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Employee Benefits & Executive Compensation ADVISORY ■

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IRS Notice 2015-87 Provides Much-Needed Guidance for Account-Based Plans and ACA Employer Shared Responsibility Requirement (IRC 4980H)

In IRS Notice 2015-87, the agencies provided further clarification on the impact of the Affordable Care Act (ACA) group health plan market reform provisions on account-based plans and much needed guidance on the Section 4980H employer shared responsibility requirements. In many cases, common benefit design practices for employer credits and opt-outs must be revisited prior to the next annual enrollment.

Health Reimbursement Arrangements (HRAs) and ACA Market Reform Provisions

Q-1: Retiree-only HRAs; exempt retiree-only HRAs

In prior guidance, the agencies made it clear that HRAs subject to the group market reform rules cannot use the HRA to purchase individual market medical coverage. The IRS reiterates that an HRA that covers less than two current employees, such as a retiree-only HRA, is not subject to the ACA's group market reforms. The ACA's group market requirements that require plans to provide no-cost preventive care and prohibit annual or lifetime dollar limits (the "market reforms") on essential health benefits do not apply.

The IRS concluded that a retiree-only HRA can base balances in whole or in part on amounts credited to the HRA as an active employee covered by an HRA integrated with major medical coverage. That said, the IRS cautions that former employees are not eligible for premium tax credits in the Marketplace for any month HRA funds are available to them.

Q-2: HRAs cannot be used to purchase individual market coverage for current employees … they really mean it!

Once again, the IRS makes it clear that an HRA cannot be used by current employees to purchase individual market major medical coverage. An HRA that can be used to purchase individual market major medical coverage will not be considered integrated with ACA compliant group health coverage. As a result, the HRA would violate the ACA's group market reforms.

Building on that premise, the IRS adds that an integrated HRA cannot be used to purchase individual market major medical coverage even if integrated with ACA compliant group health coverage.

Practice Pointer: Notice 2015-87 closes the door on HRAs that reimburse individual market major medical coverage.

Q-3: Transition relief for spend-down HRAs for some amounts credited before 2014

In 2013 FAQ guidance, the agencies provided transition relief for certain pre-existing HRAs. Notice 2015-87 clarifies that after December 31, 2013, HRAs can reimburse medical expenses without violating the ACA's market reforms if:

1) The amounts were credited before January 1, 2013; or

2) The amounts were credited during 2013 under the terms of an HRA in effect on January 1, 2013.

However, if the HRA in effect on January 1, 2013, did not set the amounts to be credited during 2013 or the timing of the credits, the amounts credited during 2013 cannot exceed the amounts credited during 2012 and be credited on an earlier schedule or at a faster rate than the 2012 crediting schedule or rate.

Q-4: HRAs integrated with employee-only coverage cannot reimburse expenses of spouse or dependents

In a significant clarification, the IRS concluded that an HRA that is integrated with employee-only coverage cannot be used to reimburse expenses of an employee's spouse and/or dependents. The HRA only satisfies the ACA's group market reforms if it is limited to individuals who are enrolled in *both* the HRA and the employer's ACA compliant group health plan.

However, the IRS recognized that many HRAs do not currently restrict HRA reimbursements to those covered by the employer's ACA compliant group health plan. An HRA will not fail to be treated as integrated with an employer's ACA compliant group health plan for plan years beginning before January 1, 2016, solely because there is not an overlap in coverage category. In addition, an HRA and group health plan that otherwise would be integrated based on the plan's terms on December 16, 2015, will be treated as integrated for plan years beginning *before* January 1, 2017, even if it reimburses expenses of family members not enrolled in the employer's other group health plan.

Practice Pointer: Notice 2015-87 is not clear whether the family members must be enrolled in an ACA compliant plan of the same employer or whether enrollment in an ACA compliant plan of another employer would suffice. The Notice seems to say that coverage in the ACA compliant plan must be provided by the same employer; however, the final regulations issued prior to the Notice indicate that an HRA can be integrated with another employer's group health plan.

Practice Pointer: The IRS says that the employer must report each individual whose medical expenses are reimbursable as having received minimum essential coverage under Section 6055 (i.e., for 1095 reporting). In some cases, an employer might not know whose expenses are reimbursable under the HRA if the employee has never received group health plan coverage through the employer and/or the employee never filed a claim for that dependent's expenses. Further guidance would be welcome.

