COMPLIANCE ALERT

Alliant EMPLOYEE BENEFITS

Regulatory Guidance for Health and Welfare Plans

» 10/14/15 | 2015-13

Third Quarter Round Up: The PACE Act and Small Employer Definition, ACA Reporting for HRAs and Expatriates, Medicare Part D Changes and Employer Plans, Cash-in-Lieu Waiver Designs

There have been a series of minor, but important Affordable Care Act (ACA) developments in recent months that could impact employers and their group health plans in 2016. Congress passed the PACE Act, which allows states the option of increasing the size of "small employers" to those with 51-100 employees, or keeping/returning to the small employer threshold of 50 or fewer employees. The Internal Revenue Service (IRS) and Department of Treasury issued clarifying guidance on how an employer sponsoring a health reimbursement arrangement (HRA) in conjunction with the major medical plan is to report that coverage, as well as guidance on how employers sponsoring expatriate plans can provide statements to individuals covered under those plans. In addition, certain ACA-mandated changes to Medicare Part D are now effective, decreasing the financial exposure for Medicare Part D enrollees ("closing the donut hole"). These ACA changes to Medicare Part D might impact the creditability of some employer sponsored prescription drugs plans, and the content of the Medicare Part D notice that employers are required to distribute annually. Finally, while formal, direct IRS guidance has not been issued on this topic, employers that give cash to individuals who waive coverage should reconsider that design.

The PACE Act Give States the Flexibility to Define Small Group as up to 50 Employees

Under the ACA, the definition of "small employer" would have expanded nationwide to include employers with up to 100 employees on January 1, 2016. States also had the option of implementing this expansion in 2015. The PACE Act, signed by President Obama last week, eliminates the 2016 expansion mandate and instead gives states the option of increasing the size of "small employers" to 100 employees or keeping/returning to the small employer threshold of 50 or fewer employees. States must take legislative action to take advantage of this development.

There are several important issues tied to the definition of "small employer" under the ACA. Small employers must cover all ten essential health benefits and can only offer plans that fit into the actuarial value levels of platinum (90%), gold (80%), silver (70%), and bronze (60%) as defined by the ACA. Small group plans are part of a single risk pool for setting premiums. Small group insurers may only consider age, geographic location, family composition, and

tobacco use in setting rates for small groups. Large group plans are not subject to any of these requirements.

Extending the definition of small group to groups with up to 100 employees was intended to reduce premiums by enlarging the risk pool and to provide greater participant protections to a larger population. But this is not necessarily playing out as anticipated. In fact, increasing the size of small groups raised premiums for some mid-size groups as a result of age-banded rates. In response, many mid-sized groups begin exploring other options, such as self-insuring their medical plan. Significant numbers of mid-sized employers, especially healthy groups, choosing to self-insure their plans would negatively affect the small group risk pool.

Prior to the PACE Act, several states had already expanded their definition of small employer to employers with up to 100 employees. Those states include: California, Colorado, District of Columbia, Maryland, New York, Virginia, and Vermont. Whether these states will retain their 2015 definition of small employer as groups with up to 100 employees or choose to return to the threshold of 50 or fewer employees remains to be seen. Early indications are that California and the District of Columbia will retain the higher threshold. We will continue to monitor how states react to this new found flexibility under the PACE Act.

ACA Reporting Developments: HRAs and Expatriate Plans

The ACA has two reporting requirements that impact employers sponsoring a group health plan:

- Minimum essential coverage (MEC) reporting under Code section 6055 that helps the IRS enforce the individual mandate; and
- Applicable large employer (ALE) reporting under Code section 6056 that helps the IRS enforce the large employer mandate, commonly referred to as the Pay or Play mandate, and administer the advanced premium tax credit.

The IRS released two sets of forms to satisfy these reporting obligations. Providers of MEC, most often insurance carriers, will use Forms 1094-B and 1095-B for MEC reporting. Any small employers (fewer than 50 full-time employee equivalents) that sponsor a self-funded plan will also use Forms 1094-B and 1095-B to report MEC for individuals covered by their plan.

Employers that are ALEs will use Forms 1094-C and 1095-C for ALE reporting. ALEs that sponsor self-funded plans also have MEC reporting obligations, MEC and ALE reporting can be done jointly on Form 1095-C. Both reporting requirements reflect coverage provided on or after January 1, 2015. The first information returns must be filed with the IRS and the employee statements provided in early 2016.

For additional general information on the reporting requirements, please see Alerts 2014-05 and 2014-14.

Recent Guidance – Notice 2015-68

The Internal Revenue Service (IRS) and Department of Treasury (Treasury) recently issued Notice 2015-68, clarifying several issues, including how to report HRA coverage, how to provide individual statements to expatriates, and penalties for entities (with MEC reporting obligations) that are unable to obtain enrollee social security numbers.

