The government is winding up 2015 and ringing in 2016 with a bang.

In a late breaking and most welcome development, the IRS has delayed the new Affordable Care Act’s reporting and disclosure obligation, as follows.

- The 2015 Forms 1095-B and 1095-C benefit statements which were to be provided to affected individuals by February 1, 2016 now must be provided no later than March 31, 2016.
- The 2015 Forms 1094-B and 1095-B, and the 2015 Forms 1094-C and 1095-C reports must be submitted to the IRS no later than May 31, 2016 (or electronically, by June 30, 2016).

No additional requests for extensions will be granted. The IRS is encouraging employers to comply earlier, if possible; however, this automatic extension should come as welcome news for employers struggling to comply. Also see Reporting and Disclosure in the Year End Reminders below for additional information.

On December 18, 2015, President Obama signed the Consolidated Appropriations Act, 2016 and the Protecting Americans from Tax Hikes (PATH) Act of 2015 (H. R. 2029; now Public Law No. 114-113). These laws amend several provisions of the Affordable Care Act, as well as make changes in several benefit-related provisions. Of particular note, these laws:

- Extend, for two years, the imposition of the so-called Cadillac tax. The tax would be imposed on the cost of health coverage that exceeds certain thresholds. It was to take effect in 2018; the new law delays the effective date until 2020; and changes the status of the tax from an excise tax to a deductible tax.
- Place a one year moratorium for the 2017 tax year on the annual fee required to be paid by ‘covered entities’ (insurers) who engage in providing health insurance for U.S. health risks.
- Place a two-year moratorium on the medical device excise tax for 2016 and 2017.

In addition, the Internal Revenue Service issued guidance (Notice 2015-87) relating to Affordable Care Act (ACA) implementation on a potpourri of topics, as follows:

- **Employer Shared Responsibility Provisions**
  - **Affordability Standard.** For purposes of determining affordability, coverage under an employer-sponsored plan is deemed affordable if the employee’s required contribution to
the plan does not exceed 9.5% of the employee’s household income for the taxable year, based on the cost of single coverage in the employer’s least expensive plan. According to the IRS guidance, this 9.5% safe harbor is now tied to inflation. Thus, for plan years beginning in 2015, the household income threshold percentage will increase to 9.56%. For plan years beginning in 2016, the threshold percentage will increase to 9.66%.

*Increase in Excise Tax Penalties.* This guidance affirms the projected increases in the amount of penalties for purposes of calculating the ‘no coverage’ excise tax (IRC §4980H(a)) and the ‘inadequate or unaffordable’ excise tax (IRC §4980H(b)) for 2015 and 2016 (see chart below). These are the excise taxes that could apply if an applicable large employer (ALE) is found not to have offered health coverage to a full-time employee.

<table>
<thead>
<tr>
<th>Year</th>
<th>'No Coverage' Excise Tax (IRC §4980H(a))</th>
<th>'Inadequate or Unaffordable' Excise Tax (IRC §4980H(b))</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>$2,080</td>
<td>$3,120</td>
</tr>
<tr>
<td>2016</td>
<td>$2,160</td>
<td>$3,240</td>
</tr>
<tr>
<td>2017</td>
<td>$2,260 (projected)</td>
<td>$3,390 (projected)</td>
</tr>
</tbody>
</table>

*Determining Cost of Coverage*

For purposes of determining affordability applicable to employers subject to the shared responsibility rules, this guidance addresses several scenarios as it relates to determining an employee’s cost of coverage. In a nutshell:

- An employee’s cost is reduced by any newly available integrated health reimbursement arrangement (HRA) funds that can be used for premium or other plan expenses.
- *Flex credits* available to an individual, either for the purchase of other benefits or taken in cash, do not impact the employee’s cost of coverage.
- *Cash-out option.* In this situation, an employee would receive an amount of cash as a result of foregoing employer contribution to health coverage. This guidance states that the government will be issuing regulations that would require the cash-out amount to be added to the employee’s cost of coverage. An example might be where an employee’s health coverage costs $100, and if the employee declines health coverage, the employee would receive $100 in cash. In this example, the actual employee’s cost of coverage would be $200. Until these regulations are issued, the government indicates that it will not enforce this method of determining affordability for plans in place prior to December 16, 2015.
- *In determining hours worked,* all paid time is counted, including vacation, sick leave and other paid time. A question has arisen about third party paid time. This guidance affirms that as long as the employment relationship exists, third party paid time, such as short term or long term disability, does count. However, state temporary disability and state workers compensation are not counted.