Q-5: HRA or employer payment plan can reimburse individual market coverage for excepted benefits like dental and vision

The IRS clarified that an HRA or employer payment plan can reimburse individual coverage that is restricted to excepted benefits only. Typically, such excepted benefits include standalone dental and vision coverage. When funded through an HRA (as opposed to salary reduction through a cafeteria plan), such coverage should not include specified disease or other fixed indemnity coverage.

Practice Pointer: The IRS examples indicate that HRAs that reimburse individual market coverage must have terms limiting reimbursement to coverage for excepted benefits. If the terms of the HRA do not limit reimbursement of individual market coverage to excepted benefits, then the HRA violates the ACA's market reforms. Plan sponsors should review their HRA plan documents and amend them if needed.

Q-6: An employer payment plan offered under a cafeteria plan cannot be used to purchase individual market major medical coverage … again, they really mean it!

The IRS confirms that a cafeteria plan that allows employees to purchase individual market major medical coverage with pre-tax dollars would also be considered an employer payment plan and thus would be prohibited from funding individual market major medical coverage.

How HRAs, Flex Credits, Opt-Outs and Service Contract Act/Davis-Bacon Act Fringe Benefits Affect Affordability

The IRS also provided guidance on how HRA contributions, flex credits and opt-outs affect the affordability and minimum value calculations for employers subject to the ACA's employer mandate.

Q-7: Certain HRA contributions reduce employees' required contribution for affordability purposes

Based on the premium tax credit and affordability regulations, amounts made available under an integrated HRA that employees can use to pay premiums for the employer's plan in the current plan year reduce the employee's required contribution for affordability purposes, even if the employee can also use those amounts to pay cost sharing or other benefits. However, HRA contributions only reduce the employee's required contribution for affordability purposes to the extent the HRA's terms require the employer's contribution or the amount is determinable within a reasonable time before the employee must decide whether to enroll in the employer's group health plan.

For purposes of excise taxes for unaffordable coverage under Section 4980H(b) (the "tackhammer" penalty), as well as Section 6056 reporting (IRS Form 1095-C), the employer contribution is treated as made ratably for each month of the period it relates to.

Q-8 Certain "health flex contributions" reduce an employee's required contribution for affordability purposes. Cashable credits and unrestricted credits will not reduce required contributions.

Certain flex credits reduce the employee's required contribution for affordability purposes when they are "health flex contributions." Health flex contributions are employer contributions that the employee:

1) Cannot opt to receive as a taxable benefit;

2) May use to pay for minimum essential coverage; and

3) May use exclusively for Section 213 medical care.

For purposes of excise taxes for unaffordable coverage under Section 4980H(b)(the tackhammer penalty), as well as Section 6056 reporting (IRS Form 1095-C), a health flex contribution is treated as made ratably for each month of the period it relates to.

Flex contributions that are not health flex contributions do not reduce the employee's required contribution for affordability purposes. Thus, if an employee *can* use a flex credit to pay for non-health care benefits (for example, dependent care or life insurance), then the flex credit will not reduce the amount the employee pays toward the employer's group health plan for affordability purposes even if the employee ultimately uses the credit for health coverage.

The IRS based the distinction between health flex contributions and non-health flex contributions on the final Section 5000A regulations. Those regulations state that the employee's required contribution is the amount of compensation that the employee could use for something other than health-related expenses that the employee must forgo to obtain the employer's health plan coverage.

Example:

An employee who elects self-only health plan coverage must pay $200 per month toward the cost of coverage. The employer offers flex contributions of $600 per year that can only be applied toward the employee share of health plan coverage or contributed to a health FSA. In this case, the flex contribution is a health flex contribution regardless of whether the employee applies it to the employee share of health plan coverage or contributes it to the health FSA. For Section 4980H(b) and its reporting under Section 6056, the employee's monthly required contribution for group health coverage is $150 ($200 – $50).

Note that the amounts above are based on the example in Notice 2015-87. However, if more than $500 of the health flex credit can be contributed to a health FSA, then the health FSA would not be an excepted benefit, which means that the health FSA would be subject to the ACA's market reforms. Plan sponsors should use caution when applying this example.

Example:

An employee who elects self-only heath plan coverage must pay $200 per month toward the cost of coverage. The employer offers flex contributions of $600 for the plan year that can be used for any cafeteria plan benefit, including non-health benefits like dependent care. The flex credit is not available as cash. In this case, the flex contribution is not a health flex contribution and does not reduce the employee's required contribution because it can be used for purposes other than medical care.

