as to ensure flexibility to address situations that arise that have not currently been contemplated, the final regulations provide that with respect to the determination of full-time employee status, the Commissioner may prescribe additional guidance of general applicability, published in the Internal Revenue Bulletin."

In Notice 2014-49, the IRS made good on its promise. Specifically, the notice addresses two situations: The first applied to an "Employee transferring from a position to which one measurement period applies to a position to which a different measurement period applies," and the second relates to "Employer-initiated changes in measurement methods for one or more permissible categories of employees." (See our previous post on Notice 2014-49 for further explanation.)

At the end of Notice 2014-49, the IRS gives us the following clue as to how they might address mergers and acquisitions:

"Until further guidance is issued, and in any case through the end of calendar year 2016, taxpayers involved in a corporate transaction in which employers use different measurement methods may rely on the approach described in this notice in determining an employee's status as a full-time employee for purposes of § 4980H...

Recognizing that the approach described in the immediately preceding paragraphs to addressing the consequences of corporate transactions is not necessarily the only permissible approach and might in some cases present practical issues, the Treasury Department and the IRS encourage comments on this and other possible approaches."

The issue that the IRS addresses here relates to instances in which one of the parties to the deal has chosen to use the look-back measurement method to determine full-time employee status. Where both the buyer and seller have elected to use the monthly measurement method, the merger or acquisition is a non-event.

### Some examples—stock and asset deals

Set out below are the examples discussed during the above cited ABA Center for Continuing Legal Education program.

### • Stock deal—ALE acquires non-ALE

Alpha Group (an ALE) acquires the stock of Tiny Corp (a non-ALE) in 2015. The question arises, when does Tiny Corp. become an ALE member? And does it matter whether Tiny Corp. is a wholly-own subsidiary of Alpha Group or if Tiny Corp. is merged up into Alpha Group?

The rules governing when an employer becomes an ALE generally look to the prior calendar year. Particularly where Tiny Corp. is maintained as a wholly-own subsidiary of Alpha Group, might Tiny Corp. avoid ALE or ALE member status until 2016? In the regulator's view at least, the answer was no. Thus, 1095-Cs would need to be provided to Tiny Corp.'s employees. For months prior to the effective date of the deal, Tiny Corp. employees would be coded as not employed (i.e., Code 2A. Employee not employed during the month). It was generally agreed that no substantive pre-merger information would be required, nor would Tiny Corp. have any exposure pre-merger. This result is the same, though marginally more compelling, if Tiny Corp. is merged into Alpha Group.

## • Stock deal—ALE acquires ALE

Alpha Group (an ALE) acquires the stock of a subsidiary of Beta Group (which is also an ALE). Since both parties are already ALEs, reporting is required. But what controlled group members are included in Form 1094-C, Part IV filed by Alpha Group, and by Beta Group, the acquired subsidiary? Since the purpose of Form 1094-C, Part IV is to apprise the IRS of any sources of exposure, it is likely any rule that the Treasury Department and IRS adopt will provide that the reporting will include all entities even if not part of the group of employers under common control for the entire year.

# Asset purchase

Alpha Group (an ALE) acquires the assets of Charlie Co. In connection with the sale, Charlie Co. terminates all of its employees. Alpha Group hires some, but not all, of Charlie Co.'s former employees. Are there any circumstances under which Alpha Group would need to report its newly-hired employees (former Charlie Co. employees) as other than new employees in applying the look-back measurement method?

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Based on the above-cited text from Notice 2014-49, it's pretty clear (to the author at least) that the IRS intends to apply some sort of successor employer rule here. Whether the IRS would be able to enforce such a rule absent further guidance is another matter entirely. In the case of an asset sale, the parties may agree to treat the buyer as a successor employer. But even in this case, it's not clear whether that would be sufficient to be the basis for exposure for assessable payments under Code § 4980H.

# Week 8:

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Reporting Offers of Coverage "On Behalf of Another Entity"

Posted By Alden Bianchi on September 9th, 2015

The Affordable Care Act's (ACA) employer shared responsibility rules provide applicable large employers (i.e., those with 50 or more full-time and full-time equivalent employees on business days during the preceding calendar year) with a choice: make an offer of group health plan coverage to substantially all of the employer's full-time employees or pay a non-deduct-ible excise tax if at least one full-time employee qualifies for a premium tax credit from a public insurance exchange or marketplace. (The particulars of the tax are explained in a set of Questions and Answers issued by the Internal Revenue Service.) Because the amount of the tax for failing to offer any coverage is substantial, most employers view the employer shared responsibility rules as imposing a mandate rather than offering a meaningful choice. Consequently, what constitutes an offer of coverage, and how the offer is reported, is of interest to employers.

In the vast majority of cases, the offer of coverage will be made to employees under a plan that is established and maintained by the employer or an affiliate of the employer. In the regulations and other guidance implementing the employer shared responsibility rules, a single applicable large employer is referred to as an ALE, and members of a group of related entities that together make up an ALE are referred to as applicable large employer member(s) (or "ALE member(s)"). Where coverage is offered by an affiliate, the 2014 Instructions for Forms 1094-C and 1095-C (following the applicable final regulation) provide that an "employer offers health coverage to an employee if it, or another employer in the Aggregated ALE Group... offers health coverage on behalf of the employer." Simply put, coverage offered by an affiliate of the employer is treated as an offer of coverage by the employer.

But there are instances in which the offer of coverage is not made by the employer or an affiliate. The final regulations under Internal Revenue Code § 4980H implementing the employer shared responsibility rules recognize and provide separate rules for three such instances: multiemployer or single employer Taft-Hartley plans, multiple employer welfare arrangements (ME-WAs), and offers of health coverage made by staffing firms. There are, of course, other cases not necessarily contemplated by the final regulations. These instances are sometimes collectively referred to as "inadvertent MEWAs." They include:

- Instances in which employees remain on the group health plan of a seller for a period of time following a corporate transaction:
- Joint ventures that offer group health plan coverage to venture employees under a group health plan maintained by one of the parties to the venture;
- Cases in which an employer extends coverage to employees of an unrelated vendor that serves the employer or its workforce; and
- Situations in which employers mistakenly believe they are under common control only to later discover they are not.

**NOTE:** Inadvertent MEWAs can pose a host of problems beyond those relating to ACA reporting. MEWAs are generally subject to other reporting requirements under ERISA.

Under the final regulations, an offer of coverage includes an offer of coverage made on behalf of an employer, including an offer made by a multiemployer or single employer Taft-Hartley plan or a MEWA to an employee on behalf of a contributing employer of that employee. Moreover, if certain conditions are met, an offer of coverage to an employee performing services for an employer that is a client of a professional employer organization (PEO) or a staffing firm (in cases where the staffing firm is not the common law employer of the worksite employee) is treated as an offer of coverage by the employer.

### Multiemployer plans

Reporting by employers who offer coverage to their collectively bargained employees under a multiemployer (Taft-Hartley) plan is particularly challenging, both because it would require a level of cooperation by the multiemployer trustees that was previously rare if not unheard of and also because there are other potential legal impediments—e.g., the HIPAA privacy rules—that may prevent the sharing of the information. The draft 2015 Instructions for Forms 1094-C and 1095-C provided some welcome relief on this score. For 2015, employers are allowed to use code 1H ("no offer of coverage") on Form 1095-C, Line 14 for any month in which they claim the benefit of the multiemployer plan transition relief made available in the pream-

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ble to the final Code § 4980H regulations. Employers signal that they are taking advantage of the transition relief by entering Code 2E on Form 1095-C, Line 16. Before the draft 2015 instructions, an employer had to determine whether each of its full-time collectively bargained employees was actually covered by the multiemployer plan. That the employer was contributing on the employee's behalf was insufficient, nor was the employer permitted to simply leave Form 1095-C, Line 14 blank.

For an excellent discussion of the impact of the reporting rules where multiemployer plans are concerned, please see, <u>Latest Guidance for Employers and Multiemployer Plan Sponsors on Reporting Required by the Affordable Care Act, published by Segal Consulting.</u>

### **Multiple Employer Welfare Arrangements**

The typical MEWA is offered by a trade or industry association, where the levels of cooperation are typically high. The relief provided by the draft 2015 Instructions to multiemployer plans is not available. Nor is that relief necessary, since employers usually know which employees are enrolled in the offered coverage.

Inadvertent MEWAs are another matter entirely. In the case of post-corporate transaction coverage, the buyer and seller will need to cooperate and coordinate to ensure that the buyer has the information that it needs to prepare Form 1095-Cs for its employees. This is a matter that perhaps should be included in the purchase agreement. Provided the parties are aware of the issue, obtaining the requisite information to prepare Form 1095-Cs should not prove too troublesome in the case of joint ventures and companies that extend coverage to an unrelated workforce. Awareness is critical, however, and it is often missing. The problems compound in the case of employers that mistakenly believe they are under common control. In each of these cases, it might well be that Form 1095-Cs are provided, and information is transmitted on Form 1094-C, but by the wrong party. One would hope that penalties would be waived under the transitional good faith compliance standard or abated if corrected voluntarily in advance of an audit based on a showing of reasonable cause.

### **PEOs and Staffing Firms**

The special rule provided in the final Code § 4980H final regulations has been the source of considerable confusion where staffing firms are concerned. The rule provides as follows:

(2) Offer of coverage on behalf of another entity. For purposes of section 4980H, an offer of coverage by one applicable large employer member to an employee for a calendar month is treated as an offer of coverage by all applicable large employer members for that calendar month... For an offer of coverage to an employee performing services for an employer that is a client of a staffing firm, in cases in which the staffing firm is not the common law employer of the individual and the staffing firm makes an offer of coverage to the employee on behalf of the client employer under a plan established or maintained by the staffing firm, the offer is treated as made by the client employer for purposes of section 4980H only if the fee the client employer would pay to the staffing firm for an employee enrolled in health coverage under the plan is higher than the fee the client employer would pay the staffing firm for the same employee if that employee did not enroll in health coverage under the plan. (Emphasis added.)

The rule applies by its terms in instances where the worksite employees are the common law employees of the client. (For a discussion of the rule and its over-use, please see our earlier post on the subject.) While there is some difference of opinion on the matter, PEOs typically treat worksite employees as the client's common law employees, while staffing firms do the opposite. (For a thorough discussion of the issue please click here.) For entities affected by the rule, the proper reporting entity is the common law employer. Thus, in the case of the typical PEO, the PEO will need to provide the client company with the information on participant elections, coverage offered, minimum value, and affordability that the client needs to prepare and file Forms 1094-C and 1095-C.

The staffing industry takes the position that, in the great majority of cases, the worksite employees should be considered the common law employees of the staffing firm—and there is historical precedent in support of that position. Nevertheless, as a precaution, staffing firms are charging additional fees for worksite employees who accept their offer of coverage if the client expresses concern about the issue. If it turns out on audit that the worksite employees are in fact the common law employees of the client, then the client is treated as having offered the coverage for purposes of compliance with the employer shared responsibility rules. While this strategy is sound in our view, if the worksite employees are determined on audit to be the common law employees of the client, then the client and not the staffing firm should have filed the Forms 1095-C. It is unclear why, as a policy matter, this should be of concern provided that the staffing firm filed the reports based on a reasonable, good faith assumption that it was the common law employer.

Separately, the question of the employer status of staffing firms and their clients has been muddled by the recent National Labor Relations Board decision in Browning-Ferris Industries of California, Inc. There, the NLRB held that, under the National Labor Relations Act, workers at a Browning-Ferris recycling facility were employees of both Browning-Ferris and its subcontractor, despite that Browning-Ferris never actually exercised its authority to control the terms and conditions of the workers' employment. (We discuss this decision in a <u>prior post</u>.) Unlike labor law, however, there is no such thing as joint employment for tax and employee benefits law purposes. Thus, this decision has no bearing on the interpretation of who is the common law employer for purposes of the ACA's employer shared responsibility rules.

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# Week 9:

The Affordable Care Act's Reporting Requirements for Carriers and Employers: Unraveling the Mystery of Indicator Code 2D—What Exactly is a "4980H(b) Limited Non-Assessment Period" (and why is there no "4980H(a) Limited Non-Assessment Period")?

Posted By Alden Bianchi on September 14th, 2015

# Written by Alden Bianchi and Ed Lenz

The Affordable Care Act's reporting rules—which are set out in Internal Revenue Code §§ 6055 and 6056—solicit the information needed by the Internal Revenue Service to enforce the individual and employer shared responsibility rules and to support the proper administration of premium tax subsidies. Occasionally, the reporting rules also manage to shine a light into the substantive workings of the statute. This is the case with the Form 1095-C, Part II, Line 16, Indicator Code 2D ("Employee in a section 4980H(b) Limited Non-Assessment Period").

The final Code § 4980H regulations define the term "Limited Non-Assessment Period." Though the term "4980H(b) Limited Non-Assessment Period" is not defined, it is nevertheless clear that Indicator Code 2D is not appropriate to use any time a full-time employee is in a "Limited Non-Assessment Period." Rather, only certain "Limited Non-Assessment Periods" qualify. This post explains which "Limited Non-Assessment Periods" qualify for Indicator Code 2D and which do not. (For a high-level description of the reporting rules please see the first post in this series.)

## **Background**

The final Code § 4980H regulations define the term "Limited Non-Assessment Period" to mean, generally, "the limited period during which an employer will not be subject to an assessable payment under section 4980H(a), and in certain cases section 4980H(b)," with respect to certain employees. There follow six specific instances in which an employer will not be subject to an assessable payment despite failing to make an offer of coverage. These include:

- (i) The transition rule for an employer's first year as an applicable large employer;
- (ii) The three full calendar month period beginning with the first full calendar month in which an employee is first otherwise eligible for an offer of coverage under the monthly measurement method;
- (iii) The application of the employer mandate during the initial three full calendar months of employment for an employee reasonably expected to be a full-time employee at the start date, under the look-back measurement method;
- (iv) The application of the employer mandate during the initial measurement period to a new variable hour employee, seasonal employee or part-time employee determined to be employed on average at least 30 hours of service per week, under the look-back measurement method;
- (v) The application of the employer mandate following an employee's change in employment status to a full-time employee during the initial measurement period, under the look-back measurement method; and
- (vi) The application of the employer mandate to the calendar month in which an employee's start date occurs on a day other than the first day of the calendar month.

# Treas. Reg. § 54.4980H-1(a)(26)(i) through (vi).

To understand why the IRS needed to confine Indicator Code 2D to "4980H(b) Limited Non-Assessment Periods" requires a brief digression into other provisions of the regulations, particularly those establishing the rules for determining full-time employee status under the monthly measurement method and the look-back measurement method.

# The monthly measurement method

The monthly measurement method includes a special rule that applies to an employee who, in a calendar month, "first becomes otherwise eligible to be offered coverage under a group health plan of an employer." Under this rule, an employer is not subject to an assessable payment under Code § 4980H(a):

[W]ith respect to an employee for each calendar month during the period of three full calendar months beginning with the first full calendar month in which the employee is otherwise eligible for an offer of coverage under a group health plan of the employer, provided that the employee is offered coverage no later than the first day of the first calendar month immediately following the three month period if the employee is still employed on that day. Treas. Reg. § 54.4980H-3(c)(2).

Moreover, if the coverage for which the employee is otherwise eligible during the three-month period, and which the employee is actually offered on the day following that three month period if still employed, provides minimum value, the employer also will not be subject to an assessable payment under Code § 4980H(b) with respect to that employee for the three-month period.

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The workings of this rule are best illustrated by an example:

Employer X is an applicable large employer that elects to determine full-time employee status using the monthly measurement method. Employer X's only group health plan covers preventive services and nothing else. The plan does not provide minimum value. (These plans are sometimes referred to as "MEC" plans.) X pays the entire premium cost. Employees (and their dependents) are permitted to enroll after 60 days of employment. X will not be subject to the Code § 4980H(a) penalty with respect to any full-time employee for failing to offer coverage during the 60-day waiting period. X is, however, exposed to the Code § 4980H(b) penalty during the waiting period and for all subsequent coverage months, since the plan does not provide minimum value.

If Employer X instead offered to all of its full-time employees (and their dependents) coverage that provided minimum value, X would not be subject to assessable payments under Code § 4980H(b) with respect to any employee for whom coverage was affordable.

### The look-back measurement method

A similar rule applies under the look-back measurement method during the initial full three calendar months of employment. The employer is not subject to an assessable payment under Code § 4980H(a):

[F] or any calendar month of the three-month period beginning with the first day of the first full calendar month of employment if, for the calendar month, the employee is otherwise eligible for an offer of coverage under a group health plan of the employer, provided that the employee is offered coverage by the employer no later than the first day of the fourth full calendar month of employment if the employee is still employed on that day. Treas. Reg. § 54.4980H-3(d)(2)(iii).

Again, if the offer of coverage for which the employee is otherwise eligible during the first three full calendar months of employment, and which the employee is actually offered by the first day of the fourth month if still employed, provides minimum value, the employer is also not subject to an assessable payment under Code § 4980H(b) with respect to that employee for the first three full calendar months of employment.

## Transition rule for an employer's first year as an applicable large employer

A similar approach applies in the case of the transition rule for an employer's first year as an applicable large employer. The preamble to the final Code § 4980H regulations generally provides that:

- If the employer offers coverage on or before April 1 of the first year in which the employer is an applicable large employer, the employer will not be subject to an assessable payment under Code § 4980H(a) by reason of its failure to offer coverage to the employee for January through March of that year; and
- The employer will not be subject to an assessable payment (for January through March of the first year the employer is an applicable large employer) under Code § 4980H(b) if the coverage offered provides minimum value.

If the employer fails to offer coverage to the employee by April 1, the employer may be subject to a Code § 4980H(a) assessable payment for those initial calendar months in addition to any subsequent calendar months for which coverage is not offered. If the employer does offer coverage by April 1, but the coverage does not provide minimum value, the employer may be subject to a Code § 4980H(b) assessable payment for those initial calendar months and any subsequent calendar months for which coverage does not provide minimum value or is not affordable.

