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REFORM UPDATE

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CLARIFICATION ON AFFORDABLE CARE ACT (ACA) PROVISIONS

IRS Notice 2015-87 provides further guidance on various provisions of the Affordable Care Act (ACA) as they apply to employer-sponsored health coverage and other legislative issues. The Notice addresses the following topics:

- Additional guidance on health reimbursement arrangements (HRAs)
- Treatment of flex credits and opt-out payments on affordability determinations
- Update on affordability determinations and penalty amounts
- Clarification on hours of service determinations
- Government employers and employer reporting
- Clarification on health savings accounts (HSAs) and individuals eligible for benefits administered by the Department of Veterans Affairs (VA)
- Clarifications related to health flexible spending account (FSA) carryovers
- Additional information related to good faith compliance relief for employer reporting

This Notice sheds light on many compliance issues that employers have not clearly understood.

ADDITIONAL GUIDANCE ON HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs)

The following issues related to permissible HRA plan designs were clarified:

- An HRA that covers fewer than two participants who are active employees (such as one covering only retirees or former employees) is not subject to the ACA's market reforms. That means these HRAs are permitted. Retiree-only HRAs are permitted even if the amounts credited are tied to the period when the retiree was an active employee covered by an HRA integrated with another group health plan. However, please note that former employees will not be eligible for premium tax credits to purchase coverage in the Marketplace for any month in which funds are still available to them in the HRA.
- An HRA for current employees fails to be considered integrated with another group health plan if the amounts credited to the HRA can be used to purchase individual coverage in the Marketplace. Therefore, if a former employee is allowed access through COBRA to an HRA for current employees, then that former employee cannot use the HRA funds to purchase individual coverage. An HRA for current employees that includes terms permitting the purchase of

individual coverage will be considered a group health plan that fails to meet the ACA's market reforms (because is not considered integrated with another group health plan).

- An HRA is not permitted to reimburse expenses for an employee's spouse or dependent child if the HRA is integrated with self-only employer group health plan coverage. The individuals must be enrolled by both the employer group health plan and the HRA in order for the HRA to be considered integrated for ACA purposes. If a spouse or dependent child is not enrolled in the employer's group health plan, they cannot be enrolled in the HRA. If an employer allows individuals that are not covered by their group health plan to enroll in the HRA, then the plan will not be considered integrated and will fail to meet the ACA's market reform requirements. Employers can easily meet this requirement by tying enrollment in the group health plan to HRA enrollment. The IRS recognizes, however, that many employers do not currently do this. Therefore, the IRS will **not** treat an HRA, available for the expenses of family members not enrolled in the employer's group health plan for plan years beginning before January 1, 2016, as failing to be integrated with an employer's other group health plan for those plan years. They will not treat an HRA and group health plan that otherwise would be integrated, based on the terms of the plan as of December 16, 2015, as failing to be integrated with an employer's group health plan for plan years beginning before January 1, 2017, solely because the HRA covers the expenses of one or more of an employee's family members, even if those family members are not also enrolled in the employer's group health plan. However, under section 6055, an employer will be responsible for reporting the HRA as minimum essential coverage for each individual, not also enrolled in the employer's group health plan, for whom medical expenses are reimbursable by the HRA.
- An HRA or employer payment plan is allowed to reimburse premiums for individual coverage that offers only "excepted" benefits, which includes standalone dental and vision plans.

This information clarifies previous guidance related to HRAs. Employers that offer HRAs integrated with their group health plan will need to verify that the eligibility for the HRA is limited to individuals who are actually enrolled in the group health plan.

TREATMENT OF FLEX CREDITS AND OPT-OUT PAYMENTS ON AFFORDABILITY DETERMINATIONS

Some employers still offer credit-based flex plans and opt-out bonuses. A credit-based flex plan involves an employer setting price tags for various benefit options. The employer then provides credits that employees use to select the benefits they want. Many of these plans offer additional flex credits that can be used by the employee for different purposes. Opt-out bonuses are an amount of money paid to an employee who elects to waive employer-sponsored medical coverage.

Employers that offer credit-based flex plans or opt-out bonuses have wondered how to determine if the coverage passes any affordability safe harbors.