*Individual Premium and HRAs*

The government has said repeatedly that an employer cannot directly or indirectly contribute to individual premium. This guidance affirms previously issued guidance relating to health reimbursement arrangements (HRAs), as well as makes the following clarifications:
• HRAs for active employees must be integrated with comprehensive health coverage. This guidance clarifies that to be integrated, and if the HRA covers dependents, the dependents must be covered by the plan to which the HRA is integrated.

• An HRA that covers retiree-only individuals need not be integrated with a comprehensive plan. Further, HRA funds can be used to pay for excepted benefits, such as a dental-only plan, without violating the prohibition against premium payment plans.

MARKET REFORM: FINAL RULES
On November 18, 2015, the Affordable Care Act’s tri-governing agencies (Departments of Health and Human Services, Labor and Treasury) released final rules relating to market reforms. These final rules incorporate the previously issued interim final rules and sub-regulatory guidance issued to date. While these rules do not break new ground, they do provide some clarifications, as follows:

• **Grandfathered Health Plan Coverage.** Grandfathered group health plans (those in existence since the ACA’s enactment date, March 23, 2010) are exempt from certain ACA market reforms such as the patient protection provisions and providing coverage of preventive health services, immunizations, and screenings without any cost sharing (see the chart of the types of mandates applicable to grandfathered plans). As long as the plan is not significantly changed from that date forward, it can retain grandfathered status. Of particular note, these regulations affirm that a statement of grandfathered status must be included in plan communications; however, these statements need only be included in general plan communications provided to plan participants such as a summary plan description and not, for example, in an explanation of benefits (EOB).

• **Essential Health Benefits.** Beginning in 2014, the ACA requires non-grandfathered plans in the individual and small group markets issued both in and outside of the marketplace to cover essential health benefits (EHBs). Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover EHBs. However, to the extent that self-funded plans and large insured plans offered outside the marketplace offer EHBs, these essential benefits cannot be subject to annual and lifetime limits, whether provided in-network or out of network. According to the final regulations, a plan can elect to use a benchmark plan for purposes of determining whether a particular benefit is an EHB. A plan can use any of the 51 state-based benchmark plans, or the Federal Employee Health Benefit Plan-based benchmark plan, to make its EHB determination. Additional information about the various EHB based benchmarking plan designs can be accessed on the CMS’ Center for Consumer Information & Insurance Oversight website.

• **Preexisting Condition Exclusions.** The regulations affirm that while a plan cannot impose preexisting condition exclusion, it can have a benefit exclusion. However, the plan cannot impose an exclusion on benefits that it would otherwise cover.

• **Coverage of Dependent Child to Age 26.** The regulations affirm that an HMO cannot exclude coverage for a dependent child simply because the child moves outside the service area, such as when a child goes to college.

• **Rescission of coverage.** The regulations clarify that a rescission is a retroactive termination of coverage and can only be imposed due to fraud or misrepresentation. A prospective termination of coverage does not constitute a rescission.
Designation of Primary Care Provider. The regulations affirm that each covered life has the right to designate his/her primary care provider.

Integrated health plans. The regulations affirm previously issued guidance relating to health reimbursement arrangements (HRAs) and integrated health plans. For an employer employing fewer than 20 employees, and therefore not subject to the Medicare secondary payor (MSP) rules, the HRA can be coordinated with Medicare. This is not permissible for employers subject to the MSP rules.

Effective Date. The final market reform regulations become effective on January 19, 2016 and apply to group health plans beginning on the first day of the first plan year beginning on or after January 1, 2017.