# **Using Indicator Code 2D**

The title of this post asks, "Why is there no "4980H(a) Limited Non-Assessment Period"?" The answer is simple. There is no need for one. Information relating to an employer's exposure under Code § 4980H(a) is not reported on Form 1095-C, Part II, Lines 14, 15 or 16. Form 1095-C, Part II, Lines 14, 15 and 16 deal instead with an employer's liability under Code § 4980H(b). Line 14 asks for the code indicating whether a particular employee had an offer of coverage, the type of coverage and to whom it was offered, and if the coverage offered had minimum value and whether it was affordable; Line 15 asks for the dollar amount of the employee's contribution to self-only minimum value coverage; and Line 16 asks for the code indicating whether the employer has an excuse for failing to offer coverage, e.g., that the employee was in a Limited Non-Assessment Period as indicated by Indicator Code 2D.

Information relating to an employer's exposure under Code § 4980H(a) is reported on Form 1094-C, Part III. Form 1094-C, Part III, Column (b) asks for "Full-Time Employee Count for ALE Member" and Column (c) asks for the "Total Employee Count for ALE Member." The form 1094-C and 1095-C instructions provide that, "For purposes of reporting on Forms 1094-C and 1095-C, an employee in a Limited Non-Assessment Period is not considered a full-time employee." So an employee in a 4980H(a) Limited Non-Assessment Period would not be reported in Column (b), but he or she would appear in Column (c). This would be the case where, for example, an applicable large employer offered non-minimum value coverage after a waiting period or following an appropriate measurement period.

Of course, if the employer failed to offer minimum essential coverage to substantially all of its full-time employees, and if at least one of these employees qualified for a premium tax credit or a cost-sharing subsidy, the employer would owe an assessable payment under Code§ 4980H(a) based on the number of full-time employees reported in Column (b).

As previously noted, Indicator Code 2D on line 16 of Form 1095-C, Part II signals that no Code § 4980H(b) penalty will be

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imposed during the Limited Non-Assessment Period. Once the period expires, the general reporting rules apply. If coverage, once actually offered, is affordable, then the proper Indicator Code is 2F (Form W-2 safe harbor), 2G (federal poverty line safe harbor), or 2H (affordability rate of pay safe harbor), as the case may be. If the coverage is not affordable, and if the employee does not enroll in the coverage, then Line 16 would be left blank, thereby signaling that a penalty would be imposed if the employee qualifies for a premium tax credit in the months following the Limited Non-Assessment Period.

# Conclusion

The lesson is simple but sometimes overlooked: Indicator Code 2D is not a catch all for reporting employees in a Limited Non-Assessment Period. It is, rather, reserved for specific instances in which an employee would otherwise have the benefit of an offer of minimum value coverage but for being in a Limited Non-Assessment Period.

# Week 10:

The Affordable Care Act's Reporting Requirements for Carriers and Employers: IRS Issues Final Form 2015 Instructions for Forms 1094-B and 1095-B, 1094-C and 1095-C—Good News for HRAs, Changes to COBRA Reporting, Clarifications for Multiemployer Plans, and More

Posted By Alden Bianchi on September 21st, 2015

The IRS recently issued final instructions for Forms 1094-B and 1095-B and Forms 1094-C and 1095-C. The 2015 Instructions for Forms 1094-B and 1095-B implement a suggestion we made in a previous post relating to the reporting of Health Reimbursement Arrangements (HRAs) that are integrated with other group health plan coverage. The 2015 Instructions for Forms 1094-C and 1095-C make a substantive change in the manner in which offers of COBRA coverage are reported and clarify the reporting of multiemployer plan coverage. The Treasury Department and IRS also issued Notice 2015-68, which announces their intent to propose regulations to reflect recent changes in the law (e.g., the Expatriate Health Coverage Clarification Act of 2014) and to clarify existing regulations (e.g., the reporting of coverage under integrated HRAs, as discussed below.

## Reporting of HRAs

Our previous post entitled, The Affordable Care Act's Reporting Requirements for Carriers and Employers (Part 5 of 24): Reporting of Health Reimbursement Arrangements under Code § 6055 discussed an apparent change of position in the draft instructions for IRS Forms 1094-B and 1095-B that, if implemented, would (among other things) require the separate reporting of HRAs that are integrated with fully-insured group health plan coverage. We opined in that post that such a rule would be particularly burdensome for small employers, i.e., those employers with fewer than 50 full-time and full-time equivalent employees, who fully insure their group health benefits. These employers presumed that they had no reporting obligations. The carrier would be preparing and filing the Forms 1094-B and 1095-B, and the employer would not be required to file Forms 1094-C and 1095-C. The draft rule would have required small employers to get into the reporting business. In addition, large employers with an integrated HRA that fully-insure would have to complete Part III of Form 1095-C.

The final 2015 Instructions to Form 1094-B and 1095-B do not adopt this approach to HRA reporting in the case of an integrated HRA that is paired with a group health plan of the same plan sponsor. But what, exactly, is an "integrated" HRA? Viewed in isolation, HRAs impose annual limits, and they generally do not provide first dollar coverage for preventive services. Such an HRA—which is referred to as a "stand-alone" HRA—would ordinarily trigger ACA penalties if the arrangement covers active employees. But HRAs for the most part do not operate in isolation. Rather, the vast majority of HRAs provide amounts that can be applied by employees and their dependents to reduce cost-sharing and/or to pay premiums under the employer's primary group health plan. Where this is the case, and where certain additional requirements (enumerated below) are satisfied, the HRA is said to be "integrated" with the employer's group health plan. Integrated HRAs are permitted to piggy-back on the employer's primary group health plan for purposes of determining whether the combined arrangement complies with the ACA insurance market reforms. (For a discussion of integrated and stand-alone HRAs, please see this presentation I gave earlier this year on the intricacies of health premium reimbursements.)

For an HRA to be integrated with an employer's group health plan that provides major medical benefits (or, in the parlance of the ACA, the plan provides "minimum value"), it must satisfy the following criteria:

- The employer must offer a group health plan to the employee that provides minimum value;
- The employee receiving the HRA must actually be enrolled in a group health plan that provides minimum value, regardless of whether the employer sponsors the plan (e.g., the group health plan may be that of the employee's spouse);
- The HRA must be available only to employees who are actually enrolled in the group coverage; and
- Under the terms of the HRA, an employee (or former employee) is permitted to permanently opt out of and waive future reimbursements from the HRA at least annually, and, upon termination of employment, either the remaining amounts in the

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HRA are forfeited or the employee is permitted to permanently opt out of and waive future reimbursements from the HRA. Because the ACA's insurance market reforms do not apply to an HRA that has "fewer than two participants who are current employees on the first day of the plan year," stand-alone retiree HRAs are permitted.

When paired with the group health plan of the employer that sponsors the HRA, an integrated HRA does not function like a separate group health plan. Instead, it modulates the costs of coverage to the employee by providing funds to pay premiums or help with cost-sharing. In the case of the former (payment of premiums), the HRA affects affordability; in the case of the latter, the HRA affects minimum value. According to a 2013 proposed regulation implementing the minimum value standard for group health coverage (that has been amended but not finalized), amounts newly available for the current plan year under an HRA offered in connection with a group health plan are treated as follows:

- Amounts that can be used only to reduce cost-sharing under the employer's primary group health plan are taken into account in determining minimum value;
- Amounts that can be used only to pay premiums under the employer's primary employer group health plan are taken into
  account in determining affordability; and
- Amounts that can be used either to pay premiums or help with cost-sharing under the employer's primary group health plan are taken into account only in determining affordability (they may not be taken into account for minimum value purposes).

There are some important exceptions to these rules under which the HRA does not count toward the affordability or minimum value requirements. These include instances in which the HRA is integrated with the plan of another employer, and cases in which the purpose of integrating the HRA is to enable the employer's primary plan to satisfy the ACA's preventive services or annual dollar limit requirements.

The reporting consequences of integrated HRAs under Code §§ 6055 and 6056 are as follows:

# • Small employer; fully-insured group health plan

In the case of a small employer (i.e., an employer that is not subject to the ACA employer mandate) that maintains a fully-insured group health plan and an integrated HRA, the carrier will prepare, distribute to employees, and transmit, as appropriate, the Forms 1094-B and 1095-B with respect to the fully-insured group health plan.

Under the final 2015 Instructions for Forms 1094-B and 1095-B, this employer would not be required to transmit or report on Forms 1094-B or 1095-B with respect to any employee that is covered by the combined HRA/group health plan. But if the HRA was integrated with another group health plan, e.g., that of the employer's spouse, then the employer would be required to issue a separate Form 1095-B and transmit on Forms 1094-B or 1095-B for the HRA coverage.

# • Small employer; self-funded group health plan

In the case of a small employer that maintains a self-funded plan, the plan itself is an issuer of minimum essential coverage. The employer/plan sponsor in this instance will prepare, distribute to employees, and transmit, as appropriate, the Forms 1094-B and 1095-B that will cover the integrated arrangement (group health plan/HRA). (For a group health plan maintained by a single employer, the plan sponsor is the employer. For a multiple employer welfare arrangement, the plan sponsor is each participating employer. And for a multiemployer plan, the plan sponsor is the joint board of trustees.)

# • Large employer; fully-insured group health plan

In the case of a large employer (i.e., an employer that is subject to the ACA's employer mandate) that maintains a fully-insured group health plan and an integrated HRA, the carrier will prepare, distribute to employees, and transmit, as appropriate, the Forms 1094-B and 1095-B. If the HRA may be used only to pay premiums, then the HRA will affect the amount that is reported on Form 1095-C, Line 15 ("Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage"). If the HRA may be applied to reduce cost sharing, irrespective of whether it may also be applied to the payment of premiums, then the result will be an adjustment to the plan's minimum value. This may, in turn, change which series-1 Indicator Code is appropriate for Form 1095-C, Line 14 ("Offer of Coverage"). Under the final 2015 Instructions for Forms 1094-C and 1095-C, this employer does not fill out Forms 1095-C, Part III ("Covered Individuals (Lines 17-22)") for employers covered by the HRA and the employer's group health plan. But they would do so if the HRA was integrated with a group health plan other than that of the employer.

# • Large employer; self-funded group health plan

In the case of a large employer that maintains a self-funded group health plan and an integrated HRA, the employer will prepare, distribute to employees, and transmit, as appropriate, the Forms 1094-C and 1095-C (including Part III), which will include the information ordinarily solicited and provided by Forms 1094-B and 1095-B. In this case, the effect of the integrated HRA will appear in Part II of Form 1095-C. If the HRA may be used only to pay premiums, then the impact will appear on Part II, Line 15 (relating to affordability). If the HRA may be applied to reduce cost sharing, irrespective of whether it may also be applied to the payment of premiums, then the result will be an adjustment to the plan's minimum value. This may, in turn, change which series-1 Indicator Code is appropriate.

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The final Instructions include this helpful example:

An ALE Member with a self-insured major medical plan and a health reimbursement arrangement (HRA) is required to report the coverage of an individual enrolled in both types of minimum essential coverage in Part III under only one of the arrangements. An ALE Member with an insured major medical plan and an HRA is not required to report in Part III HRA coverage of an individual if the individual is eligible for the HRA because the individual enrolled in the insured major medical plan. An ALE Member with an HRA must report coverage under the HRA in Part III for any individual who is not enrolled in a major medical plan of the ALE Member (for example if the individual is enrolled in a group health plan of another employer (such as spousal coverage)).

# **COBRA**

Under prior instructions, the manner in which an offer of COBRA coverage was reported depended on the nature of the qualifying event—i.e., reduction in hours vs. termination of employment—and on whether the offer of coverage was accepted. Where the terminated employee elects COBRA coverage, the employer would use the same series-1 Indicator Code that would apply in the case of similarly situated active employees (i.e., Form 1095-C, Part II, Line 14 Indicator Codes 1B through 1E, as appropriate) going forward. The cost to the employee of the single COBRA premium would appear on line 15 (i.e., the "employee share of the lowest cost monthly premium for self-only minimum value coverage"). And line 16 would be code "2C" ("employee enrolled in coverage"). But where the terminated employee declined coverage, the employer would report no offer of coverage using Indicator Code 1H on line 14; leaving line 15 blank; and using code 2A ("employee not employed during the month") in line 16.

In the case of a reduction in hours, however, the offer of COBRA coverage was reported irrespective of whether the coverage was elected.

Under the final 2015 Instructions, an offer of COBRA continuation coverage made to a former employee upon termination of employment is no longer reported as an offer of coverage on Form 1095-C, Part II, Line 14 irrespective of whether the employee accepts or declines the coverage. Instead, the Indicator Code 1H ("no offer of coverage") is applied for any month for which the offer of COBRA continuation coverage applies. An offer of COBRA coverage made to an active employee (e.g., an offer of COBRA continuation coverage that is made due to a reduction in the employee's hours resulting in the loss of eligibility under the employer's group health plan) is reported in the same manner and using the same code as an offer of that type of coverage to any other active employee.

### Multiemployer Plan Reporting

In a previous post, we discussed the problems with the reporting rules as originally issued and how the rules were subsequently revised. The 2014 instructions required participating employers to obtain information from the multiemployer plan concerning which employees were actually enrolled. In addition to some practical problems, this posed a challenge under the HIPAA privacy rules. In a subsequent set of Q&As on the subject, the draft 2015 Instructions for Forms 1094-C and 1095-C allowed participating employers to use code 1H ("no offer of coverage") on Form 1095-C, Line 14 for any month in which the employer claimed the benefit of the multiemployer plan transition relief made available in the preamble to the final Code § 4980H regulations. These employers also were instructed to enter code 2E ("multiemployer interim rule relief") on Form 1095-C, Line 16. Some employers were confused by this instruction based on the direction to use code 2C as the default when more than one code might apply. Code 2C ("employee enrolled in coverage") is used in instances where more than one code might be appropriate. Here, either 2C or 2E would be appropriate. The 2015 final instructions clarified that 2E is the proper code.

# Notice 2015-68

Notice 2015-68 sets out a series of items with respect to which the Treasury Department and IRS intend to propose regulations which includes (i) providing that health insurance issuers must report coverage in catastrophic health insurance plans through a public exchange, (ii) allowing electronic delivery of statements reporting coverage under expatriate health plans unless the recipient explicitly refuses consent or requests a paper statement, (iii) allowing filers reporting on insured group health plans to use a truncated taxpayer identification number (TTIN) to identify the employer on the statement furnished to a taxpayer, and (iv) specifying when a provider of minimum essential coverage is not required to report coverage of an individual who has other minimum essential coverage. The Notice also advises the U.S. territories that they are not required to report coverage under Medicaid and CHIP, and it provides that the state government agency sponsoring coverage under the Basic Health Program is required to report that coverage.

For purposes of this post, the most interesting part of Notice 2015-68 is its treatment of HRAs. In an instance of refreshing candor, the Notice explains,

The supplemental coverage rule in § 1.6055-1(d)(2) is intended to eliminate duplicate reporting of an individual's minimum essential coverage under circumstances when there is reasonable certainty that the provider of the "primary" coverage will report. This rule has proven to be confusing. (Emphasis added.)

According to the notice, the Treasury Department and the IRS anticipate proposing regulations that would replace this rule with rules providing that:

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(1) If an individual is covered by multiple minimum essential coverage plans or programs provided by the same provider, reporting is required for only one of them

Under this rule, if an individual is enrolled in a self-insured group health plan and also has a self-insured health reimbursement arrangement (HRA) from the same employer, the provider (the employer) is required to report only one type of coverage for that individual. But if an employee is covered under both arrangements for some months of the year but retires or otherwise drops coverage under the non-HRA group health plan and is covered only under the HRA, the employer must report coverage under the HRA for the months after the employee retires or drops the non-HRA coverage. The employer must also report the coverage of any individual who is covered by only one arrangement.

(2) Reporting generally is not required for an individual's minimum essential coverage for which an individual is eligible only if the individual is covered by other minimum essential coverage for which § 6055 reporting is required.

Under this rule, reporting would not be required for an HRA that is available only to employees and other individuals who enroll in an employer's insured group health plan for months that the individual is enrolled in the insured group health plan. This rule would apply only if the two types of coverage are eligible employer-sponsored coverage of the same employer. If an employee is enrolled in an employer's HRA and in a spouse's non-HRA group health plan, the employee's employer would be required to report for the HRA, and the employee's spouse's employer (or the health insurance issuer or carrier, if the plan is insured) would be required to report for the non-HRA group health plan coverage.

Though not stated explicitly, it should be inferred that the type of coverage elected under the group health plan and the integrated HRA are the same. Thus, for example, if the employee elects self-only coverage, then the HRA must also be self-only. If the group health plan coverage is self-only but the HRA is also available to the employee's spouse and dependents, then presumably the HRA would violate the ACA requirements relating to preventive care and annual limits as to the spouse and dependents.

# Week 11:

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Reporting 2015 Coverage of "MV-Lite" Plans on Form 1095-C

Posted By Alden Bianchi on September 29th, 2015

In Notice 2014-69, the Treasury Department and the IRS clarified that a group health plan that fails to provide substantial coverage for in-patient hospitalization and physician services will not be treated as providing minimum value, despite that the plan might otherwise return a value of 60% from the Department of Health and Human Service's (HHS) online minimum value calculator. These arrangements were sometimes referred to for marketing purposes as "MV-lite" or "MVP-lite" plans. By whatever name, they were particularly attractive to employers with large cohorts of low- and moderate-wage employees who were not previously offered coverage.

Notice 2014-69 provided a transition rule under which a plan that was adopted before November 4, 2014 and that had a plan year beginning no later than March 1, 2015 would not be subject to the new rules until the following plan year. Such a plan was treated for purposes of complying with the Affordable Care Act's employer shared responsibility rules as providing minimum value. But employees covered under an affordable MV-lite plan were not barred from qualifying for premium subsidies from a public insurance exchange.