How flex credits are offered will determine what number should be used when calculating if a plan is affordable. It depends on whether the contribution can be deemed a "health flex" credit. A contribution is considered a health flex credit 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.
3. The employee may use the amount to pay exclusively for medical care under Section 213.

A health flex credit can be used to reduce an employee's required contribution for affordability testing. An example will help. An employer offers group health plan coverage through a Section 125 plan. An employee electing for self only is required to pay $200 per month for that coverage. An employer offers $600 in annual flex credits. The credits may only apply to the employee's share of the contribution or be contributed to a medical FSA. Since the $600 can only be used for health expenses, it is considered a health flex contribution. Therefore, the employer would test affordability on $150 monthly contribution. That is the $200 monthly contribution less $50 (the monthly value of the $600 annual health flex contribution).

If the employer's flex contribution can be taken as a taxable benefit or can be used to pay for non-health benefits, then the contribution is **not** considered to be a health flex contribution. This amount cannot be used to reduce the employee contribution for health plan coverage. In the example above, if the $600 can be used to purchase health coverage, voluntary life or disability coverage, or taken as taxable income, then the $600 does not offset the employee contribution. The employer will have to test the entire $200 contribution for medical coverage to determine affordability.

The IRS understands this situation was not particularly clear before the issuance of this Notice. Therefore, flex credits adopted prior to December 16, 2015, which **may** be used by the employee to pay for health coverage, can be treated as an offset to the employee contribution when determining affordability. A flex contribution will be considered as adopted prior to December 16, 2015 if:

1. The employer offered the flex contribution arrangement for a plan year including December 16, 2015.
2. A board, committee, or similar body, or an authorized officer of the employer, specifically adopted the flex contribution arrangement before December 16, 2015.
3. The employer provided written communications to employees on or before December 16, 2015 indicating that a flex contribution would be offered.

In addition, for plan years beginning before January 1, 2017, employers may reduce the amount of an employee's contribution by a non-health flex contribution for the purposes of information reporting under Section 6056 (line 15 on Form 1095-C). However, the IRS is encouraging employers not to reduce the contribution by the non-health flex contribution because it could affect an employee's eligibility for tax subsidies in the Marketplace (i.e., it impacts affordability). If the IRS determines the employer would be subject to a penalty because an employee purchased subsidized coverage in the Marketplace, they will give the employer an opportunity to respond. The employer will be able to state that they qualify for this relief and that coverage is affordable when the non-health flex credit is netted out. The penalty will then be waived.

For employees, the contribution without crediting a non-health flex credit will be the contribution that is used to determine affordability and subsequently eligibility for premium tax credits.

The Notice also provides more detail on how opt-out bonuses should be accounted for when determining affordability. This issue was not clear in the guidance issued to date, but the IRS intends to address this issue in future guidance. At this point, however, it is clear that if an employer offers an ***unconditional*** opt-out bonus, that amount needs to be added to the employee contribution when determining affordability. An unconditional opt-out bonus is paid whenever an employee opts out of coverage with no restrictions tied to payment of the bonus. For example, assume an employer offers minimum value coverage with a single contribution of $100. An employee waiving coverage under the plan is offered a $600 annual opt-out

bonus. The test for affordability should be made with a $150 contribution, which is the $100 salary reduction plus the $50 per month bonus the employee must forgo by electing coverage.

The IRS again recognizes that the guidance issued to date on this point has not been particularly clear. Therefore, they are offering relief to employers that allow them not to include the unconditional opt-out bonus when testing affordability if:

1. The employer offered the unconditional opt-out bonus for a plan year including December 16, 2015.
2. A board, committee, or similar body, or an authorized officer of the employer, specifically adopted the unconditional opt-out arrangement before December 16, 2015.
3. The employer provided written communications to employees on or before December 16, 2015 indicating that an opt-out bonus would be offered.

If an employer adopts an unconditional opt-out arrangement after December 16, 2015, they will be required to include the amount of the opt-out bonus with the employee contribution when testing affordability.