Health Reimbursement Arrangement (HRA) Reporting

The ACA MEC reporting regulations were intended to eliminate duplicate reporting where an employer sponsors a major medical plan that is minimum essential coverage, and an HRA that is also considered minimum essential coverage. An updated version of the Form 1094/5-B Instructions, however, lead to some confusion on this topic. Those Instructions required an employer that offers a fully insured medical plan with an integrated HRA to do MEC reporting on the HRA. This caused concern because, absent the HRA, an employer sponsoring a fully insured medical plan has no MEC reporting obligations. Notice 2015-68 addresses this concern by providing the following two rules that will generally eliminate duplicate reporting for employers that sponsor an integrated HRA:

1. Where an individual is covered by multiple minimum essential coverage plans provided by the same provider, MEC reporting is required for only one of them.

> **Example:** Joe is enrolled in his employer's self-funded major medical plan, and also has an HRA from the same employer. Joe's employer is required to report only one type of coverage for that individual, which will generally be the self-funded major medical plan. If Joe retires and drops coverage under the major medical plan, but remains covered under the HRA, the employer must report coverage under the HRA for the months after he retires.

2. MEC reporting is generally not required on a minimum essential coverage plan for which an individual is eligible only if they are covered by other minimum essential coverage for which MEC reporting is already required. This means that employers would not have to do MEC reporting for an HRA that is available only to employees and other individuals who enroll in the employer's fully-insured medical plan.

Example: If Joe is enrolled in both his employer's fully-insured major medical plan and the employer's HRA, the employer is not required to do MEC reporting on Joe's HRA coverage. (The carrier will do the MEC reporting on the fully-insured major medical coverage.) But if Joe is enrolled in an employer's HRA and in his spouse's major medical plan (this is possible, but not common, under the HRA integration rules), the employer would be required to do MEC reporting on Joe's HRA coverage, and his spouse's employer (or the carrier insuring the spouse's major medical plan) would be required to do the MEC reporting on the major medical coverage.

Relief from Penalties for "Reasonable Cause"

The IRS will not impose penalties where an employer can demonstrate good faith efforts to comply with the reporting requirements. This relief applies to incorrect or incomplete reporting, including TINs and dates of birth reported on MEC returns or employee statements. Existing regulations provide specific procedures for soliciting tax identification numbers (TINs) which, if followed, establish that a reporting entity has acted in a responsible manner and should not be penalized. Employers and other reporting entities have indicated that these procedures are not always workable. The Notice requests comments on the application of the rules relating to TIN requests and reporting. Pending additional guidance, employers will not be subject to penalties for failure to report the SSN of an enrolled individual if they comply with the following modified, and more flexible, rules:

1. The initial request must be made at an individual's first enrollment, or if already enrolled on September 17, 2015, the next open enrollment;
2. The second request must be made at a reasonable time thereafter; and
3. The third request must be made by December 31 of the year following the initial request.

Reporting for Individuals Covered by Expatriate Plans

Expatriate plans are not exempt from ACA reporting requirements. This means that employers with self-funded plans covering expatriates will need to meet MEC reporting requirements. For employers with insured plans, ALE reporting is required for ACA full-time employee expatriates. ALE reporting may be limited by the fact the hours worked outside of the US do not "count as hours" when determining full-time status under the ACA. Individual statements may be furnished to expatriates electronically unless the recipient affirmatively refuses consent or requests a paper copy. (The standard rules require that an individual affirmatively consent before an employer or other entity can provide the individual statement electronically.) This

rule applies to expatriate plans that are issued or renewed on or after July 1, 2015. For a more in-depth discussion of Expatriate Plans and the ACA, contact your Alliant representative for our Alliant Insight on the ACA's application to expatriate plans.

Medicare Donut Hole Closing – Changes May Affect Creditable Status of Employer-Sponsored Prescription Drug Plans

The Centers for Medicare and Medicaid Services (CMS) parameters on Medicare Part D plan coverage are used by group health plan sponsors to determine whether their prescription drug plans are creditable. This information is necessary for the Medicare Part D disclosure that employers must make annually (and at other specified times) to Part D eligible individuals and to CMS. In recent years, the deductible for the Part D defined standard plan has been lower than prior years. In addition, the ACA gradually increases Part D coverage for Medicare enrollees who reach the prescription drug coverage gap (known as the "donut hole"). These changes could impact the creditability of employer-sponsored prescription drug plans and, therefore, the content of their Medicare Part D notices. Note that creditability only matters for employees and dependents who are eligible for Medicare. Individuals who are not Medicare eligible are not impacted by the creditable status of the employer prescription drug plan.

> **Alliant Insight**: To ensure compliance, send the Medicare Part D notice to all employees annually and to new hires to ensure distribution to all Medicare eligible employees and dependents).

Action Items on Medicare Part D Changes

For fully-insured plans, carriers should be implementing changes for groups that intend to offer Part D creditable prescription drug coverage. Self-funded plans, or plans with self-funded prescription drug programs that want to maintain a Part D creditable plan should discuss this issue with their third-party administrators and/or seek an actuarial determination on the creditability of their existing program against the new CMS parameters for 2016.