The 2015 Final Instructions for Forms 1094-C and 1095-C do not provide a way for employers to claim reliance on the Notice 2014-69 transition relief. Coverage under an MV-lite plan will be reported as not providing minimum value, thereby overstating penalties under Internal Revenue Code § 4980H(b) in many, if not most, instances. This will require sponsors of MV-lite plans to engage with the IRS in the assessment process in order to establish that they qualify for the relief.

### **Background**

Under Code § 36B, low- and moderate-income individuals may qualify for a premium tax credit to assist with the purchase of a qualified health plan from a public exchange or marketplace. The credit is not available, however, to individuals who have other coverage that qualifies as "minimum essential coverage" or "MEC." An employer-sponsored group health plan is MEC, but for purposes of the premium tax credit an employee is generally treated as not eligible for MEC under an employer-sponsored plan unless the plan is affordable and provides minimum value (MV). An employer-sponsored plan provides MV only if the plan's "share of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent of the costs." An employee who is eligible for coverage under an employer-sponsored plan that is both affordable and provides MV to the employee may not receive a premium tax credit. If the employer coverage does not provide MV, the employee may be entitled to a premium tax credit even if the coverage is affordable. Final HHS regulations and (originally) proposed Treasury regulations generally allowed plans to determine the MV percentage by using an on-line MV calculator.

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MV-lite plans arrive at 60% or greater MV without covering inpatient hospital and physician services by offsetting the loss in actuarial value caused by the absence of inpatient hospital coverage by increased spending on other benefits. For background on the emergence of MV-lite plans and the reaction of the regulators, please see our prior post on the subject.

Noting that MV-lite plans "fail to meet universally accepted minimum standards of value expected from, and inherent in the nature of, any arrangement that can reasonably be called a health plan intended to provide the primary health coverage for employees," the regulators pledged to modify the MV regulations accordingly. This promise is reflected in recently issued <u>amendments to the proposed regulations</u> under Code § 36B that implement the changes adopted by Notice 2014-69. The preamble to the amended proposed regulations explains:

"[T]hese proposed regulations... provide that an eligible employer-sponsored plan provides minimum value only if the plan's share of the total allowed costs of benefits provided to an employee is at least 60 percent and the plan provides substantial coverage of inpatient hospital and physician services."

# The preamble goes on to flesh out the transition rule:

These regulations are proposed to apply for plan years beginning after November 3, 2014. However, for purposes of section 4980H(b), the changes to the minimum value regulations (in § 1.36B–6(a)(2) of these proposed regulations) do not apply before the end of the plan year beginning no later than March 1, 2015 to a plan that fails to provide substantial coverage for in-patient hospitalization services or for physician services (or both), provided that the employer had entered into a binding written commitment to adopt the noncompliant plan terms, or had begun enrolling employees in the plan with noncompliant plan terms, before November 4, 2014. For this purpose, the plan year is the plan year in effect under the terms of the plan on November 3, 2014. Also for this purpose, a binding written commitment exists when an employer is contractually required to pay for an arrangement, and a plan begins enrolling employees when it begins accepting employee elections to participate in the plan. The relief provided in this section does not apply to an applicable large employer that would have been liable for a payment under section 4980H without regard to § 1.36B–6(a)(2) of these proposed regulations.

### The Final Instructions

The "Definitions" section of the Final 2015 Final Instructions for Forms 1094-C and 1095-C defines "minimum value" as follows: **Minimum value**. A plan provides minimum value if the plan pays at least 60 percent of the costs of benefits for a standard population and provides substantial coverage of inpatient hospitalization services and physician services. An offer of coverage under a plan that fails to provide substantial coverage of inpatient hospitalization and physician services should be reported on Form 1095-C as not providing minimum value, even if an employer qualifies for the section 4980H transition rule under Notice 2014-69 (emphasis added).

What this means, of course, is that series-1 Indicator Codes 1A through 1E for Form 1095-C, Part II, Line 14 are not available to an employer that offered MV-lite coverage but that is relying on the transition rule to escape exposure for assessable payments under Code § 4980H(b). Each of these Codes requires that the employer make an offer of minimum essential coverage that provides minimum value. Rather, the proper series-1 Indicator Code is 1F ("Minimum essential coverage NOT providing minimum value offered to employee; employee and spouse or dependent(s); or employee, spouse and dependents") (emphasis in the original). Consequently, covered employers will be able to claim a premium tax credit in appropriate cases, but the employer will need to subsequently claim reliance on the transitional relief. That is, the employer will first receive an assessment—a "preliminary letter"—from the IRS that will require a response. While the particulars of how this will occur are as yet unknown, the process will in all likelihood be similar to any other appeal of an excise tax. Additionally, we expect that employers will be required to file a declaration confirming that:

- As of November 4, 2014, the plan year of the MV-lite plan in question began no later than March 1, 2015;
- The employer had entered into a binding written commitment (i.e., the employer was contractually required to pay for an arrangement) to adopt the noncompliant plan terms, or had begun enrolling employees in the plan (i.e., accepting employee elections to participate in the plan) with noncompliant plan terms, before November 4, 2014.

One wonders how stringent the IRS will be on this score.

# **Week 12:**

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Deconstructing Form 1095-C, Parts II and III

Posted By Alden Bianchi on October 5th, 2015

This series is devoted principally to the reporting requirements imposed by Internal Revenue Code §§ 6055 and 6056 as added by §§ 1502 and 1514 of the Affordable Care Act (ACA), respectively. The former reports offers of minimum essential coverage, which allows taxpayers to demonstrate that they have complied with the law's individual mandate. The latter solicits

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from applicable large employers the information needed to enforce the law's employer mandate. As we have explained in a <u>previous post</u>, the IRS has prescribed <u>Form 1094-B</u> and <u>Form 1095-B</u> for purposes of reporting minimum essential coverage, and <u>Form 1094-C</u> and <u>Form 1095-C</u> for purposes of reporting by applicable large employers, except that self-funded plans consolidate their reporting on a single form, Form 1095-C. These ACA reporting rules (and related forms) are far more complex than other reporting requirements (and their forms) to which employers are accustomed.

This post attempts to clarify how the Forms 1095-B and 1095-C have been structured by the IRS (and how the forms should be completed) to obtain this data (in particular Form 1095-C, Parts II and III).

While the mechanics of the Code §§ 6055 and 6056 reporting scheme mirror the reporting rules for wages and withholding on IRS Forms W-2 and W-3, they are far more complicated. To comply, employers need to access and collate information from a number of disparate sources such as payroll, HRIS, and other employment records. The IRS also has designed Form 1095-C to elicit information needed to enforce the individual mandate and the administration of premium tax credits available to low-and moderate-income individuals through public insurance exchanges, thereby adding to the complexity. Much of the data that the IRS needs for these disparate purposes is provided, in the case of fully-insured plans maintained by applicable large employers, on Form 1095-B and Form 1095-C, Part II and, in the case of self-funded plans, on Form 1095-C, Parts II and III.

### Form 1095-B

Form 1095-B is prepared by the "Issuer or Other Coverage Provider." In the case of a fully-insured plan, this is the carrier. Part IV of the form lists the covered individuals, i.e. the covered employee, and his or her spouse and/or dependents, as the case may be. Part IV(d) is checked "if the individual was covered for at least **one day** per month for all 12 months of the calendar year." (Emphasis in the original.) Part IV(e) solicits the same information month-by-month in cases where the individual was not covered for at least one day per month for all 12 months of the calendar year. If an individual was not covered during any month of the calendar year, no Form 1095-B would be issued.

In the case of a self-funded plan, the Issuer or Other Coverage Provider is the plan sponsor of a single employer plan or the joint board of trustees of a multiemployer plan. Each participating employer in a multiple employer welfare arrangement or "MEWA" reports separately with respect to its own employees. With some minor exceptions, the information solicited by Form 1095-B is in each case instead provided in Part III of Form 1095-C, discussed below.

### Form 1095-C

The data central to the enforcement of the individual mandate, eligibility for premium tax subsidies and exposure for assessable payments is solicited in Part II of Form 1095-C as follows:

# • Line 14—"Offer of Coverage"

Line 14 is concerned with whether the employee actually had an offer of coverage, irrespective of whether the employer is required to make the offer and without regard to the employer's exposure for assessable payments under the employer shared responsibility rules. For example, there might be no offer of coverage because the employee is in a waiting period, or the employer may offer coverage to part-time employees for whom no offer is required. What constitutes an offer for Line 14 purposes is explained in some detail in the <u>instructions</u>:

An employer offers health coverage for a month only if it offers health coverage that would provide coverage for every day of that calendar month. Thus, if an employee terminates coverage before the last day of the month, the employee does not actually have an offer of coverage for that month. (Emphasis added.)

Thus, for purposes of reporting minimum essential coverage on Form 1095-B, coverage on any day of the month qualifies, but for purposes of making an offer of coverage for purposes of the employer mandate, coverage must be offered for every day of the month.

# Line 15—"Employee Share of the Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage"

This line goes to affordability. If an employer makes an offer of coverage that provides minimum value (think, Bronze level plan), and if that coverage is affordable then the employee is barred—or "firewalled"—from obtaining a premium tax credit from a public insurance exchange even if he or she would otherwise qualify. This is important because, where any particular employee cannot qualify for a subsidy, there can be no penalty under Code § 4980H(b) with respect to that employee. The IRS needs this information to determine whether the employee is firewalled.

The amount included here need not in all cases refer to coverage offered by the employer. An employer participating in a MEWA, for example, would include the self-only premium cost of the MEWA coverage.

## • Line 16—"Applicable Section 4980H Safe Harbor"

This is where the employer explains why, even where coverage is not offered, there is no exposure for an assessable payment under Code § 4980H(b) with respect to that employee. If this line is left blank, then the employer may be assessed a penalty.

# **Examples**

The interaction among Form 1095-C, Lines 14, 15 and 16, and Part III in the case of a self-funded plan is perhaps best illustrated by some examples. In each example below, assume that (i) the plan is self-funded, provides minimum value, and is

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offered to employees, and their spouse and dependents; (ii) the plan imposes a 90-day waiting period; (iii) the employer has elected to determine full-time employee status under the look-back measurement method; (iv) the cost of self-only coverage is \$150 per month; and (v) the employer has elected to use the W-2 affordability safe harbor.

(1) Employee A is an ongoing employee who previously qualified for an offer of coverage for the 2015 stability period. During the 2015 annual open enrollment period, A was offered but declined coverage. A's W-2, Box 1 for 2015 shows income of \$25,000.

The proper Line 14 indicator code is 1E (Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse). This would be entered in the "all 12 months" column. The Line 15 amount would be \$150, and the Line 16 indicator code would be 2F (Section 4980H affordability Form W-2 safe harbor).

Comment: The cost of coverage in this instance is 7.2% ((\$150 x 12)/\$25,000), which is less than 9.5%. Coverage is therefore affordable.

Part III would be left blank, indicating that coverage was declined.

# (2) Employee B was hired on February 15, 2015, expecting to work full-time. B elected single coverage that commenced May 16, 2016.

For January through and including May, the Line 14 indicator code is 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)). For June through December, the proper code is 1E (Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse).

Line 15 is left blank through May. For June to December, the proper amount is \$150.

Line 16 is coded 2A (Employee not employed during the month) for January; 2D (Employee in a section 4980H(b) Limited Non-Assessment Period) (i.e., a waiting period) for February through May, and 2C (Employee enrolled in coverage offered) for the balance of the year.

Part III indicates that coverage was offered commencing in May through and including December. This despite that Line 14 indicates that there was no offer of coverage for May.

**Comment:** The disparate reporting on Line 14 and Part III reflects that an offer of coverage for Line 14 reporting purposes must be for all days during the month while an offer of minimum essential coverage for purposes of Part III requires that the employee be covered on any day of the month.

(3) Employee C is hired February 15, expecting to work full-time. C elects single coverage on May 15, but transfers to part-time status on July 15, whereupon C is provided a COBRA notice (the COBRA premium is \$350 per month). C's earns \$25,000 for the year. C works fewer than 130 hours per month in every month except September and December.

Line 14 is coded 1H (No offer of coverage) for January through and including May, and 1E (Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse) for the balance of the year.

Line 15 is left blank through May; \$150 for June and \$350 for July through December.

For January, the Line 16 code is 2A (Employee not employed during the month). For February through and including May, the proper code is 2D (Employee in a section 4980H(b) Limited Non-Assessment Period). For July, August, October and November (i.e., the months in which C worked part-time), the Line 16 code is 2B (Employee not a full-time employee). For September and December, there is no Line 16 entry, thereby indicating that the employer may be liable for an assessable payment if C applies and qualifies for a premium tax subsidy.

**Comment:** Under the look-back measurement method, an employee who is classified as full-time as of his or her date of hire is tested for full-time status month-by-month until he or she has completed a full standard measurement period. The employer's offer of COBRA coverage is treated as an offer of coverage for Code § 4980H purposes in this instance because C remains an active employee. The bump-up in the premium cost to \$350 per month, however, makes the coverage unaffordable. Had the employer offered to subsidize the COBRA coverage, the proper code for those months would be 2F (Section 4980H affordability Form W-2 safe harbor), the employee would have been firewalled, and the employer would not be liable for assessable payments with respect to C for those months.

The examples in this post were adapted from a series of ten examples originally prepared by **Linda Mendel** of Vorys, LLP, **Helen Morrison**, Ernst & Young LLP and **Tiffany Santos**, Trucker Huss, APC for a March 2015 program sponsored by the American Bar Association Center for Continuing Legal Education, entitled Reporting Common Employment Situations on Form 1095-C.

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# **Week 13:**

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Coding Form 1095-C, Part II for Short- and Long-Term Disability Benefits

Posted by Alden Bianchi on October 13th, 2015

Compliance with the Affordable Care Act's (ACA) employer shared responsibility rules requires that applicable large employers identify their full-time employees. A "full-time employee" for this purpose is an employee who works on average 30 hours per week or 130 hours per month. "Hours of service" includes both hours for which an employee is paid for the performance of services, as well as hours for which an employee is paid for a period during which no duties are performed—including short- and long-term disability leave. Including paid hours for which no work is performed poses some unique reporting challenges, principally due to the need to make adjustments to compensation that affect affordability and the lingering question of the period of time for which hours must be attributed in the case of individuals on long-term disability. This post examines these challenges.

### Background—hours of service

The final Code § 4980H regulations define the term "full-time employee" to mean, "with respect to a calendar month, an employee who is employed an average of at least 30 hours of service per week with an employer." For convenience, the regulation further provides that, "130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week." "Hours of service" for this purpose is defined as follows:

The term hour of service means 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 (as defined in 29 CFR 2530.200b–2(a)).

As a consequence, an otherwise full-time employee who ceases active employment and is placed on paid short- or long-term disability leave continues to accrue hours of service.

# The effect on affordability

Form 1095-C, part II, Lines 15 and 16 solicit information relating to the employee cost of coverage and whether the coverage is deemed to be affordable. This information allows the Internal Revenue Service to determine whether the employee is prevented from receiving premium subsidies for coverage through a public insurance exchange or marketplace. This occurs where the employee either fails to offer coverage to substantially all of its full-time employees, or where the offered coverage either fails to provide minimum value (i.e., major medical coverage) or is unaffordable. Where an employee is so barred or "firewalled," the employer will not incur an excise tax penalty with respect to that employee.

Employer-provided coverage is affordable if the employee's share of the premium for self-only coverage is less than 9.5% of the employee's annual household income. Recognizing that employers don't necessarily know their employees' household income, the final regulations establish the following three affordability safe harbors:

### • The Form W-2 wages safe harbor

The Form W-2 wages safe harbor generally is based on the amount of wages paid to the employee that are reported in Box 1 of that employee's Form W-2.

# • The rate of pay safe harbor

The rate of pay safe harbor generally is based on the employee's rate of pay at the beginning of the coverage period, with adjustments permitted for an hourly employee if the rate of pay is decreased (but not if the rate of pay is increased).

# • The federal poverty line (or "FPL") safe harbor

The federal poverty line safe harbor generally treats coverage as affordable if the employee contribution for the year does not exceed 9.5% of the federal poverty line for a single individual for the applicable calendar year.

An employer is free to choose one or more of these safe harbors for all of its employees or for any reasonable category of employees, provided it does so on a uniform and consistent basis for all employees in a category.

In the ordinary course, short-term disability benefits simply continue paying wages for a specified period of time, e.g. 13 or 26 weeks. In this instance, the reporting of a full-time employee will not change. But long-term disability benefits usually result in some reduction in pay. It is common, for example, for long-term disability benefits to be paid at the rate of 60 percent or 70 percent of an employee's regular pay. Complicating matters is that, while almost all short-term disability benefits are paid in after-tax dollars, long-term disability benefits may be paid after-tax (i.e., where the benefit is entirely employer-paid) or pre-tax (where the benefit is employee paid). Where long-term disability benefits are paid pre-tax, there might be no net reduction. This would occur, for example, in the case of an executive with long-term disability benefits of 70 percent of regular

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salary who is in the 30 percent tax bracket.

Where an active full-time employee is covered under his or her employer's group health plan for a portion of the year and then goes on disability, he or she continues to accrue hours of service. An employer that is applying the W-2 safe harbor or the FPL safe harbor will not make any adjustments to Form 1095-C, Line 15. In the case of the W-2 safe harbor, the final 2015 regulations provide that the W-2 compensation for the year is averaged across working months. Similarly, no adjustments would be required in the case of the FPL safe harbor.

Where the rate of pay safe harbor is concerned, there are separate rules for hourly and non-hourly employees.

# Hourly employees

For an hourly employee, the rate of pay safe harbor is based on the employee's rate of pay at the beginning of the coverage period. Where the rate of pay decreases, the affordability calculus changes, however. The result for reporting purposes will appear in Line 16. By way of example, if an employee is paid at the rate of \$25 per hour on January 1, which is the first day of the plan year, coverage will be affordable if the employee cost of coverage is less than \$308.75 per month. ((\$25 x 130 hours)  $\times 9.5\% = \$308.75$ ). If the employer charges \$300 per month for coverage, the proper Line 16 indicator code for the month is 2H (section 4980H affordability rate of pay safe harbor) indicating that the coverage is affordable based on the rate of pay safe harbor. If the employee goes on short-term disability commencing on February 1 for 13 weeks, then the coding for Lines 15 and 16 does not change for February, March and April. If the employee then qualifies for long-term disability commencing May 1, at which time his pay is reduced to \$20 per hour, then coverage becomes unaffordable. ((\$20 x 130 hours)  $\times 9.5\% = \$247$ ). In that case, assuming no adjustment to the employer subsidy, Line 16 would be left blank, indicating that the employer may face exposure for an assessable payment under Code \$ 4980H(b).