In addition, the IRS anticipates issuing additional guidance that will apply to plan years beginning on or after January 1, 2017. Until that point, employers are not required to increase the employee contribution for the unconditional opt-out amount (unless adopted after December 16, 2015) when testing for affordability. They are not required to include the opt-out amount when reporting on line 15 of the Form 1095-C. However, employees can treat the unconditional opt-out amount as part of the contribution if they are applying for subsidized coverage in the Marketplace. The employee may qualify for subsidized coverage with the inclusion of the opt-out amounts in the cost of coverage. However, if the employees enroll for subsidized coverage in the Marketplace, the employer will not be penalized if they pass affordability on the contribution without including the opt-out bonus.

The IRS anticipates that future guidance will address and request comments on conditional opt-out arrangements. These opt-outs impose eligibility conditions for an opt-out payment. For example, the opt-out amount is only payable if the employee provides proof of having other coverage, such as a spouse's employer-sponsored plan. At this point, conditional opt-out bonuses can be treated in the same manner as non-conditional opt-out bonuses. Expect the new proposed guidance to address conditional opt-outs in more detail.

Employers that are taking advantage of the transitional relief for non-health flex credits or opt-out bonuses are encouraged to notify employees about the fact their coverage may not be considered affordable. Employees should be encouraged to contact the telephone number provided on the Form 1095-C to obtain accurate information about their contributions. The employee may not have affordable coverage and may thus be eligible for subsidized coverage through the Marketplace.

UPDATE ON AFFORDABILITY DETERMINATIONS AND PENALTY AMOUNTS

The ACA contains indexing factors on affordability determinations and employer penalty mandate amounts.

The affordability threshold was originally set at a cost for single coverage that did not exceed 9.5 percent of household income. That percentage was increased to 9.56 percent in 2015 and 9.66 percent in 2016. However, the indexed increases applied only to the determination of affordability when an individual applies for individual coverage in the Marketplace.

Guidance related to the employer mandate included many provisions referring to affordability as 9.5 percent of earnings. These provisions were not tied to the indexed factor. For example, all the safe harbors used to determine affordability were based on 9.5 percent. This Notice now ties the following aspects of the employer mandate guidance to the indexed figure, rather than keeping the measure at 9.5 percent:

- The Federal Poverty Limit (FPL) safe harbor
- The rate of pay safe harbor
- The W-2 safe harbor
- The multiemployer plan interim relief
- The definition of a qualifying offer and other aspects related to the employer reporting requirements

It appears these changes are intended to be applicable back to December 16, 2015. Employers will now need to apply the indexed percentage (9.66 percent in 2016) to all aspects related to the employer mandate and reporting.

The penalties associated with the employer mandates are also intended to be indexed annually. As a result, the penalties will be as follows:

	2015 Annual Amount	2016 Annual Amount
Penalty for failing to offer substantially all full-time employees minimum essential coverage (originally $2,000)	$2,080	$2,160
Penalty for failing to offer a full-time employee minimum value/affordable coverage, and the employee buys subsidized coverage in the Marketplace (originally $3,000)	$3,120	$3,240

The annual indexed amount will be posted in future years on the IRS website.

CLARIFICATIONS ON HOURS OF SERVICE DETERMINATIONS

Hours of service determine whether or not an individual is considered a full-time employee. Hours of service is broadly defined, and 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 the 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.” To avoid any potential penalties, employers need to offer full-time employees minimum value, affordable coverage.

This Notice discusses the extent to which the rules under pension plans (29 CFR 2530.200b-2) regarding hours of service are incorporated in the definition of hours of service in the employer mandate regulations. These clarifications are included in proposed regulations under the employer mandate rules effective December 16, 2015.

The proposed clarifications do not include all the pension rules related to the hours of service. For the purposes of the employer mandate regulations, hours of service do not include any hours after the individual terminates employment with the employer. An hour of service also does not include:

1. An hour for which an employee is directly or indirectly paid or entitled to payment on account of a period where no duties are performed, if such payment is made or due under a plan that is maintained solely to comply with workers compensation laws, unemployment laws or disability insurance laws.
2. An hour of service for a payment which reimburses an employee solely for medical or medically-related expenses incurred by the employee.