Penalties for failure to comply with ACA market reforms
As a reminder, group health plans that fail to comply with certain federal laws, including violations relating to the ACA’s market reform provisions could trigger the imposition of an excise tax, in accordance with IRC Section 4980D. The amount of the penalty is $100 per employee/per day of noncompliance. Employer/plan sponsors, insurers and third party administrators who are liable for the excise taxes are required to self-report ACA violations on the IRS Form 8928.

ACA Provisions Effective in 2016

Cost Share Limits
The Affordable Care Act imposes certain cost-share restrictions on essential health benefits provided under non-grandfathered group health plans, including non-grandfathered self-insured and large group health plans. In 2016, the out-of-pocket limit increases to $6,850 for self-only coverage; $13,700 for other than self-only coverage. For plan years beginning January 1, 2016, an individual cannot be subject to more than the individual statutory out-of-pocket limit on essential benefits, even if the individual is covered by a family plan. The Centers for Medicare and Medicaid Services are proposing to increase these limits in 2017 to $7,150 for self-only coverage; $14,300 for other than self-only coverage. As a reminder, the 2016 out-of-pocket limits applicable to high deductible health plans used in conjunction with health savings accounts are $6,550 for individual coverage; $13,100 for family coverage.

Individual Shared Responsibility Requirement
• For 2015, the applicable fee for individuals who failed to maintain health insurance and did not qualify for an exemption is the greater of $325 or 2% of annual household income. In 2016, the fee increases to $695 per person or 2.5% of income, whichever is higher. The fee is calculated based on the number of months the individual, his/her spouse or tax dependents went without qualifying minimum essential coverage.

• The annual open enrollment period for 2016 coverage via HealthCare.gov closes on January 31, 2016. Unless a special enrollment event occurs, individuals who fail to enroll by that date would have to wait for the next annual enrollment opportunity (November 1, 2016 through January 31, 2017).
EMPLOYER SHARED RESPONSIBILITY REQUIREMENT

- **Applicability.** For purposes of the ACA’s employer shared responsibility requirement and reporting and disclosure requirements, applicable large employer (ALE) status is determined each calendar year, based on the average size of the employer’s workforce during the prior year. Thus, if you averaged at least 50 full-time employees, including full-time equivalent employees, during 2014, you are most likely an ALE for 2015 and are subject to the reporting and disclosure requirements due in early 2016.

- **Required Reporting and Disclosure.** The ACA imposes two Internal Revenue Code sections. One requires reporting of minimum essential coverage (MEC); the other requires employers subject to the employer shared responsibility provisions to report on offers of coverage. The forms for both of these reporting requirements are the Form 1094 transmittal and Form 1095 benefit statement. IRC Section 6055 reporting is accomplished on the B series of the form; the employer shared responsibility reporting is accomplished on the C series. A self-funded employer subject to shared responsibility can satisfy both its IRC Sections 6055 and 6056 reporting obligations by completing all parts of the Form 1095-C.

**Deadlines for Filing and Distributing Forms 1094 and 1095**
As mentioned above, the IRS has delayed the filing and distribution due dates applicable to the 2015 Forms, as follows.

**Filing Forms with IRS.** The 2015 Forms 1094-B and 1095-B, and the 2015 Forms 1094-C and 1095-C reports must be submitted to the IRS no later than May 31, 2016 (or June 30, 2016, if filing electronically). Thereafter (beginning with the 2016 reporting forms), the due date for filing the Forms 1094 and 1095 is February 28th of each year (or by March 31st of each year, if filing electronically), or by next business day.

Employers issuing 250+ forms must file the reports electronically (efile) with the IRS. If you are required to efile the Forms 1094 and 1095, you should review IRS Publication 5165, *Guide for Electronically Filing Affordable Care Act (ACA) Information Returns*. This guide provides specific details on the procedures, transmission formats, business rules and validation procedures for returns that must be transmitted in 2016.

**Furnish 2015 Form 1095 to Individuals.** Individuals listed in the 2015 Forms 1094 and 1095 must be furnished copy of the relevant Form 1095 by March 31, 2016. Thereafter (beginning with the 2016 forms), individuals must receive a copy of the relevant Form 1095 by January 31st each year, or by next business day.