**NOTE:** These examples assume that hours must be imputed during the entire period of disability. The reason for this assumption, and the controversy that it has engendered, is discussed below.

## Non-hourly (salaried) employees

In the case of a non-hourly or salaried employee, the rate of pay safe harbor is satisfied if the employee portion of the premium for self-only coverage does not exceed 9.5 percent of the employee's monthly salary, as of the first day of the coverage period. But where a salaried employee experiences a reduction in compensation, the rate of pay safe harbor is not available. Here is the rule:

An applicable large employer member satisfies the rate of pay safe harbor with respect to a non-hourly employee for a calendar month if the employee's required contribution for the calendar month for the applicable large employer member's lowest cost self-only coverage that provides minimum value does not exceed 9.5 percent of the employee's monthly salary, as of the first day of the coverage period (instead of 130 multiplied by the hourly rate of pay); provided that if the monthly salary is reduced, including due to a reduction in work hours, the safe harbor is not available... (Emphasis added).

Though this result seems harsh, the reason for the rule is not difficult to discern; the employer could set an employee's salary at some unreasonably high amount on the first day of the coverage period, then reduce it immediately thereafter. But a reduction in the case of long-term disability is hardly abusive. So it would seem that an exception might be in order. Absent an exception, the employer would need to rely on one of the other safe harbors. In that case, the instructions for Form 1095-C admonish that, "[i]f an employer uses this [W-2] safe harbor for an employee, it must be used for all months of the calendar year for which the employee is offered health coverage." Presumably, "employees on disability" is a reasonable category of employees.

# Period during which hours must be imputed due to disability

Readers familiar with the regulation of tax-qualified retirement plans will immediately recognize the treatment of hours of service for which pay is received but no services are performed as a rule that has applied to retirement plans since 1978. While the rule appears straightforward on its face, it is worth examining the Department of Labor regulation—i.e., 29 CFR 2530,200b–2(a)—cited in the definition of "hours of service" set out above. It reads, in relevant part:

- (a) General rule. An hour of service which must, as a minimum, be counted for the purposes of determining a year of service, a year of participation for benefit accrual, a break in service and employment commencement date (or reemployment commencement date) under sections 202, 203 and 204 of the Act and sections 410 and 411 of the Code, is an hour of service as defined in paragraphs (a)(1), (2) and (3) of this section. The employer may round up hours at the end of a computation period or more frequently.
- (1) An hour of service is each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer during the applicable computation period.
- (2) An hour of service is each hour for which an employee is paid, or entitled to payment, by the employer on account of a period of time during which no duties are performed (irrespective of whether the employment relationship has terminated) due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence. Notwithstanding the preceding sentence,
  - (i) No more than 501 hours of service are required to be credited under this paragraph (a)(2) to an employee on ac-

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- count of any single continuous period during which the employee performs no duties (whether or not such period occurs in a single computation period);
- (ii) An hour for which an employee is directly or indirectly paid, or entitled to payment, on account of a period during which no duties are performed is not required to be credited to the employee if such payment is made or due under a plan maintained solely for the purpose of complying with applicable workmen's compensation, or unemployment compensation or disability insurance laws; and
- (iii) Hours of service are not required to be credited for a payment which solely reimburses an employee for medical or medically related expenses incurred by the employee.

In a notice issued in 2011, the IRS described a potential rule under which, for any single continuous period during which the employee was paid or entitled to payment but performed no duties, no more than 160 hours of service would be counted as hours of service. Thus, in the above examples, this would have the effect of crediting no further hours of service after a little more than a month. But in response to criticism, this rule was modified in the proposed regulations. The preamble to the proposed regulations provided the following explanation for the modification (78 Fed. Reg. 218, 223 (proposed Jan. 2, 2013): A number of commenters on Notice 2011–36 requested that the 160-hour limit be removed because they viewed it as restrictive, and expressed concern about the potential negative impact on employees who are on longer paid leaves, such as maternity or paternity leave. In response, these proposed regulations remove the 160-hour limit on paid leave, so that all periods of paid leave must be taken into account. (Emphasis added).

While this rule was carried over in the final regulations, it does not appear that it is being uniformly followed. Noting that 29 CFR 2530.200b–2(a) (2) (ii) imposes a 501 hour cap, some argue that there is a limit, i.e., 501 hours. To be sure, it is less than clear what the reference to "29 CFR 2530.200b–2(a)" modifies in the definition of hours of service. So this argument is not without merit. But it is clear that the Treasury Department and the IRS do not read the rule this way. Fortunately, in most cases, the penalties on an employer that imposes a 501 hour cap would in the vast majority of cases be inconsequential, since the cohort of employees on disability at any given time is likely to be very small in comparison to the applicable large employer's workforce.

# **Week 14:**

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Coding Form 1095-C, Part II for Mid-Month Hires, Re-Hires and Terminations

Posted By Alden Bianchi on October 23rd, 2015

When reporting offers of coverage to full-time employees under the Affordable Care Act's (ACA) employer shared responsibility rules, much of the detail appears in Part II of IRS Form 1095-C, Lines 14, 15 and 16. For the most part, the instructions to Forms 1095-C (and also Form 1094-C) are clear enough, but the decision by the regulators to also use Form 1095-C to both solicit information relating to compliance with the ACA's individual responsibility rules and to collect information necessary to administer premium tax subsidies, has made the form more complicated than many had hoped or expected. This is particularly true in the case of reporting for employees with less than full months of coverage.

This post explains the rules that apply when reporting offers of coverage for mid-month hires, re-hires and terminations.

### **Mid-Month Hires**

The instructions provide the following rule relating to mid-month hires:

"An employer offers health coverage for a month only if it offers health coverage that would provide coverage for every day of that calendar month." (Emphasis added).

Even where an employee receives an offer of coverage on his or her first day of employment, the proper Line 14 indicator code for the month is 1H (no offer of coverage). The same is true if the effective date of coverage is deferred until the employee completes an otherwise permissible waiting period. The final regulations implementing the ACA's employer shared responsibility rules do not penalize employers that otherwise make a timely offer of coverage mid-month, however. This is so irrespective of whether the offer of coverage is immediate or follows an otherwise permissible waiting period.

The ACA also added a separate rule limiting waiting periods to 90 days. The final regulations implementing the waiting period rules permit an orientation period of up to 30 days in addition to the 90-day waiting period. While this rule appears to be intended to permit the coordination of the 3-plus month delay under the employer shared responsibility rules with the waiting period rules, most employers appear to be adopting waiting periods of 90 days or less.

The final waiting period rules also adopt a rule for waiting periods that rely on cumulative hours of service. This latter rule generally allows employers to impose a cumulative hours of service requirement of up to 1,200 hours without violating the waiting period requirement. What has not been made entirely clear is whether compliance with the cumulative hours of service

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requirement avoids penalties under Code § 4980H for an employer who elects to determine an employee's status under the monthly measurement method. For an excellent discussion of this question, please <u>click here</u>.

• Coverage offered to employees and dependents that is either unaffordable or fails to provide minimum value: monthly measurement method for new full-time employee under the look-back measurement method

Penalties associated with offers of coverage under the monthly measurement method, and in the case of new full-time employees under the look-back measurement method, are generally subject to a 3-plus month delay. Even where the coverage is unaffordable or fails to provide minimum value, no penalty is imposed under Code § 4980H(a) (generally considered the far more onerous penalty) for the three full calendar month period beginning with the first full calendar month of employment, provided that coverage is offered immediately thereafter. Where the offered coverage does not provide minimum value, Form 1095-C, Part II, Lines 15 and 16 will be left blank, indicating that the employer may be subject to penalties under Code § 4980H(b) during the first three full calendar months of employment. For the months preceding the month that includes the date of hire, the Line 16 series-2 indicator code would be 2A (employee not employed during the month). The subsequent extension of coverage, beginning with the first full month during which coverage is offered, will be reported on Form 1094-C, Part III, where the employer certifies whether it made an offer of coverage to a sufficiently large percentage of employees to avoid exposure to penalties under Code § 4980H(a). Once coverage is offered, the series-1 indicator code would switch to 1F (minimum essential coverage not providing minimum value).

 Coverage offered to employees and dependents that is either unaffordable or fails to provide minimum value: part-time, seasonal or variable hour employees under the look-back measurement method

Part-time, seasonal or variable hour employees are not treated as full-time employees for Code § 4980H purposes during their initial measurement periods. Where coverage is offered to substantially all full-time employees (70% in 2015, 95% in 2016 and later years), but where that coverage is either unaffordable or fails to provide minimum value (as we assume here), no penalty is imposed under Code § 4980H(a) during the initial measurement period and any associated administrative period, provided that coverage is offered immediately thereafter. Similar to the treatment under the monthly measurement method described above, if the offered coverage does not provide minimum value, Form 1095-C, Part II, Lines 15 and 16 will be left blank, indicating that the employer may be subject to penalties under Code § 4980H(b) during the first three full calendar months of employment. For the months preceding the month that includes the date of hire, the Line 16 series-2 indicator code would be 2A (employee not employed during the month). The timely extension of coverage will impact the response to Form 1094-C, Part III relating to whether the employer makes an offer of coverage to a sufficiently large percentage of employees to avoid exposure to penalties. Once coverage is offered, the series-1 indicator code would switch to 1F (minimum essential coverage not providing minimum value).

Coverage offered to substantially all full-time employees that is both affordable and provides minimum value: monthly
measurement method and look-back measurement method

The final Code § 4980H regulations provide that no liability for assessable payments is incurred during a "limited non-assessment period." Where an applicable large employer elects to determine full-time employee status under the monthly measurement method, the limited non-assessment period is the three full calendar month period beginning with the first full calendar month of employment. In the case of an applicable large employer that elects to determine full-time employee status under the look-back measurement method there are two possibilities. For a new employee who is reasonably expected to be full-time, the limited non-assessment period extends to the first of the month following the employee's initial three full calendar months of employment. For a new employee who is reasonably expected to be part-time, seasonal or temporary, the limited non-assessment period extends to the first of the month following the employee's initial measurement period and any associated administrative period.

Where the offered coverage provides minimum value, and provided that coverage is timely offered thereafter, no penalties are imposed during the "4980H(b) limited non-assessment period" despite that the actual offer of coverage is delayed. (For a discussion of what constitutes a 4980H(b) limited non-assessment period, please see our previous post.) For the months preceding the month that includes the date of hire, the Line 16 series-2 indicator code would be 2A (employee not employed during the month). For the initial month of coverage, and during the balance of the 4980H(b) limited non-assessment period, the proper series-1 indicator code on Form 1095-C, Part II, Line 14 is 1H (no offer of coverage); Line 15 is left blank; and the proper series-2 indicator code on Line 16 is 2D (4980H(b) limited non-assessment period).

Once the 4980H(b) limited non-assessment period ends, Line 14 would report the appropriate offer of coverage indicator code (1A (qualifying offer), 1C (minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) (not spouse)) or 1E (minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse)). (Indicator code 1B (minimum essential coverage providing minimum value offered to employee only) may also be used in the case of an employee who qualifies for the dependent coverage transitional rule.) Line 15 would report the "employee share of the lowest cost monthly premium for self-only minimum value coverage." And Line 16 would report the appropriate affordability safe harbor. These include 2F (W-2 safe harbor), 2G (federal poverty line safe harbor), and 2H (rate of pay safe harbor).

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Where a new part-time, seasonal or variable hour hire is either not an employee or is under his or her initial measurement period (i.e., in a limited non-assessment period) for each month during the calendar year, then no Form 1095-C need be filed for the new hire for the year. To qualify for this treatment, the new hire and his or her dependent(s) must be eligible for an offer of health coverage no later than the end of the applicable waiting period or initial measurement period as the case may be.

### Mid-Month Re-Hires

The treatment of re-hires depends on whether there has been a break-in-service for employer shared responsibility purposes. Under both the monthly measurement method and look-back measurement method, a full-time employee returning to a previous employer after a break in service of less than 13 consecutive weeks (or 26 weeks in the case of an educational institution) is treated as a "continuing employee" and not a new hire. A continuing employee being tested under the monthly measurement method, or a continuing employee in a stability period under the look-back measurement method, must generally be offered coverage as of the first day he or she is credited with an hour of service upon returning to work or as soon as administratively practicable thereafter. An offer of coverage made by the first day of the calendar month after returning to work is deemed to be made as soon as administratively practicable. An employee who is rehired following a break-in-service may be treated as a new hire.

If a continuing employee returns to work, without incurring a break-in-service, during a stability period with respect to which he or she previously qualified for (having been timely offered and declined) coverage, a special rule applies. If the employee previously declined the employer's offer of coverage, the employer is treated as having offered coverage for the entire stability period. The employer is not required to make a new offer of coverage for the remainder of the stability period due to the employee's resumption of services.

While the rules governing continuing employees work fine in the case of an employee who is re-hired early in a calendar month, it's less clear how to apply them in the case of a continuing employee who is re-hired, say, on the last day of the month. If, for example, an employer can make the offer of coverage available as of the end of the following week, and if the employee thereupon immediately re-enrolled, coverage would not be offered on each day of the month. So there would be no offer of coverage for the month, and the appropriate series-1 indicator code would be 1H (no offer of coverage). Provided the coverage is both affordable and provides minimum value, the proper series-2 indicator code is 2D (employee in a section 4980H(b) limited non-assessment period).

### **Mid-Month Terminations**

Recall that, if an employee terminates coverage before the last day of the month, the employee is not treated as having an offer of coverage for that month. Where an employee terminates coverage before the last day of the month, the instructions are again helpful:

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).

Thus, in the month of termination, Form 1095-C, Line 14 would be coded 1H (no offer of coverage); Line 15 would be left blank; and Line 16 would be coded 2B (employee not a full-time employee). Mid-month terminations and reductions in hours also implicate COBRA, which will be the subject of our next post in the series.

# **Week 15:**

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Coding Form 1095-C, Part II for Offers of COBRA Coverage

Posted By Alden Bianchi on October 27th, 2015

As we noted in a previous post, the recently issued final 2015 Instructions for Forms 1094-C and 1095-C changed certain of the rules relating to the reporting for offers of COBRA coverage where the COBRA qualifying event occurs in the reporting year. This post explains these changes in detail and also covers the reporting of COBRA in years subsequent to the year in which the qualifying event occurs.

# Background—COBRA's Place in the Code § 4980H Scheme

The publication of final regulations under the Affordable Care Act's employer shared responsibility rules in February 2014 resulted in some initial confusion concerning the place of COBRA in the regulatory scheme. The source of the confusion, and how it manifested, was illustrated in 2015 American Bar Association/Joint Committee on <a href="Employee Benefits Q&As">Employee Benefits Q&As</a> with the Treasury Department/IRS, Question 23.

NOTE: Representative members of the ABA Joint Committee on Employee Benefits and personnel from the Treasury De-

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partment and the IRS meet in May of each year for an informal Q&A session to discuss questions and proposed answers on current topics of interest submitted to the regulators in advance. The ABA members and their Treasury and IRS interlocutors spend a good deal of time and effort in soliciting, curating and responding to these questions, and participation by the regulators is particularly welcome. The sessions are transcribed and are posted to the <u>ABA website</u>. Importantly, the regulators' responses reflect their unofficial, individual views. The responses are not official guidance, and they may not be relied on. Nevertheless, they provide useful insight into the way the government representatives view a particular matter.

The facts in the Q&A are as follows:

Employer B (who has elected to use the look-back measurement method) utilizes a standard measurement period that begins on January 1 and ends on December 31 for purposes of determining its full-time employees. The corresponding standard stability period begins on the immediately following January 1 and ends on the following December 31. Employee A was hired as a full-time employee (i.e., 30 or more hours per week) on April 12, 2014. Employee A elected to enroll in Employer B's group health plan effective as of July 1, 2014. Employee A transferred to a part-time position on February 28, 2015 and became ineligible for coverage. Employee A's group health plan coverage terminates on February 28, 2015 in accordance with the terms of the plan.

The questioner asks, "What measurement period applies to Employee A when he becomes a part-time employee? How does COBRA interact with subsequent offers of coverage that may have to be made during 2015?"

In the proposed response, the questioner correctly assumes that Employee A must be offered COBRA coverage if he loses coverage as a result of his transfer to part-time status. The proposed response next assumes that "[i]f Employee A averages 30 hours of service per week during March 2015, Employer B must offer to reinstate Employee A's group health plan coverage immediately retroactively back to March 1, 2015." The proposed answer also assumes that, thereafter, any coverage that Employee A lost because he did not work 30 hours per week for a particular month would trigger a new offer of COBRA coverage.

The question is a thoughtful one. One need not stray too far (if at all) from the text of the final regulations to find support for it. Nevertheless, the IRS disagreed with the questioner's last two assumptions. Here, in relevant part, is what they had to say: Based on the stated facts, Employee A was ineligible for group health plan coverage under the terms of the plan beginning February 28, 2015. Accordingly, Employer B may owe an assessable payment under Section 4980H(b) for any calendar month in which Employee A averages at least 30 hours a week, assuming that Employee A has purchased coverage on an exchange and receives a premium tax credit for that month. The offer of COBRA continuation coverage does count as an offer of coverage for Section 4980H purposes; however, this offer of coverage would be sufficient to avoid a Section 4980H(b) assessable payment only if the offer was affordable and provided minimum value. If Employer B wishes to avoid an assessable payment under Section 4980H(b), one option would be to offer subsidized COBRA coverage at a low enough cost to satisfy one of the affordability safe harbors. (Emphasis added).