The 2016 parameters are set forth below:

- Initial Deductible: increased by $40 to $360 in 2016.
- Initial Coverage Limit: increase from $2,960 in 2015 to $3,310 in 2016.
- Out-of-Pocket Threshold: increase from $4,700 in 2015 to $4,850 in 2016.
- Coverage Gap (donut hole): begins once you reach your Medicare Part D plan's initial coverage limit ($3,310 in 2016) and ends when you spend a total of $4,850 in 2016.

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In 2016, Part D enrollees will receive a 55% discount on the total cost of their brand-name drugs purchased while in the donut hole. The 50% discount paid by the brand-name drug manufacturer will apply to getting out of the donut hole, however the additional 5% paid by the Medicare Part D plan will not.

Cash in Lieu/Waiver of Coverage Designs

Some employers have historically offered cash when an individual waives an offer of major medical coverage. This type of program creates compliance concerns and is a design that employers should reconsider.

The ACA requires that applicable large employers (ALEs) offer affordable, minimum value coverage to full-time employees and their dependents. Coverage is affordable when the employee's portion of the single premium does not exceed 9.5% of the employee's household income. A cash-in-lieu program could impact the affordability of an employer's plan. Informal IRS guidance notes that the amount of the cash-in-lieu (e.g., $50/month for waiver of coverage) should be added to the premium in determining affordability. The reasoning is that the individual must forgo that additional cash in order to enroll in benefits, which ultimately increases the premium cost. Adding the waiver amount to the premium could cause problems for employers that charge close to the 9.56% affordability threshold for employee-only coverage, or for employers that intend to use an affordability safe harbor.

Under the ACA, employers are prohibited from giving employees money to purchase individual health insurance. To avoid having the cash-in-lieu amount factored into an employee's regular rate of pay for overtime purposes they must be able to show proof of other coverage. While a compliant cash-in-lieu program might be permissible, questions remain as to whether these programs are compliant where the individual's proof of other coverage is individual health insurance. It appears that a generic gross up in taxable wages remains an acceptable practice as long as the wages are not ear marked for the purchase of individual health insurance. Given the issues outlined above, where possible we recommend discontinuing cash-in-lieu programs. At the very least, clients should closely evaluate those programs with their own counsel, and we certainly recommend against establishing new cash-in-lieu programs at this time.

Note that cash-in-lieu programs are different from employers that offer a cashable flex credit through a cafeteria plan, which is common with public sector employer plans, and also problematic under the ACA. For detailed information about cashable flex credit designs, contact your Alliant representative for a copy of our Alliant Insight on flex credit designs in light of the ACA.

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2015 Shoring Up and Alliant Support

Employers should be in their final stages of preparing for employer reporting requirements in the first quarter of 2016. In summary, these requirements are as follows:

- **Applicable Large Employer Reporting:** Applicable large employers (ALEs), defined as those with 50 full-time employees (including full-time equivalents) will be required to report their compliance with the Pay or Play rules by completing forms 1094/1095-C on behalf of their full-time employees. This requirement applies to *all* ALEs whether fully-insured or self-funded. Employers with 50-99 full-time and full-time equivalent employees may be eligible for transition relief to delay the onset of penalties, but even those employers must report on 2015 offers of coverage.
- **Minimum Essential Coverage Reporting:** Coverage providers will report on all individuals with minimum essential coverage (MEC) so that individuals can verify their compliance with the ACA's individual mandate. If the coverage provider is a self-funded plan, the employer does the MEC reporting by completing an additional field on form 1095-C. For fully-insured plans, the carrier will complete MEC reporting. In a multiemployer plan, the union will complete MEC reporting.

  If you need additional information on any of the above requirements, please refer to our previous alerts on the topic, which you can access here:
  - Filling in the Blanks: IRS Releases Employer Reporting Instructions
  - Clarification on ACA Reporting: Reporting on COBRA Participants, Mid-Month Hired and Terminations, and More
  - More ACA Reporting Fun: Increased Employer Reporting Penalties and New IRS System for Electronic Filing of ACA Returns

  You can also request a copy of our proprietary Alliant Employer Reporting Guide, as well as a copy of employer reporting presentation materials from February 2015 (note that there have been some changes in reporting regulations since February 2015, but the basic concepts described above are covered in these materials; any changes are discussed in the Alerts).
- **Vendor Support:** The importance of quality vendor support with reporting cannot be overstated. The information needed for compliant reporting requires information that has historically been maintained in separate employer systems (payroll and benefits administration). The vendor marketplace has responded by offering a variety of different solutions to comply with these reporting requirements. By now, vendors have limited capacity and many are no longer taking new clients for the 2015 reporting season. Employers who want support with reporting for 2015 (due in the first quarter

of 2016) should make this a priority. Please contact your Alliant representative if you would like any of the following materials:

- ACA Reporting Vendor Considerations
- ACA Vendor List
- Preferred Pricing ACA Vendors

Compliance Alert is presented by the Compliance Practice Group of Alliant Employee Benefits