**Methods for Furnishing the Form 1095.** The employer can provide a paper copy of the Form 1095 by hand, or send by mail, unless the recipient affirmatively consents to receive the Form 1095 in electronic format.

To provide the statements electronically, the employer must first obtain affirmative consent from the individual to receive it electronically. The consent can be provided to the individual by paper, or electronically such as by email.
Once affirmative consent is obtained, the Form 1095 can be provided to the individual either electronically by email, or by informing individuals how to access the Form 1095 on the employer’s website, if applicable. If posting on the employer’s website, the employer is then required to notify the recipient that the Form 1095 is available on its website; this notice of website availability can be provided to recipients by mail, by email, or in person. The website availability notice must provide instructions on how to access and print the Form. If providing this notice by email, the phrase, “IMPORTANT TAX RETURN DOCUMENT AVAILABLE” must appear in all caps in the email subject line.

**FORM W-2 REMINDER - AGGREGATE COST OF HEALTH COVERAGE**

The Form W-2 must include the aggregate cost of health coverage. The aggregate cost information is to be reported in Box 12, using Code DD. For details about this mandatory reporting, see these CBIZ Health Reform Bulletins, [Reminder: Fast Approaching Form W-2 Reporting Requirement](#) and [Additional IRS Guidance on W-2 Reporting Requirement](#).

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**TAX INFORMATION REPORTING PENALTIES**

As a reminder, the IRS can assess penalties when certain tax information is not provided on a timely basis. Specifically, penalties may be assessed for failure to file information returns or provide payee statements, such as the Forms 1094 and 1095, as well as the Form W-2. Beginning in 2016, the penalty for failure to file an information return is $250 for each return for which such failure occurs, with the total penalty for all failures during a calendar year capped at $3 million. The penalty for failure to provide a correct payee statement is $250 for each statement with respect to which such failure occurs, with the total penalty for a calendar year not to exceed $1.5 million. Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to furnish a payee statement.

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**SUMMARY OF BENEFITS AND COVERAGE**

Under ACA, all group health plans, including grandfathered plans, whether insured or self-funded, are required to provide a Summary of Benefits and Coverage (SBC) to plan participants within certain timeframes:

1. Upon application;
2. By the first day of coverage;
3. Within 90 days of enrollment be special enrollees;
4. Upon contract renewal; and
5. Upon request.

**MARKETPLACE NOTICE OBLIGATION**

All employers subject to Fair Labor Standards Act have an on-going obligation to provide the Notice of Marketplace Options to all new hires within 14 days of hire. The purpose of the Notice is to explain important information about the pros and cons of buying coverage through the marketplace. The DOL provides [model notices](#) (in both English and Spanish) that can be used by employers who offer health coverage to some or all employees, and for those who do not offer coverage.
CBIZ HEALTH REFORM BULLETIN

Patient-Centered Outcomes Research Institute Fee

The Patient Centered Outcome Research (PCOR) fee is required to be reported annually to the IRS on the second quarter Form 720 and paid by its due date, July 31, is based on the average number of lives covered under the policy or plan. For plan years ending between October 1, 2014 and October 1, 2015, the fee was $2.08. The fee increases to $2.17 for policy and plan years ending between October 1, 2015 and October 1, 2016. For additional information about the PCOR fee, see IRS webpage, questions and answers and chart of plans subject to the fees.

Transitional Reinsurance Fee

The ACA imposes a transitional reinsurance fee, the goal of which is to help stabilize premiums in the individual market due to enrollment of higher risk individuals in the marketplace. All insurers and plan sponsors of self-funded plans are required to contribute to this reinsurance fund over a three year period from 2014 through 2016. The contribution rate for the 2015 benefit year is $44 per covered life; in 2016, this amount drops to $27 per covered life.

About the Author:

Karen R. McLeese is Vice President of Employee Benefit Regulatory Affairs for CBIZ Benefits & Insurance Services, Inc., a division of CBIZ, Inc. She serves as in-house counsel, with particular emphasis on monitoring and interpreting state and federal employee benefits law.

Ms. McLeese is based in the CBIZ Kansas City office.

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