The IRS goes on to observe that, "[t]he proposed answer as initially drafted seems to assume that Section 4980H could override the plan terms and require coverage in any month in which the employee is full-time for Section 4980H purposes. This is not the case." The response explains that Code § 4980H is relevant only for purposes of whether an assessable payment is owed. It does not dictate plan eligibility. The offer of COBRA coverage in the case of a reduction in hours may, however, affect affordability.

### The "old" rules for COBRA reporting

The 2014 Instructions for Forms 1094-C and 1095-C provided rules (explained below) that applied where COBRA coverage is provided to an employee who was employed during any month of the reporting year. In Q&As posted to the <u>IRS website</u>, the IRS established two sets of rules, one for terminating employees and another for employees with a reduction in hours.

### Terminated employees

For an employee who lost coverage as a result of termination, the proper reporting treatment depended on whether the employee enrolled in coverage, and who else enrolled (e.g., employee only, employee and spouse, etc.). Under this rule, an offer of COBRA continuation coverage made due to termination of employment was reported as an offer of coverage on Form 1095-C, Part II only if the former employee enrolled in the COBRA coverage. If COBRA coverage was offered to the former employee's spouse or dependents as well as the former employee, but only the former employee enrolled, the correct series-1 indicator code for Line 14 was 1B (Minimum essential coverage providing minimum value offered to employee only) (assuming, of course, that the coverage qualified as minimum essential coverage). But if the former employee elected COBRA coverage for additional family members, the series-1 indicator code for Line 14 indicated the type of coverage offered to the former employee, dependents and spouse. Lastly, if the former employee did not elect COBRA coverage, but a previously covered individual such as a spouse or dependent elected COBRA coverage, the coverage was not reported on Form 1095-C, Part II.

# Reduction in hours

Where an employer makes an offer of COBRA continuation coverage to an employee who lost eligibility due to a reduction in hours (e.g., a change from full-time to part-time status resulting in loss of eligibility under the plan) the employer was

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instructed to report the offer of COBRA coverage as an offer of coverage in Part II of Form 1095-C.

# The "new" rules for COBRA reporting

The 2015 instructions simplify the reporting for offers of COBRA coverage in the case of terminated employees. An offer of COBRA coverage made to a former employee upon termination of employment is no longer reported as an offer of coverage on line 14. Instead, series-1 code 1H (No offer of coverage) must be entered for any month for which the offer of COBRA continuation coverage applies. The 2015 instructions complete the reporting treatment for terminated employees as follows: "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)."

An offer of COBRA continuation coverage that is made to an active employee (e.g., as a result of a reduction in hours resulting in the loss of eligibility for coverage under the plan) is reported in the same manner and using the same code as an offer of that type of coverage to any other active employee. Of course, if the employee cost increases (as it would if there is no employer subsidy—which is the common case) then the affordability calculus will change. This will be reflected in Form 1095-C, Part II, Line 15, and if the coverage is thereby rendered unaffordable Line 16 may also be affected.

**NOTE:** As of the date of this post, the IRS's Q&As cited above have not been updated to reflect the new COBRA reporting rules.

COBRA coverage provided to employees not employed during any month of the reporting year

The 2015 instructions cover the subject of COBRA coverage provided to employees not employed during any month of the reporting year under the heading of "Reporting of Enrollment Information for Non-Employees." There is no requirement to provide a Form 1095-C to a non-employee, but where coverage is provided, there is an obligation to provide a Form 1095-B and transmit on a Form 1094-B. In the case of a fully-insured plan, the carrier will have the obligation to provide the Form 1095-B and transmit on Form 1094-B.

In the case of a self-funded plan, employers that offer coverage to non-employees who enroll in the coverage (e.g., COBRA, retiree coverage, or coverage provided to non-employee directors) have an option: they may use Forms 1094-B and 1095-B, rather than Form 1095-C, Part III, to report the coverage provided to those individuals and family members, where appropriate. If the employer chooses to use Form 1095-C, Part III to report the coverage, the proper series-1 reporting code is 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-funded coverage for one or more months of the calendar year). The instructions hasten to add that, "[t]he Form 1095-C may be used only if the individual identified on line 1 has an SSN."

# **Week 16:**

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Reporting for, and Clearing Up Confusion Over, Post-65 Retiree Health Reimbursement Arrangements

Posted By Alden Bianchi on November 3rd, 2015

In an <u>earlier post</u>, we reported on a troubling development in the <u>draft 2015 instructions for Forms 1094-B and 1095-B</u> which, if adopted, would have required sponsors of Health Reimbursement Arrangements ("HRA") to issue separate Forms 1095-B and transmit on Form 1094-C when the HRA was integrated with fully-insured coverage. We argued in that post that this made little sense under the circumstances, as covered individuals were already receiving a Form 1095-B for the fully-insured coverage. We were therefore pleased to see the IRS change course in the final <u>2015 Instructions</u>. There, the IRS adopted a rule under which,

"An employer with an insured major medical plan and HRA coverage for which an individual is eligible because the individual enrolls in the insured major medical plan is not required to report the coverage under the HRA for an individual covered by both arrangements."

This rule applies only to coverage provided to active employees and only in instances where the employer sponsors both the fully-insured major medical plan and the HRA, however. Noting residual "confusion" about the reporting obligations that apply to retiree-HRAs, Notice 2015-68 offers some welcome clarification—which is the topic of this post.

# **Background**

While retiree coverage takes many forms, the most common is to provide a traditional indemnity or PPO plan for pre-Medicare eligible retirees and an HRA for Medicare eligible retirees. "Medicare eligible" for this purpose usually means that a retiree is actually enrolled in Medicare or a Medicare Advantage Plan. (For purposes of this post, we will assume that eligibility for the retiree-HRA is conditioned on Medicare enrollment.) In the typical case, the HRA may be applied to the purchase of a Medicare supplemental policy or may be used to pay Part B premiums or other non-covered medical costs.

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The subject of the reporting of post-age 65 retiree-HRAs is addressed in the final Code § 6055 regulations. Treas. Reg. § 1.6055-1(d)(2) provides as follows:

No reporting is required under paragraph (a) of this section [i.e., the regulation's basic reporting requirement] for minimum essential coverage that provides benefits in addition or as a supplement to a health plan or arrangement that constitutes minimum essential coverage if—

- (i) The primary and supplemental coverages have the same plan sponsor; or
- (ii) The coverage supplements government-sponsored coverage (as defined in section 5000A(f)(1)(A) and the regulations under that section) such as Medicare.

Minimum essential coverage includes coverage under an "eligible employer-sponsored plan," which is defined to mean a group health plan that provides "medical care" (which a retiree-HRA does), but it does not include a plan that provides only excepted benefits (which a retiree-HRA does not). A retiree-HRA satisfies clause (ii) of the regulation cited above, since the coverage that the HRA supplements is Medicare. So if one reads only the final regulations, it would seem that reporting is not required. But the 2015 final instructions are less than clear on the subject. Here is what they have to say:

# Coverage in More Than One Type of Minimum Essential Coverage

If an individual is covered by more than one type of minimum essential coverage, reporting is required of only one of the types, if one of the following rules applies.

- If an individual is covered by more than one type of minimum essential coverage provided by the same provider, the provider is required to report only one of the types of coverage.
- A provider of minimum essential coverage generally is not required to report coverage for which an individual is eligible only if the individual is covered by other minimum essential coverage for which reporting is required. (For employer-sponsored coverage, this exception applies only if both types of coverage are under group health plans of the same employer).

Under the first exception, if an individual is covered by a self-insured major medical plan and a health reimbursement arrangement (HRA) provided by the same employer, the employer is the provider of both types of coverage and therefore is required to report the coverage of the individual under only one of the arrangements.

The second exception applies in the following situations.

- An insurance company offering a Medicare or TRICARE supplement for which only individuals enrolled in Medicare or TRICARE are eligible is not required to report coverage under the Medicare or TRICARE supplement.
- A state Medicaid agency is not required to report Medicaid coverage for which only individuals enrolled in other minimum essential coverage, such as employer-sponsored coverage or a qualified health plan, are eliqible.
- An employer with an insured major medical plan and HRA coverage for which an individual is eligible because the individual enrolls in the insured major medical plan is not required to report the coverage under the HRA for an individual covered by both arrangements.

The problem with the second paragraph is that it appears to limit the second exception, perhaps unnecessarily. The first bullet point refers to "an insurance company offering a Medicare... supplement" and the third-bullet point refers to enrollment in an insured major medical plan. Noticeably absent is an exception for an employer-sponsored retiree-HRA, eligibility for which is conditioned on Medicare enrollment.

### Notice 2015-68 to the rescue

While not referring expressly to retiree-HRAs, Notice 2015-68 acknowledges the problem and offers a solution:

The supplemental coverage rule in § 1.6055-1(d)(2) is intended to eliminate duplicate reporting of an individual's minimum essential coverage under circumstances when there is reasonable certainty that the provider of the "primary" coverage will report. This rule has proven to be confusing. Accordingly, the Treasury Department and the IRS anticipate proposing regulations that would replace this rule with rules providing that (1) if an individual is covered by multiple minimum essential coverage plans or programs provided by the same provider, reporting is required for only one of them; and (2) reporting generally is not required for an individual's minimum essential coverage for which an individual is eligible only if the individual is covered by other minimum essential coverage for which § 6055 reporting is required. (Emphasis added).

Under the regulation as currently constituted, reporting is not required in the case of supplemental minimum essential coverage in two discrete instances. The first is where the supplemental coverage and the primary coverage have the same plan sponsor. The second is where the coverage "supplements government-sponsored coverage... such as Medicare." The proposed change to the final regulation, which is anticipated by the final 2015 instructions, appears to narrow the first prong, since the coverage must be from the same "provider" rather than the same plan sponsor. It enlarges the second prong, however, also in a way that is anticipated by the final regulations.

The 2015 final instructions to Form 1094-B and 1095-C and the changes to the final Code § 6055 regulations presaged by Notice 2015-68 are nearly identical, but the latter is not burdened by any further clarifications. According to Notice 2015-68, therefore, an employer-sponsored retiree-HRA that conditions participation on Medicare enrollment need not be separately reported on Form 1095-B, which is what we thought the current regulation said.

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# **Week 17:**

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Reporting for Offers of Coverage and Auto-enrollment

Posted By Alden Bianchi on November 11th, 2015

The recently enacted Bipartisan Budget Act of 2015 repealed Section 1511 of the Affordable Care Act (ACA), which generally would have required employers with more than 200 full-time employees to automatically enroll new full-time employees in one of the employer's health benefits plans (subject to any waiting period authorized by law). The provisions were originally slated to take effect in 2014. In <u>Technical Release No. 2012-01</u> (Feb. 9, 2012), the Department of Labor announced that compliance would not be required "until final regulations under FLSA section 18A are issued and become applicable." Final regulations were never issued.

Despite that auto-enrollment is no longer required under the ACA, some carriers are insisting on it as a precondition to offering their products. This approach lends itself to boosting enrollment in instances where coverage was not previously widely offered—e.g., industries with large cohorts of variable and contingent workers—and in which anticipated take-up rates are low and the expectation of adverse selection is high.

This post explores the impact of carrier-required auto-enrollment on reporting.

### **Background**

Generally, if an applicable large employer makes an offer of group health plan coverage that provides minimum value (e.g., major medical coverage) and is affordable, then the employee is barred—or "firewalled"—from obtaining a premium tax credit from a public insurance exchange even if he or she would otherwise qualify for the subsidy. This is important because, where any particular employee cannot qualify for a subsidy, there can be no penalty under Code § 4980H(b) with respect to that employee. Here, it is the mere offer of coverage that results in the employee being firewalled.

If an applicable large employer makes an offer of group health plan coverage that qualifies as minimum essential coverage but fails to provide minimum value (e.g., major medical coverage) and/or is unaffordable, then the employee is firewalled only if he or she accepts the employer's offer of coverage. Thus, an employer could, at least in theory, auto-enroll an employee in such a plan and thereby avoid penalties. Because each auto-enrolled individual would have minimum essential coverage, he or she would be ineligible for premium subsidies.

In the preamble to a notice of proposed rulemaking issued May 3, 2013 relating to <u>minimum value</u>, the Treasury Department and IRS rejected auto-enrollment of employees into a plan that was either unaffordable or failed to provide minimum value, or both, saying:

Any arrangement under which employees are required, as a condition of employment or otherwise, to be enrolled in an employer-sponsored plan that does not provide minimum value or is unaffordable, and that does not give the employees an effective opportunity to terminate or decline the coverage, raises a variety of issues... Such an arrangement would also raise additional concerns. For example, it is questionable whether the law permits interference with an individual's ability to apply for a section 36B premium tax credit by seeking to involuntarily impose coverage that does not provide minimum value... If an employer sought to involuntarily impose on its employees coverage that did not provide minimum value or was unaffordable, the IRS and Treasury, as well as other relevant departments, may treat such arrangements as impermissible interference with an employee's ability to access premium tax credits, as contemplated by the Affordable Care Act.

The final Code § 4908H regulations formally adopt this approach in the context of the ACA's employer shared responsibility rules:

An applicable large employer member will not be treated as having made an offer of coverage to a full-time employee for a plan year if the employee does not have an effective opportunity to elect to enroll in the coverage at least once with respect to the plan year, or does not have an effective opportunity to decline to enroll if the coverage offered does not provide minimum value or requires an employee contribution for any calendar month of more than 9.5 percent of a monthly amount determined as the federal poverty line for a single individual for the applicable calendar year, divided by 12. For this purpose, the applicable federal poverty line is the federal poverty line for the 48 contiguous states and the District of Columbia. Whether an employee has an effective opportunity to enroll or to decline to enroll is determined based on all the relevant facts and circumstances, including adequacy of notice of the availability of the offer of coverage, the period of time during which acceptance of the offer of coverage may be made, and any other conditions on the offer.

# Treas. Reg. § 54.4980H-4(b)(1).

And the 2015 final Instructions to Form 1094-C and 1095-C are in accord:

Offer of health coverage. An employer makes an offer of coverage to an employee if it provides the employee an effective opportunity to enroll in the health coverage (or to decline that coverage) at least once for each plan year. An employer makes an offer of health coverage to an employee for the plan year if it continues the employee's election of coverage from a prior year but provides the employee an effective opportunity to opt out of the health coverage. If an employer

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provides health coverage to an employee but does not provide the employee an effective opportunity to decline the coverage, the employer is treated as having made an offer of health coverage to the employee only if that health coverage provides minimum value and does not require an employee contribution for the coverage for any calendar month of more than 9.5 percent of a monthly amount determined as the mainland federal poverty line for a single individual for the applicable calendar year, divided by 12. (Emphasis added).

Thus, automatic enrollment in an employer's group health plan would qualify (and is reported as) an offer of coverage for purposes of the employer shared responsibility rules only if the coverage provides minimum value and is affordable based on "the mainland federal poverty line for a single individual for the applicable calendar year." This means affordability for this purpose is being measured under an even more restrictive standard than is required under the federal poverty line affordability safe harbor. The federal poverty line safe harbor set out in <a href="Ireas.Reg.">Ireas. Reg. § 54.4980H-5(e)(2)(iv)</a> requires that the employee's required contribution not exceed "9.5 percent of a monthly amount determined as the federal poverty line for a single individual for the applicable calendar year, divided by 12." The regulation provides that the "applicable federal poverty line is the federal poverty line for the State in which the employee is employed." (Emphasis added). For purposes of assessing offers of coverage, the standard that applies is the <a href="mainland">mainland</a> federal poverty line for a single individual for the applicable calendar year.

The carrier-imposed auto-enrollment requirements that we have encountered are generally couched in the form of an optout election. That is, the employee is provided with a form that explains that he or she will be automatically enrolled, and that he or she may decline coverage. One supposes that, done right and in good faith, this approach should result in the employee receiving an "effective opportunity to decline the coverage." Whether this is the case, however, is determined based on all the relevant facts and circumstances, "including adequacy of notice of the availability of the offer of coverage, the period of time during which acceptance of the offer of coverage may be made, and any other conditions on the offer."

# Reporting on Form 1095-C

If an auto-enrollment feature is properly structured to furnish the employee with an effective opportunity to decline the coverage, then the proper 1-series indicator code entered on Form 1095-C, Part II, Line 14 will disclose that an offer of coverage was made. The proper code will be 1A though 1E. Where the coverage is accepted, the proper 2-series indicator code entered on Form 1095-C, Part II, Line 16 is 2C (employee enrolled in coverage offered). If the coverage is declined, the proper 2-series indicator code entered on Form 1095-C, Part II, Line 16 would be the appropriate safe harbor code, if the coverage is intended to be affordable.

But if the auto-enrollment feature fails to provide an effective opportunity to decline the coverage, then the proper 1-series code is 1H (no offer of coverage) <u>unless</u> the coverage provides minimum value and is affordable based on the mainland federal poverty line for a single individual. The proper 2-series code on Form 1095-C, Part II, Line 16 in this instance would not be 2C (employee enrolled in coverage offered), since there was no "offer of coverage" for Code § 4980H(b) purposes that the employee could accept. Lines 15 and 16 would be left blank.

### Conclusion

It does not take too much imagination to anticipate the problems with automatic enrollment under the scenarios described above. An employee might not return the form declining coverage for months (he or she may not have paid any attention to it). He or she might then apply and even qualify for subsidized coverage from a public insurance exchange. It may be some time before the employee realizes that he or she was not entitled to the subsidy. This will prove most troublesome to an employee who first discovers that he or she was not subsidy-eligible at the end of the year when he or she receives a Form 1095-C.