Again, note that a flex credit of more than $500 that cannot be cashed out would prevent a health FSA from being considered an excepted benefit, which would violate the ACA's market reforms.

Example:

An employee who elects self-only heath plan coverage must pay $200 per month toward the cost of coverage. The employer offers flex contributions of $600 for the plan year that can be used for any cafeteria plan benefit, including non-health benefits like dependent care, and is available as taxable cash. In this case, the flex contribution is not a health flex contribution and does not reduce the employee's required contribution because it can be used for purposes other than medical care or taken as cash.

Note, however, that the flex credit is payable as taxable cash, so the health FSA could still be considered an excepted benefit.

Solely for purposes of the Section 4980H(b) tackhammer penalty and for plan years beginning *before* January 1, 2017, employer flex contributions that are not health flex contributions, but that can be applied toward health coverage, will be treated as reducing the employee's required contribution for health plan coverage. However, these flex contributions must be made under an arrangement adopted before December 17, 2015. Flex contribution arrangements adopted after December 16, 2015, or arrangements that substantially increase the flex contribution after that date, are not eligible for this relief. A flex contribution arrangement is treated as adopted before December 17, 2015, if:

1) The employer offered the flex contribution arrangement (or a substantially similar flex contribution arrangement) for a plan year that included 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; or

3) The employer had provided written communications to employees *on or before* December *16*, 2015, indicating that the flex contribution arrangement would be offered to employees at some time in the future.

Additionally, for plan years beginning *before* January 1, 2017 (i.e., 2015 and 2016), an employer may reduce the amount of the employee's required contribution by the amount of a non-health flex contribution on line 15 of Form 1095-C even if the flex credit qualifies for the above relief. However, the IRS encourages employers not to reduce the amount of the employee's required contribution by the amount of non-health flex contributions on Form 1095-C because the reduction might affect the employee's eligibility for premium tax credits. As a result, if the employer does not reduce the employee's required contribution on line 15 and is contacted by the IRS regarding excise taxes under Section 4980H(b), the employer can respond to the IRS by showing that:

1) The *employee* would not have been entitled to the premium tax credit if it had reduced line 15 by the non-health flex contribution amount; or

2) The *employer* would have qualified for an affordability safe harbor if the employee contribution had been reduced.

In this situation, both the employer and the employee win, as the employer will be relieved from the 4980H(b) penalty, but the non-health flex contribution will not reduce the employee's required contribution when determining eligibility for the premium tax credit.

Practice Pointer: Notice 2015-87 reminds employers that flex credits an employee can elect to receive as cash or a taxable benefit are counted toward the limit on salary reduction contributions to health FSAs under Section 125(i).

Q-9: Availability of unconditional "opt-out" arrangements increase the employee's required contribution for affordability determinations

Many employers provide "opt-out credits" for employees who decline health coverage. The IRS clarified its position regarding unconditional opt-out payments, which are payments when an employer offers an amount that cannot be used for coverage under its health plan and is only available if the employee declines or waives coverage. An opt-out payment is "unconditional" if it is conditioned solely on the employee declining coverage and not on the employee satisfying other meaningful requirements, such as providing proof of coverage through a spouse's employer.

The IRS stated that the choice between cash and coverage for an unconditional opt-out payment is the same as the cash or coverage choice employees make with salary reductions. In both cases, the employee can purchase health coverage only by giving up a specified amount of cash that he or she would otherwise receive (in other words, salary for salary reductions, or other compensation for the opt-out payment). For example, an employee who must reduce his or her compensation by $1,000 to pay for employer-provided health coverage is making a choice similar to the employee who is not required to pay anything for coverage, but who receives an additional $1,000 in compensation for declining coverage. In both cases, the employee must give up $1,000 in compensation that otherwise would be available.

Example:

An employer requires employees who elect self-only coverage to contribute $200 per month through its cafeteria plan. However, the employer offers an additional $100 per month in taxable wages if the employee declines coverage. The offer of $100 in additional compensation has the effect of increasing the employee's contribution to $300 per month because he or she must forgo $100 per month in compensation in addition to the $200 per month salary reduction for coverage.

The IRS intends to issue proposed regulations regarding this rule. However, the IRS anticipates amounts offered or provided under an unconditional opt-out arrangement that is adopted after December 16, 2015, will increase the employee's contribution for affordability purposes. An opt-out arrangement is treated as adopted after December 16, 2015, if:

1) The employer offered the opt-out arrangement (or a substantially similar 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 opt-out arrangement *before* December *16*, 2015; or

3) The employer had provided written communications to employees *on or before* December *16*, 2015, indicating that the opt-out arrangement would be offered to employees at some time in the future.