The Notice also incorporates the hour of service pension rules as they relate to the source of payment for an hour of service for which no duties were performed. As a result, any period where an employee is not performing services but is receiving payments due to short term or long term disability results in an hour of service for any part of the period during which the recipient retains the status of an employee, unless the employer did not contribute directly or indirectly to the premiums. If an employee pays for disability contributions with after-tax dollars, this would be treated as an arrangement to which an employer did not contribute and does not give rise to an hour of service.

These are important clarifications. Many employers may choose to have long term disability benefit programs paid for with after-tax dollars to avoid the requirements to count hours of service. In addition, it will be important to pay attention to when employees are formally terminated. Employers also need to take care when terminating employment in situations where an employee is disabled. Most employers will have to go through a process to determine if any accommodations can be made.

These proposed employer mandate rules do not incorporate all aspects of the hours of service related to pension guidance. For example, there is no 501-hour limit on the hours of services required to be credited to an employee on account of any single continuous period where no duties are performed.

Another important clarification is made in terms of counting hours of service for employees who perform services for one or more educational institutions. The employer mandate rule stipulates that, in general, a rehired employee may only be treated as new hire after a 13-week break in service. However, the government included special rules for educational institutions, recognizing that they have unique needs. An educational institution can only treat a rehired employee as a new hire after a 26-week break in service. The Notice indicates that the IRS will propose amendments to the employer mandate rule to address situations where educational institutions have begun to use third-party staffing agencies to obtain services for certain positions, such as bus drivers and cafeteria workers. Because the educational institution may not be considered the individual's employer, and the staffing agency is not an educational organization, these educational institutions believe the individuals are not subject to the 26-week break-in-service rule, and can be treated as new hires after a 13-week break in service.

The IRS views this strategy as circumventing the intent of the special rule for educational institutions. The proposed amendments to the employer mandate regulations will apply the special rule to individuals who provide services to one or more educational institutions, even if that organization is not the individual's actual employer. Once these regulations come out, the 26-week break in service rules will apply not only to employees of educational institutions, but also to any employee providing services to one or more educational institutions for whom a meaningful opportunity to provide services during the entire year is not made available.

MORE DETAILS ON GOVERNMENT EMPLOYERS AND EMPLOYER REPORTING

A few clarifications are provided on different governmental employer issues:

- Participants in the AmeriCorps program are not considered to be employees of the grantee receiving assistance. They are also not considered federal employees.
- For the purposes of any liability related to the employer mandate, and also for employer reporting, an offer of TRICARE coverage due to employment is treated as an offer of minimum essential coverage under the employer-sponsored plan for that month.
- The aggregation rules under the employer mandate determine what member employers need to be combined to determine if the employer has 50 or more full-time employees. In addition, the exclusion of the first 30 full-time employees (lowered from 80 in 2015) under the mandate penalty is pro-rated amongst member employers. The regulations cited on determining aggregation rules do not address governmental entities. Therefore, the employer mandate rules allow governmental entities to apply a reasonable, good faith interpretation of the employer aggregation rules. The good faith interpretation determines whether government entities should be aggregated to determine if they exceed the 50-employee threshold, and in terms of distributing the 30-employee exclusion under the mandate penalty.
- Each separate governmental employer that is considered an Applicable Large Employer (ALE) must report under their own employer identification number (EIN). The requirement is not changed if the entity transfers reporting responsibility to a Designated Governmental Entity (DGE).

These clarifications should help governmental employers understand the impact of the employer mandate and reporting on their organization.

CLARIFICATIONS ON HEALTH SAVINGS ACCOUNTS (HSAs) AND INDIVIDUALS ELIGIBLE FOR BENEFITS ADMINISTERED BY THE DEPARTMENT OF VETERANS AFFAIRS (VA)

An individual actually receiving medical benefits from the VA is not disallowed from making HSA contributions if the medical benefits consist solely of:

1. Disregarded coverage
2. Preventive care
3. Hospital care or medical services under any law administered by the VA for a service-connected disability

These exclusions are difficult for HSA vendors to manage. To ease administrative difficulties, any medical services or hospital care received from the VA by a veteran with a disability rating will be considered care for a service-connected disability. A veteran can contribute to the HSA even if they receive care with a disability rating.