# **Week 18:**

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Terminations, Changes in Status and Service Breaks under the Monthly Measurement Method

Posted By Alden Bianchi on November 20th, 2015

The <u>final regulations</u> under Code § 4980H establish two—and only two—methods for determining an employee's status as full-time: the monthly measurement method and the look-back measurement method. Under the former (as the name suggests) an employee's status as full-time is determined month-by-month. An employee who works on average at least 30 hours per week, or 130 hours per month, is full-time. (An employer may alternatively use 120 hours per month in months with 4 weeks and 150 hours per month in months with 5 weeks.) The monthly measurement method is particularly well-suited to employers and industries with stable workforces and low turnover. In most instances, the reporting burdens for these employers will be relatively manageable. But even in this environment, employees will from time-to-time terminate, change status, or incur service breaks. This post explores the reporting challenges associated with employee terminations, changes in status, and breaks in service under the monthly measurement method. Next week's post will do the same for the look-back measurement method.

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### **Background**

As we have explained in a <u>previous post</u>, obtaining the information elicited by Part II of Form 1095-C (Lines 14, 15 and 16) is particularly challenging since the required data is unique to each employee and the reporting is done month-by-month. Part II furnishes the IRS with information relating to the administration of three separate provisions of the Internal Revenue Code, i.e., Code § 5000A (the individual mandate), Code § 36B (eligibility for premium subsidies), and Code § 4980H(b) (the second of the two layers of penalties under the employer shared responsibility rules).

- Line 14 solicits information about what coverage the employer actually There are, of course, instances in which the failure to offer coverage in a month does not result in any exposure, e.g., the failure to offer coverage during a waiting period. Line 14 is agnostic on this score.
- Line 15 asks for the "Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage." This enables the IRS to determine whether coverage is affordable.
- Line 16 asks the employer to explain why it might not have exposure under Code § 4980H(b). The employer establishes this to be the case by providing the appropriate "Applicable Section 4980H Safe Harbor" code, if applicable. Where line 16 is left blank, the employer will incur a penalty under Code § 4980H(b) for the month if the employee has qualified for a premium subsidy from a public insurance exchange or marketplace.

For the balance of this post, we will assume that the employer is an applicable large employer (i.e., an employer subject to the employer shared responsibility rules) and that the employer makes an offer of minimum essential coverage to its full-time employees and their spouses and dependents that is both affordable (based on the W-2 safe harbor) and provides minimum value. We will also assume that the employer's group health plan under which the minimum essential coverage is provided covers only full-time employees. A transfer to part-time would, therefore, result in a loss of coverage. Lastly, we will assume that the plan imposes a 90-day waiting period and that the employer is not an educational institution. In sum, the employer in this case has adopted a compliance strategy that is intended to entirely avoid exposure under Code §§ 4980H(a) and (b). (That the employer is not subject to penalties under Code § 4980H(a) will be reported on Form 1094-C.)

## The (Boring) Basics of Reporting

For 1095-C reporting purposes, the simplest case is an employee who is full-time for all 12 months of the calendar year. In the "All 12 months" box for Line 14, the employer would enter 1-series indictor code 1E (Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse). And, in the "All 12 months" box for Line 15, the employer would insert the employee premium (i.e. his share of the lowest-cost premium for self-only coverage offered to him), which we have already assumed is affordable. If the employee accepted the coverage, the proper 2-series indicator code, in the "All 12 months" box, would be 2C (Employee enrolled in coverage offered). If the employee declined the coverage, the proper 2-series indicator code would be 2F (Section 4980H affordability Form W-2 safe harbor).

While the monthly measurement period reports whether the employer has made an offer of coverage, this does not require the employer to make a new offer every month. The <u>final instructions to Form 1095-C</u> explain the rules (pp. 14, 15): "An employer makes an offer of coverage to an employee if it provides the employee an effective opportunity to enroll in the health coverage (or to decline that coverage) at least once for each plan year." (Emphasis added).

# Mid-year termination

Reporting in the event of a mid-year termination is not complicated, but the employer—or, more likely, the software solution that the employer is relying on—has a little more work to do when compared to the example above. For starters, here the employer can no longer use the "All 12 months" box for any of lines 14, 15 or 16. If employment terminated on, say, the last day of June, each of the months during the first half of the year would look like the previous example. For July to December, however, Line 14 would be coded 1H (No offer of coverage); Line 15 would be left blank, and Line 16 would be coded 2A (Employee not employed during the month). As a result of a change made in the final 2015 Instructions for Forms 1094-C and 1095-C (which we explained here), it does not matter whether or not the employee in this case elected or declined COBRA.

Things get marginally more complicated if the employee terminates mid-month, say July 15. Here, January through and including June would be similar to the immediately preceding example, as would August through December. But for July, Line 14 would be coded 1H (No offer of coverage), since the coverage was not offered for each day of the month. Line 15 would be left blank. And Line 16 would be coded 2B (Employee not a full-time employee). The instructions provide as follows in this case:

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).

### Changes in status

Now let's assume that our full-time employee, who previously enrolled in coverage, transfers to a part-time position on July 1, and remains a part-time employee for the balance of the year. The employee would qualify for an offer of COBRA cover-

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age. For January through June, the reporting treatment would be the same as the previous example involving termination. For the balance of the year, Line 14 would continue to be coded 1E (an offer of COBRA coverage to a former employee is ignored, but an offer of COBRA coverage to an ongoing employee counts as an offer of coverage). On Line 15, the employer would report the self-only COBRA coverage rate. If the employee accepted the COBRA coverage, Line 16 would be coded 2C; if declined, Line 16 would be coded 2B (Employee not a full-time employee).

A change from part-time to full-time also has reporting consequences. Flipping the facts, assume that the employee was part-time from January to June, and full-time from July through December. From January through June, Line 14 would be coded 1H (No offer of coverage); Line 15 would be left blank, and Line 16 would be coded 2B (employee not a full-time employee). For July, August and September, Line 14 would similarly be coded 1H (No offer of coverage); Line 15 would continue to be left blank, but Line 16 would be coded 2D (Employee in a section 4980H(b) Limited Non-Assessment Period). For the remainder of the year, for Line 14, the employer would enter 1-series indictor code 1E (Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse). For Line 15, the employer would report the lowest cost employee premium for self-only coverage. If the employee accepted the coverage, Line 16 would be coded 2C (Employee enrolled in coverage offered); if the employee declined coverage, Line 16 would be coded 2F (Section 4980H affordability Form W-2 safe harbor).

#### Breaks in service

Generally, an employer is permitted but not required to treat an employee who is rehired after incurring a "break-in-service" as a new employee if the employee was not credited with an hour of service for at least 13 consecutive weeks. For educational institutions, a break must be at least 26 weeks. Under an alternative "rule of parity," a break in service is deemed to occur for periods shorter than 13 consecutive weeks if the employee was not credited with an hour of service for a period of at least four consecutive weeks, and that period is longer than the employee's previous period of employment immediately preceding the break. The break in service rules apply solely for the purpose of determining whether an individual should be treated as a continuing or new employee. They have no bearing on whether the employee is a full-time employee.

Returning to our example, assume that our employee works full-time from January to June and terminates employment on June 30, and that he or she was offered and elected coverage. The employee resumes full-time employment November 1, after a 4-month (i.e., longer than 13 weeks) break-in-service. Here, the employer has a choice. It can treat the employee either as a new, full-time employee or a continuing employee.

#### • Treatment as a new employee

For January to June, Line 14 would be coded 1E (Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse). For Line 15, the employer would report the lowest cost employee premium for self-only coverage. Line 16 would be coded 2C (Employee enrolled in coverage offered). For July, August, September, and October Line 14 would be coded 1H (No offer of coverage); Line 15 would be left blank, and Line 16 would be coded 2A (Employee not employed during the month). For the remainder of the year, Line 14 would be coded 1H (No offer of coverage) and Line 15 would be left blank. Line 16 would be coded 2D (Employee in a section 4980H(b) Limited Non-Assessment Period), since the employee would be in a waiting period.

#### • Treatment as a continuing employee

For January to October, the reporting treatment is the same as in the case of treatment as a new employee. The employer would need to offer coverage no later than December 1, under a rule that says that coverage must be offered no later than the first day of the month following the resumption of services. For the month of November, the employer would use indicator code 2D (Employee in a section 4980H(b) Limited Non-Assessment Period) in Line 16 to demonstrate that the employer need not offer coverage in November (Line 14 would be coded 1H (No offer of coverage) and Line 15 would be left blank). For December, the employer would make an offer of coverage, which would be appropriately reflected in the coding.

#### **Week 19:**

The Affordable Care Act's Reporting Requirements for Carriers and Employers: Terminations, Changes in Status and Service Breaks under the Look-back Measurement Method

Posted By Alden Bianchi on December 2nd, 2015

<u>Last week</u> we examined the reporting challenges associated with employee terminations, changes in status, and breaks in service under the monthly measurement method. As we explained, "[t]he <u>final regulations under Code § 4980H</u> establish two—and only two—methods for determining an employee's status as full-time: the monthly measurement method and the look-back measurement method." This week, we turn our attention to selected issues involving terminations, changes in status, and breaks in service under the look-back measurement method.

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Under the look-back measurement method an employee's status is determined based first on whether he or she is newly hired or has been employed for some time (an "ongoing employee"). In the case of new hires, employees are further classified as full-time, part-time, seasonal or variable hour. The status of a newly hired part-time, seasonal or variable hour employee is determined based on a measurement period of up to 12 months commencing with the date of hire or the first day of the month following the date of hire, during which coverage need not be offered and no penalties are imposed. Where the newly hired employee qualifies as full-time during the measurement period, he or she must be offered coverage during a corresponding stability period (irrespective of hours worked, provided the employee is still employed). A similar approach applies to ongoing employees, except that the measurement and stability period are fixed in advance. Newly hired full-time employees are treated much the same way as they would be treated under the monthly measurement method, i.e., the determination of full-time status is made month-by-month. (The particulars of the look-back measurement method are explained here.)

#### **Background**

Obtaining the information elicited by Part II of Form 1095-C (Lines 14, 15 and 16) is particularly challenging since the required data is unique to each employee and the reporting is done month-by-month. (Click here for the reasons why.) Part II furnishes the IRS with information relating to the administration of three separate provisions of the Internal Revenue Code, i.e., Code § 5000A (the individual mandate), Code § 36B (eligibility for premium subsidies), and Code § 4980H(b) (the second of the two layers of penalties under the employer shared responsibility rules).

- Line 14 solicits information about what coverage the employer *actually* provides. There are, of course, instances in which the failure to offer coverage in a month does not result in any exposure, e.g., the failure to offer coverage during a waiting period. Line 14 is agnostic on this score.
- Line 15 asks for the "Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage." This enables the IRS to determine whether coverage is affordable.
- Line 16 asks the employer to explain why it might not have exposure under Code § 4980H(b). The employer establishes this to be the case by providing the appropriate "Applicable Section 4980H Safe Harbor" code, if applicable. Where Line 16 is left blank, the employer will incur a penalty under Code § 4980H(b) for the month if the employee has qualified for a premium subsidy from a public insurance exchange or marketplace.

#### The Basics of Reporting

The look-back measurement method is particularly useful in the case of employees with irregular or intermittent work schedules. Where an employee is determined to be part-time, seasonal or variable hour as of his or her date of hire, the employer incurs no Code § 4980H penalties despite failing to make an offer of group health plan coverage. The employee in this instance is <u>not</u> treated as a full-time employee during his or her initial measurement period. As a consequence, where an employee's initial measurement period does not end in the calendar year of hire, the employer does not provide a Form 1095-C to the employee for the year. The employee in this instance is in a limited non-assessment period. According to the final <u>2015</u> <u>Instructions for Forms 1094-C and 1095-C</u> (the "instructions"), "[F]or purposes of reporting on Forms 1094-C and 1095-C, an employee in a Limited Non-Assessment Period is not considered a full-time employee during that period."

Once a newly hired employee completes his or her initial measurement period, then the employer must make an offer of coverage for the corresponding stability period irrespective of actual hours if the employee worked on average 30 or more hours per week during the initial measurement period.

**NOTE:** While the consequences of failing to offer coverage during a stability period to an employee who has qualified as full-time are not specified in any formal guidance, representatives of the Treasury Department and IRS, in non-binding, off-the-record comments, have asserted that the benefit of the look-back measurement method is retroactively unavailable with respect to affected employees, thereby requiring an amended Form 1094-C and 1095-C for the prior year. In addition, depending on the facts-and-circumstances, there might be penalties for filing an inaccurate Form. (For a discussion of penalties, please our previous post on the subject.)

During the stability period, the proper 1-series indicator code for Form 1095-C, Part II, Line 14 would be the code that would otherwise apply to any other full-time employee, even in a month in which the employee does not work full-time hours. Line 15 would reflect "the amount of the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that is offered to the employee." If the employee accepted coverage, the proper 2-series indicator code for Form 1095-C, Part II, Line 16 would be 2C (Employee enrolled in coverage offered). If the employee declined coverage, and assuming that the coverage provided minimum value and was offered to the employee and his or her dependents, the proper 2-series indicator code would be the applicable affordability safe harbor code (if the coverage is affordable) or Line 16 would be left blank (if the coverage was not affordable). The employer would follow a similar approach to ongoing employees who have qualified for coverage in the stability period that follows and corresponds to the preceding standard measurement period.

Of course, it is always possible that the employer might be more generous than required and make an offer of coverage to a part-time, seasonal or variable hour employee during his or her initial measurement period. If the employee, who is not a

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full-time employee during any month of the year, accepts the coverage, the reporting depends on whether the coverage is fully-insured or self-funded.

- If the coverage is fully-insured, then no Form 1095-C is required. (The carrier will provide the Form 1095-B to this employee.)
- If the coverage is self-funded, then the proper 1-series code is 1G (Offer of coverage to employee who was not a full-time employee for any month of the calendar year... and who enrolled in self-insured coverage for one or more months of the calendar year). Line 15 and 16 would be left blank.

#### Mid-year termination

An employee in an initial measurement period for all months of employment during a calendar year will not receive a Form 1095-C, so his or her termination will have no effect on reporting. An employee whose employment terminates during a stability period with respect to which he or she previously qualified for coverage need no longer be offered coverage. From and after the month in which termination occurs, Line 14 would be coded 1H (No offer of coverage), Line 15 would be left blank, and Line 16 would be coded 2A (Employee not employed during the month). If the termination takes place mid-month, then the 2-series code in the month of termination would be 2B (Employee not a full-time employee). As a result of a change made in the instructions, it matters not whether the employee elected COBRA.

#### Changes in status

The final regulations under Code § 4980H provide a special rule in the case of an employee who is initially classified as part-time, seasonal or variable hour and who transfers to a full-time position during his or her initial measurement period. Under this special rule, the employer will not be subject to an assessable payment for the period before the first day of the fourth full calendar month following the change in employment status or, if earlier, the date on which coverage would have been provided had there been no change and the employee otherwise qualified for an offer of coverage. For example, assume that Employee A was hired by Employer X on January 1 as a variable hour employee and transferred to full-time on July 1, and worked full-time for the balance of the year. A is offered and accepts Employer X's offer of minimum essential coverage commencing October 1 (following the appropriate waiting period). Employer X's group health plan coverage provides minimum value, imposes a 90-day waiting period, and it is offered to the employee and the employee's spouse and dependents.

For January through September, Line 14 would be coded 1H (No offer of coverage); Line 15 would be left blank; and Line 16 would be coded 2D (Employee in a Section 4980H(b) Limited Non-Assessment Period). For October, November and December, Line 14 would be coded 1E (Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse); Line 15 would report the amount of the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value; and Line 16 would be coded 2C (Employee enrolled in coverage offered).

#### Breaks in service

Under both the monthly measurement method and the look-back measurement method, an employer is permitted, but not required, to treat an employee who is rehired after incurring a "break-in-service" as a new employee if the employee was not credited with an hour of service for at least 13 consecutive weeks. For educational institutions, a break must be at least 26 weeks. Under an alternative "rule of parity," a break in service is deemed to occur for periods shorter than 13 consecutive weeks if the employee was not credited with an hour of service for a period of at least four consecutive weeks, and that period is longer than the employee's previous period of employment. The break in service rules apply solely for the purpose of determining whether an individual should be treated as a continuing or new employee. They have no bearing on whether the employee is a full-time employee.

Although the break-in-service rules that apply under the look-back measurement method are generally the same as those that apply to the monthly measurement method, there is an important difference. The break-in-service rules that apply under the look-back measurement method include service-spanning rules that apply to unpaid leaves. The monthly measurement method tests full-time status month-by-month, including months when no hours are being accrued (regardless of the reason for the non-accrual).

The reporting consequences of the service-spanning rules might best be illustrated by an example: Employee B is an ongoing employee of Employer Y. B qualified for, and enrolled in, coverage under Y's group health plan based on the immediately preceding standard measurement period. Y's group health plan is affordable based on the W-2 safe harbor, and it provides minimum value. Coverage is offered to the employee, spouse and dependents. On May 1, B goes out on FMLA leave for three months (May, June and July). B stays out for another 2 months (August and September), returning to full-time employment on October 1. Employee B retains coverage under Y's group health plan while on FMLA leave, drops coverage on August 1 and resumes coverage November 1. Because of the rules governing unpaid leaves of absence, B's break in service is only 8 weeks (August and September). For coding purposes, January through April would be coded 1E (Line 14)/2C (Line 16) and Line 15 would be completed. The same is true for the period of FMLA leave, i.e., May, June and July, and for November and December. For August and September, Line 14 would be coded 1H (No offer or coverage), Line 15 would be left blank, and Line 16 would be coded 2A (Employee not employed during the month). And for October, Line 14 would be coded 1H (No offer or coverage), Line 15 would be left blank, and Line 16 would be coded 2D (Employee in a section 4980H(b) Limited

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Non-Assessment Period). (The coding for October reflects the requirement that applies absent a break-in-service that coverage must be offered by the first day of the month following the rehire date.)

#### (Limited) Special Rule for Re-Hires

The final Code § 4980H regulations include a special rule that is useful in situations in which an employee retires and transfers to part-time, either immediately or following a brief hiatus. Under the rule, an employer using the look-back measurement method is permitted to apply the monthly measurement method to that employee beginning on the first day of the fourth full calendar month following the change in employment status. This rule applies, however, only where the employer originally offered coverage as of the first day of the calendar month following the employee's initial three full calendar months of employment and continuously thereafter.

By way of example: Employee C has worked for Employer Z for 20 years, and plans to retire January 1. Employer Z, needing C's services for an unspecified transition period, asks C to instead transfer to part-time. C agrees. Employer Z has elected to apply the look-back measurement method to determine full-time status, under which C has previously qualified for an offer of coverage. To entice C to accept, Z offers to subsidize C's first three months of family coverage such that C pays the same rate that is charged to active employees. Beginning April 1, Z determines C's status as full-time under the monthly measurement method, despite that C is in a stability period with respect to which C would otherwise be treated as full-time. Employer Z's group health plan is affordable based on the W-2 safe harbor, and it provides minimum value.

The coding consequences would be as follows: For January, February and March, Form 1095-C, Part II, Line 14 is coded 1E (Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse). (C's COBRA rights under Employer's Z's group health plan qualify as an offer of coverage.) Line 15 provides the amount of the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that is offered to the employee—which would reflect the subsidy. If C accepts coverage, then Line 16 would be coded 2C (Employee enrolled in coverage offered) and if C declines coverage, the proper 2-series code would be 2F (Section 4980H affordability Form W-2 safe harbor).

Under the above-described special rule, Employer Z is free to determine Employee C's status as full-time from April through December under the monthly measurement method. If C remains on COBRA for the balance of the year, Line 14 would continue to be coded 1E, Line 15 would reflect the full cost of the COBRA premium for self-only coverage, and Line 16 would continue to be coded 2C. If C terminated the COBRA coverage for the balance of the year, Line 14 would still be coded 1E and Line 15 would again reflect the unsubsidized self-only COBRA rate. But Line 16 would be coded 2B (Employee not a full-time employee).

#### Week 20:

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Reporting Affordability on Form 1095-C, Part II, Line 16 Using 2-Series Codes 2F, 2G, and 2H

Posted By Alden Bianchi on December 2nd, 2015

Affordability—i.e., whether health coverage is "affordable"—occupies an important place in the Affordable Care Act's (ACA) regulatory scheme. Under that law's individual mandate, no penalties are imposed for failure to maintain coverage that is not affordable. And low- and moderate-income individuals may qualify for premium subsidies on a sliding affordability scale. For applicable large employers, the group health plan coverage that they offer affects their exposure for assessable payments under the ACA's employer shared responsibility rules. Generally, if an applicable large employer makes an offer of group health plan coverage that provides minimum value (e.g., major medical coverage) and is affordable, then the employee is barred—or "firewalled"—from obtaining a premium tax credit from a public insurance exchange even if he or she would otherwise qualify for the subsidy. This is important because, where any particular employee cannot qualify for a subsidy, there can be no penalty under Code § 4980H(b) with respect to that employee.

This post examines the manner in which an employer reports "affordability" for purposes of Form 1095-C, Part II, Line 16.

#### **Background**

Coverage is affordable for purposes of determining an applicable large employer's exposure for assessable payments under Code § 4980H if the employee's required contribution for self-only coverage does not exceed 9.5 percent of the employee's household income. "Household income" for this purpose means modified adjusted gross income for the taxable year. Affordability is based on the employee cost for self-only coverage despite that the employee qualifies for and enrolls in family coverage. Because an employer generally will not know the employee's household income, the final Code § 4980H regulations establish three alternative safe harbors under which an employer can determine affordability based on information that is readily available to the employer. The safe harbors are:

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- The Form W-2 wages safe harbor,
- The rate of pay safe harbor, and
- The federal poverty line safe harbor.

A not uncommon mistake is to assume that the 9.5 percent amount has subsequently been increased since the publication of final Code § 4980H regulations in February 2014. It has not. Acknowledging the potential for confusion, the 2015 Instructions for Forms 1094-C and 1095-C ("instructions") include the following advice:

Note. References to 9.5% in the IRS guidance provides that the percentage is indexed in the same manner as that percentage is indexed for purposes of applying the affordability thresholds under Internal Revenue Code section 36B (the premium tax credit). In general this should not affect reporting for 2015, but taxpayers may visit IRS.gov for any related updates.

Where the requirements of any of these safe harbors are satisfied, the employer's offer of coverage is deemed affordable regardless of whether it is affordable to the employee under the ACA's rules governing premium tax credits. Each of the affordability safe harbors will generally understate the amount of employee contributions needed to establish affordability where there are other wage earners in the family. There are, however, rare instances, such as where a self-employed spouse has a net loss for the year, in which the safe harbors will overstate the amount of employee contributions needed to establish affordability.

According to the final Code § 4980H regulations, the safe harbors are all optional. This does not appear to be borne out in the instructions, however. There is no separate 2-series code for household income.

An employer may choose to use one or more of the affordability safe harbors for all of its employees or for any reasonable category of employees, provided it does so on a uniform and consistent basis for all employees in a category. Reasonable categories include specified job categories, nature of compensation (for example, salaried or hourly), geographic location, and similar bona fide business criteria. In contrast, an enumeration of employees by name would not be considered a reasonable category. While not addressed, it would seem that a reasonable category might include employees for whom one of the other safe harbors is unavailable.

#### Series 2, Code 2F: Section 4980H affordability Form W-2 safe harbor

Under the Form W-2 safe harbor, the employer is permitted to calculate the affordability based solely on the wages paid to the employee as reported in Box 1 of the Form W-2 (Wage and Tax Statement) for the year. Additionally, the employee's required contribution must remain a consistent amount or percentage of all Form W-2 wages during the year. Thus, the employer is not allowed to make discretionary adjustments to the required employee contribution for a pay period. Where an employee is employed for less than the full year, the employee's required contribution is adjusted accordingly.

The advantage of the Form W-2 safe harbor is that it most closely approximates household income, at least when compared to the other safe harbors.

The downside of the Form W-2 safe harbor is its inflexibility. Because the amount of W-2 income is not known until after the end of the year, and because employers may not make discretionary adjustments to contributions as the year proceeds, this safe harbor is ill-suited to employees with unpredictable or variable work schedules. Moreover, since the income reported on Box 1 of Form W-2 is net of pre-tax contributions for 401(k) or cafeteria plans, each employee's individual elections will affect the affordability determination. This safe harbor is best suited to employers with stable workforces that have historically provided robust group health benefits to all of their employees with generous employer subsidies. Conversely, it is least useful in industries and companies with large cohorts of variable and contingent workers.

#### Series 2, Code 2G: Section 4980H affordability federal poverty line safe harbor

According to the final Code § 4980H regulations:

An applicable large employer member satisfies the federal poverty line safe harbor with respect to an employee for a calendar month if the employee's required contribution for the calendar month for the applicable large employer member's lowest cost self-only coverage that provides minimum value does not exceed 9.5 percent of a monthly amount determined as the federal poverty line for a single individual for the applicable calendar year, divided by 12.

The advantage of this safe harbor is its predictability. There is no need to separately calculate affordability by employee. Instead, this safe harbor operates as a fail-safe, which accounts for its popularity among carriers and third-party-administrators. The disadvantage of the federal poverty line safe harbor, of course, is that this safe harbor least closely approximates household income, and it almost always understates the amount of employee contributions needed to establish affordability. Consequently, it is the most expensive way for an employer to comply. According to the 2015 Poverty Guidelines for the 48 contiguous states and the District of Columbia, the 2015 FPL is \$11,770. The maximum affordable employee contribution for the year is \$93.18. In contrast, under the W-2 safe harbor, a contribution of \$119.38 would be affordable for an employee making the current Federal minimum wage of \$7.25.

#### Series 2, Code 2H: Section 4980H affordability rate of pay safe harbor

The rate of pay safe harbor is, at the same time, the most practical and the most challenging affordability safe harbor. In contrast to the W-2 safe harbor, this safe harbor is best suited to industries and companies with large cohorts of variable and

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contingent workers. The final Code § 4980H regulations provide two separate rate of pay safe harbor rules, one for hourly employees and another for non-hourly employees:

#### Hourly employees

An applicable large employer member satisfies the rate of pay safe harbor with respect to an hourly employee for a calendar month if the employee's required contribution for the calendar month for the applicable large employer member's lowest cost self-only coverage that provides minimum value does not exceed 9.5 percent of an amount equal to 130 hours multiplied by the lower of the employee's hourly rate of pay as of the first day of the coverage period (generally the first day of the plan year) or the employee's lowest hourly rate of pay during the calendar month.

#### • Non-hourly employees

An applicable large employer member satisfies the rate of pay safe harbor with respect to a non-hourly employee for a calendar month if the employee's required contribution for the calendar month for the applicable large employer member's lowest cost self-only coverage that provides minimum value does not exceed 9.5 percent of the employee's monthly salary, as of the first day of the coverage period (instead of 130 multiplied by the hourly rate of pay); provided that if the monthly salary is reduced, including due to a reduction in work hours, the safe harbor is not available,... (Emphasis added).

The attractiveness of this safe harbor is that the amount at which an employee's contribution is affordable may be known up front. The challenges, however, are many. In the case of hourly employees, the hourly rate is multiplied by 130 hours, despite that the employee may work more hours. Also, the rate of pay for an hourly employee can change if the rate of pay decreases (but not where it increases). Worse, the rate of pay safe harbor is unavailable in the case of non-hourly employees whose monthly salary is reduced mid-year. Thus, the safe harbor cannot be used, as a practical matter, for tipped employees or for employees who are compensated solely on the basis of commissions. For these employees, the employer must use one of the two other affordability safe harbors.

#### **Week 21:**

## The Affordable Care Act's Reporting Requirements for Carriers and Employers: Reporting for "MEC" Plans

Posted By Alden Bianchi on December 14th, 2015

It took a while, but most employers and their advisors have finally gotten the hang of the Affordable Care Act's employer shared responsibility rules. That is, they understand generally that:

- 1. "Applicable Large Employer Members" (i.e., each separate legal entity within a controlled group that collectively comprises an Applicable Large Employer) must make an offer of "minimum essential coverage" to substantially all of their full-time employees or face the prospect of a potentially very big penalty;
- 2. If coverage is offered, but it is unaffordable or fails to provide minimum value, then the employer faces the prospect of a potentially (hopefully, maybe) not very big penalty; and
- 3. If coverage is offered that is both affordable and provides minimum value, then the employer has no penalty exposure, but this approach might be costly.

When it comes to telling the government about compliance, however, not everyone has gotten the proverbial "hang-of-it," and many questions remain (at least enough to fill this blog from week-to-week). Most too have heard that the IRS has announced that it will be applying a "good faith" standard. While they get that this is a "good thing," many are not sure why, exactly. (Trust me, it's a good thing.) And there are of course a cohort of presumably small but indeterminate size employers that remain unaware of the rules or simply assume that their consultant or payroll service has it covered.

The lingering reporting-related questions appear to cluster around full-time employee determinations, offers of coverage, and eligibility, participation and coverage. This post examines issues relating to coverage, both under the rules governing the reporting of minimum essential coverage and under the employer shared responsibility rules, with a particular emphasis on "MEC plans."

#### **Minimum Essential Coverage**

In the context of the ACA, the term "minimum essential coverage" has come to be used in four different ways:

- 1. Under Code 5000A, U.S. taxpayers and green card holders must have minimum essential coverage or pay a tax penalty unless an exception applies;
- 2. Under Code 36B, low- or moderate-income income individuals who might otherwise qualify for premium tax credits from a public insurance exchange are rendered ineligible for subsidies if they have other minimum essential coverage (or are eligible for minimum essential coverage under an employer-sponsored group health plan if the coverage provides minimum value and is affordable);

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- 3. Under Code 4980H, applicable large employers face exposure for assessable payments for failing to offer minimum essential coverage to substantially all of their full-time employees; and
- 4. Vendors, promoters and some carriers have created and established for sale in the group market a preventive-services-only plan that has come to be known as a minimum essential coverage or MEC plan. Unlike the first three uses of the term MEC, this latter use is purely colloquial and market-driven. For the balance of this post, we will refer to preventive-services-only plans as "MEC plans."

The term "minimum essential coverage" can be confusing, since it refers not to the content of the coverage but to its source. Individual and group market coverage can qualify as minimum essential coverage, as can coverage under a governmental program such as Medicare or Medicaid. There is an important distinction to be made here, however. When coverage is offered through a public insurance exchange, that coverage must include a list of 10 essential health benefits which result in an aggregate benefit that qualifies as "minimum value." (For an explanation of minimum value, please see our previous post on the subject.)

In contrast, applicable large employers are not required to offer minimum value coverage, though there can be consequences for not doing so. As we noted above, an employer that offers minimum essential coverage that does not provide minimum value faces penalty exposure, though of a likely smaller magnitude than would otherwise be the case if the employer failed to offer any coverage. MEC plans do not provide minimum value.

#### The motives for choosing to offer MEC plans are two-fold:

#### 1. Economic

There are instances in which the offer of MEC is simply the cheapest way to comply with the ACA's employer shared responsibility rules. MEC coverage is less than desirable, since it only covers preventive services. Despite that serious drawback, however, certain employees may benefit from the MEC coverage, since it satisfies the ACA individual mandate. So an employee with MEC coverage is not subject to tax.

#### 2. Practical

Minimum value coverage may be unavailable or available only at exorbitant rates. This is a not uncommon occurrence in industries with low-wage, high turnover employees, who before the ACA were either not offered coverage or were offered coverage under "mini-med" plans. While some express concern over the failure on the part of mainstream carriers to develop and make available affordable products for this market, it should come as no surprise. This market segment is rife with adverse selection, and carriers are only now getting reliable data on actual take-up rates and claims experience.

Because MEC plans are group health plans, they must satisfy the ACA insurance market reforms. As a practical matter this means that a MEC plan must:

• Not impose annual or lifetime limits on essential health benefits (i.e., the items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care);

**NOTE:** Most MEC plans are self-funded. Self-funded and large group insured plans are permitted to impose dollar limits on benefits that are not essential health benefits, and they can also apply non-dollar limits on essential health benefits. These plans must use an authorized definition of essential health benefits to determine which of the benefits they provide can be made subject to annual or lifetime dollar limits. What constitutes essential health benefits is determined state-by-state based on a "benchmark" plan. The benchmark can be designated by the state or adopted under a default rule. Self-funded plans have some latitude on the selection of a benchmark plan.

- Cover children to age 26 where the MEC plan coverage includes dependents;
- Comply with the ACA bar on rescissions of coverage;
- Not exclude participants based on a pre-existing condition; and
- Cover preventive services. Preventive services for this purpose means coverage for a wide range of health preventive and screening services. There are some 63 distinct preventive services that must be covered without the enrollee having to pay a copayment or co-insurance or meet a deductible.

Though not required, MEC plans are often bundled and sold together with hospital or fixed indemnity coverage a/k/a "excepted benefits" in the parlance of the ACA and prior law.

#### Reporting MEC vs. Minimum Value coverage

#### • Code 6055: Reporting of Minimum Essential Coverage (Forms 1094-B/1095-B)

Every provider of Minimum Essential Coverage must report coverage information by filing an information return with the IRS on Form 1094-B and furnishing a statement to individuals on Form 1095-B. Where MEC plan coverage is fully-insured, the reporting obligation rests with the carrier. But where MEC plan coverage is self-funded—which is by far the most common ap-

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proach—the coverage is reported by the employer on Part III of Form 1095-C if the employer is subject to the ACA employer shared responsibility rules, i.e., an applicable large employer member. Many employers offering MEC plan coverage are new to self-funding. This filing obligation could come as a surprise.

#### • Code 6056: Reporting by ALE Member (Forms 1094-C/1095-C)

Offers of coverage that qualify as minimum value are coded on Form 1095-C, Line 14 using Codes 1A through 1E. These codes variously identify the recipients of the offer of coverage between and among the employee, his or her spouse, and dependents. The significance of these codes is that the employer may avoid exposure under Code § 4980H(b) if the coverage is also affordable. That this is the case is reported on Lines 15 (which permits the IRS to verify whether the coverage is affordable) and 16 (which discloses that coverage was elected or points the IRS to the reason why the employer is not liable for an assessable payment under Code § 4980H(b) with respect to the particular employee).

Offers of MEC plan coverage have their own reporting Form 1095-C, Line 14 series-1 indicator code, Code 1F (Minimum essential coverage NOT providing minimum value offered to employee). Where Code 1F applies, Form 1095-C, line 15 would be left blank, thus signaling to the IRS that the employer may be liable for an assessable payment under Code § 4980H(b) (i.e., the "potentially (hopefully, maybe) not very big penalty") with respect to the particular employee.

The benefit of a broad-based offer of MEC coverage appears on Form 1094-C, Part III, Lines 23 to 35, column (a), wherein the employer reports that it "offered minimum essential coverage to at least 95% of its full-time employees and their dependents." As a consequence, the employer is not liable for penalties under Code § 4980H(a) (the "very big" penalty). Under a transition rule that applies in 2015, the 95% threshold is lowered to 70%. An employer indicates that it is taking advantage of this relief on Form 1094-C, Part III, in Lines 23 to 35, Column (e).

#### **Week 22:**

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Affordability, HRA Contributions, Flex Credits, Opt-Out Payments, and SCA Fringe Benefit Contributions under Notice 2015-87

Posted By Alden Bianchi on December 22nd, 2015

The Treasury Department and the IRS this week issued Notice 2015-87 that addresses, among other things, the effect of Health Reimbursement Account (HRA) contributions, cafeteria plan flex credits and opt-out payments on affordability determinations for purposes of assessable payments under Code § 4980H(b). The notice also includes welcome clarifications relating to fringe benefit payments under the McNamara-O'Hara Service Contract Act and other, similar laws. This post explains how Notice 2015-87 changes the affordability calculus for these arrangements, both as a matter of substance and from the reporting perspective. The positions taken in Notice 2015-87 are consistent with our earlier predictions in the matter.