CLARIFICATIONS RELATED TO HEALTH FLEXIBLE SPENDING ACCOUNT (FSA) CARRYOVERS

Many employers added the FSA carryover provision to their health FSA plans. Employers have had questions about some the details surrounding health FSA carryovers.

Carryovers complicate COBRA elections, because COBRA may not always apply to health FSAs. It depends on the benefit amount a qualified beneficiary is entitled to receive as of the qualifying event date.

Any carryover amount to which a participant is entitled from the previous plan year should be included when determining whether COBRA applies. For example, assume an employee carries over $500 from the previous plan year, and elects $2,500 for the current plan year. The employee has a total available benefit of $3,000 for the current year. The employee terminates employment on May 31. As of May 31, the employee has only used $1,100 of the health FSA funds. The employee is entitled to $1,900 in FSA benefits for the remainder of the year.

COBRA premiums for the FSA are determined at 102 percent of the applicable premium. This Notice clarifies that the applicable premium should not be calculated to include any carryover amount. In the above example, the applicable premium would be based on the salary reductions for the $2,500 annual election. The monthly premium (including the two percent COBRA administrative fee) would be $208.33 ($2,500/12 plus 2%).

Employers have to allow COBRA beneficiaries the right to carryover year-end balances if they allow carryovers for similarly-situated non-COBRA beneficiaries. The carryover must be allowed even if it continues the availability of a benefit into the next plan year. The COBRA beneficiary would not be permitted to add new contributions to the carryover amount. The availability of the carryover amount only needs to be made available until the end of the COBRA continuation period. In addition, if the qualified beneficiary has carryover amounts available into the next plan year, the employer can't charge premium for that carryover amount. In the example above, assume the qualified beneficiary elects COBRA and pays the $208.33 premium per month, but was only able to use $1,500 in benefits by the end of the plan year. The plan allows participants to roll over up to $500 into the next year. This qualified beneficiary will therefore have $400 to roll over ($1,900 benefit less $1,500). The $400 would be available until the end of the COBRA continuation period, and the qualified beneficiary would not pay any additional premiums.

Employers had other questions regarding carryovers in health FSAs. Employers can condition the ability to carryover unused amounts on the participation in the health FSA in the next plan year. This is permitted even if the plan requires a minimum salary reduction in the next year. For example, assume a plan allows up to a $500 carryover in a health FSA as long as the employee participates in the health FSA during the next year. The plan has a minimum annual election of $60. To gain access to any carryover amount, the employee will have to elect as least the minimum amount for the next plan year. This requirement could impact availability of rollover amounts to a COBRA qualified beneficiary. If the plan requires re-enrollment in the health FSA to gain access to rollover amounts and an employer is not required to allow a COBRA beneficiary to re-enroll in the next year, the COBRA participant will not be allowed access to the rollover amount.

A health FSA plan may limit the ability to carryover amounts to a maximum period of time. For example, a health FSA can limit the access to carryover amounts to one year. This plan does not require an employee to participate in the plan during the next plan year in order to use the carryover amount. If an employee carried over $30 and did not elect to participate in the health FSA for the next year, the plan can require the forfeiture of any balance remaining at the end of that plan year (i.e., the year in which the employee did not participate).

ADDITIONAL INFORMATION OF GOOD FAITH COMPLIANCE RELIEF FOR EMPLOYER REPORTING

The IRS will recognize good faith efforts and not impose penalties in this first year that employers are required to meet the reporting requirements. Specifically, relief will be provided if an employer provides incorrect or incomplete information on forms filed in 2016. The relief will not apply, however, if an employer cannot prove a good faith effort to comply with the reporting requirements. It also will not apply if an employer fails to timely provide or file the returns. Employers who fail to file in a timely manner may be eligible for penalty relief only if the IRS determines the standards for reasonable cause were met.

CONCLUDING THOUGHTS

This Notice contains important information on a number of different ACA and legislative issues. Employers can expect updated regulations in early 2016.