Before we get started, a quick note: Notice 2015-87 covers a host of other important topics including: the application of the ACA's insurance market reforms to HRAs (this has become something of a perennial topic); the application of Code § 6056 to government entities; the application of the rules for health savings accounts to persons eligible for benefits administered by the Department of Veterans Affairs (VA); the application of the COBRA continuation coverage rules to unused amounts in health FSA carry-overs; and relief from penalties under Code §§ 6721 and 6722 for employers that make a good faith effort to comply with the ACA reporting rules. We fully expect there to be a good deal of commentary on the notice. In keeping with the mission of the series, this post is limited to the notice's impact on reporting.

#### **Background**

An applicable large employer (generally, an employer with 50 or more full-time and full-time equivalent employees on business days during the prior calendar year) may be subject to tax under Code § 4980H(b) for any month for which a full-time employee has received a premium tax credit in connection with enrollment in health coverage through a public insurance exchange or marketplace. But an employee is not eligible for the premium tax credit for any month for which the employee is eligible for coverage under an eligible employer sponsored plan that provides *minimum value* and is *affordable* (or for any month for which the employee enrolls in an eligible employer-sponsored plan, regardless of whether the plan is affordable or provides minimum value). A plan that provides major medical benefits generally provides minimum value; coverage is affordable if the employee's required contribution for coverage under the plan is 9.5 % (adjusted annually) or less of the employee's household income.

The amount of an employee's required contribution for purposes of determining affordability is determined under the ACA's individual mandate rules. The term "required contribution" means:

"[i]n the case of an individual eligible to purchase minimum essential coverage consisting of coverage through an eligible employer-sponsored plan, the portion of the annual premium that would be paid by the individual (without regard to whether paid through salary reduction or otherwise) for self-only coverage."

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Consequently, the determination of coverage affordability, and whether it provides minimum value, is based on the standards set forth elsewhere in the law.

#### **Employer contributions to an HRA**

In the case of HRAs, amounts made available for the current plan year that an employee may use to pay premiums for an eligible employer-sponsored plan, or that an employee may use to pay premiums for an eligible employer-sponsored plan and also may use for cost-sharing and/or for other health benefits not covered by that plan in addition to premiums, are counted toward the employee's required contribution (thereby reducing the dollar amount of the employee's required contribution). This is the case both substantively, and for purposes of reporting on Form 1095-C.

By way of example, if the employee contribution for health coverage is \$200 per month, and the employer makes available \$1,200 under an HRA (\$100 per month) that the employee may only use to pay the employee share of contributions for the major medical coverage, the employee's required contribution for the major medical plan is \$100 (\$200 – \$100) per month. Importantly, the HRA must satisfy the requirements for integration with the major medical group health plan. Thus, if the employee in this example could use HRA amounts to pay for the cost of vision or dental coverage in addition to major medical coverage, the arrangement would still comply, but if the employee could use the HRA to purchase duplicative coverage in the individual market, it would not.

#### Cafeteria plan flex credits

It is not uncommon for a cafeteria plan to be funded both by salary reduction and employer "flex contributions" (a/k/a "flex credits"). Final regulations implementing the ACA's individual mandate provide that flex contributions reduce the employee's required contribution if and only if

- The employee may not opt to receive the amount as a taxable benefit;
- The employee may use the amount to pay for minimum essential coverage; and
- The employee may use the amount exclusively to pay for medical care.

A contribution under an arrangement that satisfies all three criteria is referred to as a "health flex contribution." A health flex contribution reduces an employee's required contribution dollar-for-dollar. Conversely, an employer flex contribution that is not a health flex contribution does not reduce an employee's required contribution. Thus, for example, if an employer flex contribution that is available to pay for health care is also available to pay for any non-health care benefits (e.g., dependent care or group term life insurance), that contribution is not a health flex contribution and, as a result, does not reduce the required employee contribution.

By way of example, assume that an employer offers employees coverage under a group health plan through a cafeteria plan, with an employee contribution for self-only coverage of \$200 per month. In addition, the employer offers employer flex contributions of \$600 for the plan year that can be used for any benefit under the § 125 cafeteria plan (including benefits not related to health). Because the \$600 employer flex contribution is not usable exclusively for medical care, it is not a health flex contribution and therefore does not reduce the employee's required contribution. For reporting purposes (Form 1095-C, Part II, Line 15), the employee's required contribution is \$200 per month. The result would be the same if the employee may also elect to receive taxable cash in lieu of the \$600 employer flex contribution.

The Treasury Department and the IRS take pains in the notice to explain their rational for these results:

The treatment of non-health flex contributions differs from the treatment of health flex contributions and contributions to HRAs... [T]he appropriate measure of an employee's required contribution is the amount of compensation that the employee could apply to something other than health-related expenses that the employee must forgo to obtain coverage under the employer's health plan. Thus, if an employer provides employees with an HRA contribution or a health flex contribution that may be used only to pay health expenses, the employee's cost of coverage (the amount of salary or other non-health benefits that the employee must forgo to obtain coverage under the employer's health plan) is reduced by the amount of the health flex contribution or HRA contribution. In that case, it is fair to assume that the employee would use the health flex contribution or HRA contribution to pay for the employer's health coverage (because the health flex contribution or HRA contribution can be used only for health benefits), and if the employee does not use it for that purpose the employee does not gain any other economic benefit... [But if] the employer provides an employee with a flex contribution that may be used to pay health expenses but also may be used for non-health benefits (that is, a non-health flex contribution), an employee who elects coverage under the employer's health plan must forgo the non-health benefits in order to take the health coverage. Because a non-health flex contribution (unlike a health flex contribution or HRA contribution) may be used for benefits other than health benefits, it is not appropriate to assume that the employee would use the non-health flex contribution to pay for health coverage; the employee might choose to use that flex contribution for another non-health benefit. Accordingly, the employee's required contribution in this case is equal to the stated amount the employee must pay for health coverage (whether that amount is paid by the employee in the form of a flex contribution, a salary reduction, or otherwise) and is not reduced by the non-health flex contribution. (Emphasis added). (Footnotes omitted).

Perhaps anticipating objections to its treatment of contributions that are not health flex contributions, Notice 2015-87 includes a welcome transition rule, available only to existing arrangements, under which, for plan years beginning before January 1,

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**2017**, an employer flex contribution that is not a health flex contribution will be treated as reducing the amount of an employee's required contribution.

Anticipating also that transition relief for plan years beginning before January 1, 2017 could cause employees who are otherwise eligible to enroll in subsidized coverage through a public insurance exchange, the regulators encourage employers "not to reduce the amount of the employee's required contribution by the amount of a non-health flex contribution for purposes of information reporting under § 6056." The notice recognizes and even anticipates that the employer who adopts this approach may be "contacted by the IRS concerning a potential assessable payment under § 4980H(b) relating to the employee's receipt of a premium tax credit." The regulators assure employers that they "will have an opportunity to respond and show that [they are] entitled to the relief" provided by the notice.

#### Cafeteria plan opt-out payments

Canonically if not universally, a cafeteria plan opt-out is an arrangement under which an employer offers to an employee an amount that cannot be used to pay for coverage under the employer's group health plan. Such arrangements can be either unconditional (i.e., an arrangement providing for a payment conditioned solely on an employee declining coverage) or conditional (e.g., an arrangement that requires the employee to provide proof of coverage provided by a spouse's employer). Readers who have made it this far can perhaps anticipate the notice's treatment of cafeteria plan opt-out payments. In the view of the regulators:

"[A]n employee who must reduce his or her compensation by \$1,000 to pay for employer-provided health coverage has a choice that is similar to the choice of an employee who is ostensibly not required to pay anything for employer-provided coverage, but who would receive an additional \$1,000 in compensation only if he or she declined coverage. In each case, the price of obtaining employer-provided health coverage is forgoing \$1,000 in compensation that otherwise would be available to the employee." This means, of course that an "opt-out payment may have the effect of *increasing* an employee's contribution for health coverage beyond the amount of any salary reduction contribution." (Emphasis added).

In the notice, the Treasury department announces their intent to propose regulations reflecting the treatment of the cafeteria plan opt-out arrangements described above. They also invite comments on the treatment of employer offers of opt-out payments.

#### Fringe benefits under the McNamara-O'Hara Service Contract Act ("SCA")

The SCA generally mandates that workers employed on certain federal contracts be paid prevailing wages and fringe benefits. An employer generally can satisfy its fringe benefit obligations by providing a particular benefit or benefits that have a sufficient dollar value. Alternatively, an employer may in most cases satisfy its fringe benefit obligations by providing the cash equivalent of benefits or some combination of cash and benefits, or it may permit employees to choose among various benefits or among various benefits and cash. If an employer chooses to provide fringe benefits under the SCA 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 would then generally be required to provide the employee with cash or other benefits of an equivalent value.

Under the rational set out above, one might expect that employer flex contributions that are available to pay for health care and non-health care benefits (including cash or other taxable compensation) under a cafeteria plan would <u>not</u> reduce the required employee contribution for affordability purposes. Wisely (in our view) and thankfully, the regulators have not adopted this rule. They have instead provided that, at least for plan years beginning before January 1, 2017, employer payments for fringe benefits made pursuant to the SCA are taken into account for purposes of determining whether an applicable large employer has made an offer of affordable minimum value coverage under an eligible employer-sponsored plan. (The notice also applies to Davis Bacon Related Acts or "DBRA").

The notice offers an example positing that an employer offers employees subject to the SCA coverage under a group health plan through a cafeteria plan. 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 and receive a taxable payment of \$700 per month. 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 is \$0; but for purposes of the ACA's individual mandate and premium subsidy rules, the employee's required contribution is \$700 per month.

As is the case with flex credits, employers are "encouraged to treat these fringe benefit payments as not reducing the employee's required contribution for purposes of reporting under § 6056."

#### Closing thoughts

Notice 2015-87 covers a series of questions and issues that have dogged employers and their advisors for some time. It is lengthy, thoughtful and well-reasoned. Not everyone will be satisfied with the notice's treatment of HRA contributions, flex credits, and opt-out payments, however. That dissatisfaction is misplaced (in our view). The regulators have approached the treatment of affordability in a manner that is consistent with other parts of the ACA that operate in an integrated and interlocking scheme.

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#### **Week 23:**

# The Affordable Care Act's Reporting Requirements for Carriers and Employers: Notice 2016-4 Postpones Reporting and Filing Deadlines

Posted By Alden Bianchi on December 28th, 2015

Under the Affordable Care Act's reporting requirements that have been the subject of this series, statements to responsible individuals (a/k/a "employees")—i.e., Forms 1095-B and 1095-C—must be furnished on or before January 31 of the year following the calendar year of coverage. The IRS may grant an extension of time of up to 30 days for the provider to furnish the statement. Similarly, transmittal forms—Forms 1094-B and 1094-C—must be submitted to the IRS in either paper format by February 28, or electronic format by March 31, of the year following the calendar coverage year. (For 2016, the January 31 and February 28 due dates fall on weekend days; accordingly, in 2016 these dates are February 1 and February 29 respectively.) Groups that file 250 or more returns must file electronically.

Responding to pleas from a handful of major trade and industry associations, the Treasury Department and the Internal Revenue Service yesterday delayed these requirements.

Specifically, in Notice 2016-4, the regulators extended the deadlines:

- For furnishing to individuals the 2015 Form 1095-B, Health Coverage, and the 2015 Form 1095-C, Employer-Provided Health Insurance Offer and Coverage, from February 1, 2016, to March 31, 2016, and
- For filing with the Service the 2015 Form 1094-B, Transmittal of Health Coverage Information Returns, the 2015 Form 1095-B, Health Coverage, the 2015 Form 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns, and the 2015 Form 1095-C, Employer-Provided Health Insurance Offer and Coverage, from February 29, 2016, to May 31, 2016, if not filing electronically, and from March 31, 2016, to June 30, 2016 if filing electronically.

According to Notice 2016-4: "In view of these extensions, the provisions regarding automatic and permissive extensions of time for filing information returns and permissive extensions of time for furnishing statements will not apply to the extended due dates." Thus, there is no need for employers to seek separate extensions of time. The notice also recognizes that some employers might miss even the newly extended due dates. These employers are nevertheless encouraged to comply late, in which case:

[T]he Service will take such furnishing and filing into consideration when determining whether to abate penalties for reasonable cause. The Service will also take into account whether an employer or other coverage provider made reasonable efforts to prepare for reporting the required information to the Service and furnishing it to employees and covered individuals, such as gathering and transmitting the necessary data to an agent to prepare the data for submission to the Service, or testing its ability to transmit information to the Service. In addition, the Service will take into account the extent to which the employer or other coverage provider is taking steps to ensure that it is able to comply with the reporting requirements for 2016.

Notice 2016-4 also provides parallel relief to individuals who file their tax returns before receiving a Form 1095-C. These individuals are not required to amend their returns after receiving these forms late.

The notice recognizes that some employees and related individuals who enrolled in coverage through a public insurance exchange could be adversely affected by the extension. For 2015 only, these individuals are entitled to rely on "other information received from employers about their offers of coverage" for purposes of determining eligibility for the premium tax credit when filing their income tax returns. Even these individuals are not required to file amended returns once they receive their Forms 1095-C. Individuals need not send this information to the Service when filing their returns but should keep it with their tax records. Similar relief is provided in the case of Form 1095-B. For 2015 only, individuals who rely upon other information received from their coverage providers about their coverage for purposes of filing their returns need not amend their returns once they receive the Form 1095-B.

The relief provided in Notice 2016-4 overrides individually-filed extensions of time to file or furnish 2015 returns and information statements. These requests will not be formally granted.

#### **Week 24:**

## The Affordable Care Act's Reporting Requirements for Carriers and Employers: 5 Predictions

Posted By Alden Bianchi on January 4th, 2016

This post concludes our half-year series of posts focusing on the Affordable Care Act's reporting requirements. These requirements are challenging in the extreme. Carriers and employers, and their vendors, service providers and strategic partners, have scrambled up a steep learning curve. And in a few short months—a few more than originally anticipated as a result of Notice 2016-4, which was covered in <u>last week's post</u> —compliance will begin in earnest. This post offers some predictions

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about how we expect compliance to unfold.

#### (1) MEC Reporting will work as advertised—for the most part

For purposes of the reporting of minimum essential coverage (MEC) under Code § 6055 on Forms 1094-B and 1095-B, carriers are largely relying on home-grown software. MEC reporting in the case of fully-insured plans has its challenges, principally relating to data collection. But the regulatory regime is not all that complex. As a consequence, there is no reason to anticipate that these systems will not work, i.e., that the inputs and outputs will match the requirements of the law and applicable regulations even if the particulars of the "black box" vary from carrier-to-carrier. Expect a good deal of finger pointing over the timely collection of correct information, however, particularly as it relates to social security numbers. One hopes that the extensions of time provided by Notice 2016-4 will go a long way toward alleviating this problem.

#### (2) Software solutions for applicable large employers may work and will converge

Where applicable large employers are concerned, the level of reporting complexity rises exponentially. (Just compare the Forms 1094-B and 1095-B to the Forms 1094-C and 1095-C to see why.) There are currently a good number of expert systems available to employers to assist with their reporting obligations. As best we can tell, vendors have generally been diligent in their efforts to beta test their products. But none of these products has yet been tested live and in real time with real data. The software solutions for reporting by applicable large employers under Code § 6056 have for the most part been developed by third parties, including payroll companies, brokers, venture-funded and other start-ups, industry-focused organizations, and interested tinkerers, among others. In contrast to MEC reporting, these products are not at all uniform. Some favor particular compliance approaches. For example, it is not uncommon for vendors to strongly urge or require customers to use the Federal Poverty Line affordability safe harbor. This simplifies the reporting on Form 1095-C, Part II, Line 15, but at a cost to employers. Others lack full functionality relating to transition rules. This will change as vendors gain experience and the industry consolidates. In time, these software products will converge such that the inputs and outputs will align seamlessly with all of the requirements of the law and applicable regulations.

#### (3) For employers, the first year will be chaos

The run-up even to the now delayed reporting deadline will involve a good deal of frantic, last-minute effort. Employers have been asked to respond to detailed data requests from their vendors to provide information from disparate sources, e.g., payroll, HRIS, and the employer's group health plan, among others. Complicating matters is that some vendor requests ask for information that is not necessary to complete the reporting process. The biggest challenges will arise in cases where the data collection and collating cannot be automated. For companies of sufficient size, this could mean that timely compliance is out of the question, which will require a "Plan B" (i.e., late filing accompanied by a request for an abatement of penalties).

#### (4) Also for employers, there will be some unwelcome surprises

The reporting process inevitably involves a detailed examination by a third party vendor of the approach that the applicable large employer adopted to comply with the ACA employer shared responsibility rules. This examination can reveal compliance problems and lapses. For example, a vendor and employer might differ on the classification of a cohort of employees as variable hour by an employer that has adopted the look-back measurement method. If that cohort is sufficiently large, the employer could be facing penalties under Code § 4980H(a). Admittedly, the chance of a lapse on this scale is lessened by the 2015 transition rule that coverage need only be provided to 70% of the employer's full-time employees rather than 95%, but the chance is still greater than zero. A similar problem might arise if the employer properly classifies variable hour employees but fails to make a timely offer of coverage following the close of the applicable administrative period to those who qualify as full-time.

#### (5) Despite items (1) through (4), there will be few train wrecks

In Notice 2016-4, the IRS extended the 2015 reporting deadlines as follows:

- The due dates for furnishing to individuals Form 1095-B and Form 1095-C were extended from February 1, 2016, to March 31, 2016; and
- The due dates for filing with the Service Form 1094-B, Form 1095-B, Form 1094-C, and Form 1095-C were extended from February 29, 2016, to May 31, 2016, if not filing electronically, and from March 31, 2016, to June 30, 2016 if filing electronically.

This relief is welcome to be sure. But an equally important feature of the notice is emphasis on the relief available to late filers. The strong implication is that the IRS is willing to grant a wide berth to organizations that approach their reporting obligations in good faith under existing rules governing the abatement of penalties. Though not explicitly stated, it's not difficult to infer the converse: the IRS will have little sympathy for employers who fail to operate in good faith—including those who claim that they filed late because they were unaware of the reporting rules.