Before the applicability date of regulations, employers are not required to increase the amount of an employee's required contribution for Section 6056 (Form 1095-C) reporting purposes if the opt-out is eligible for this relief. In addition, an opt-out payment that is eligible for relief will not increase an employee's required contribution for purposes of determining the tackhammer excise tax under Section 4980H(b).

Again, both the employer and the employee win under this guidance because until the applicability date of any further guidance and at least for plan years that begin *before* January 1, 2017, individuals can treat unconditional opt-out payments as increasing their required contribution for purposes of determining premium tax credits. Also, an individual who can demonstrate that he or she meets a condition that must be satisfied to receive an opt-out payment (e.g., coverage under a spouse's plan) in addition to declining an employer's health coverage may treat the opt-out as increasing his or her required contribution for premium tax credit purposes.

Q-10: Service Contract Act and Davis-Bacon Act fringe benefits.

The McNamara-O'Hara Service Contract Act (SCA), the Davis-Bacon Act and the Davis-Bacon Related Acts (DBRA) require workers employed on some federal contracts to be paid prevailing wages and fringe benefits. The SCA and DBRA typically allow employers to satisfy the fringe benefit obligation by providing benefits of a sufficient dollar value. Usually, employers can select the benefit or benefits they provide. As an alternative, employers usually can satisfy their fringe benefit obligation by paying cash equal to the fringe benefit, or a combination of cash and benefits. If an employer provides SCA or DBRA fringe benefits by allowing employees to elect health coverage, but the employee declines coverage, the employer usually must pay the employee cash or provide benefits of an equivalent value.

Many employers noted that when employers satisfy their SCA or DBRA fringe benefit obligations by offering employees the option to enroll in the employer's health coverage, the amount that must be provided to employees who decline coverage as cash or other benefits is substantial. In addition, amounts that are available as cash payments or other benefits would not reduce the employee's required contribution for health coverage. Employers that satisfied their SCA or DBRA fringe benefit obligation by allowing employees to elect health coverage would also need to provide a significant additional subsidy to make the offer affordable and avoid Section 4980H(b) penalties. This subsidy would result in some employees receiving amounts significantly more than the SCA and DBRA requirements.

The IRS said it will continue to study the interaction of the SCA and DBRA with the employer shared responsibility rules. However, until the applicability date of further guidance and at least for plan years beginning *before* January 1, 2017, the amount of the employer's SCA and DBRA fringe benefit obligation that the employee can use to elect health coverage will reduce the employee's required contribution even if the employee can elect other benefits or cash.

Employers can also treat SCA and DBRA fringe benefit payments as reducing the employee's required contribution on Form 1095-C. However, the IRS encourages employers not to adjust Form 1095-C so that employees can qualify for premium tax credits. The IRS says that if the IRS contacts an employer regarding a possible excise tax under Section 4980H(b), the employer can respond and show that it was entitled to the relief and that it would have qualified for an affordability safe harbor if the employee's contribution had been reduced by the fringe benefit payment. Likewise, employees are not required to take fringe benefits into account as reducing their required contribution when determining premium tax credit eligibility.

The IRS is considering methods for reporting required contributions for employees subject to the SCA or DBRA, such as indicator codes. If adopted, these codes will not apply to plan years beginning *before* January 1, 2017.

Q-11: Relief for flex credits, opt-outs and Service Contract Act/Davis-Bacon Act fringe benefits

The IRS noted that the relief for health flex credits, opt-outs and SCA/DBRA fringe benefits will not affect most employees. However, employees who enrolled in the Marketplace, but did not receive the advance premium tax credit, may need more information from their employers to determine if they can claim the premium tax credit. Employers using the relief in the Notice should notify employees that they can obtain accurate information about their required contribution by calling the number listed on Form 1095-C. Regardless of how the employee obtains this information, the employee can obtain the premium tax credit if the required contribution is not affordable and the employee is otherwise eligible regardless of the information reported on that employee's Form 1095-C due to the relief.

Cost of Living Adjustments

Notice 2015-87 also provides cost of living adjustments for the employer mandate affordability safe harbors and excise taxes.

Q-12: Good news: Affordability safe harbors increased for plan years after 2014

Under the ACA, premium assistance is available if the employee's required contribution for employer coverage exceeds 9.5 percent of household income. For plan years after 2014, this 9.5 percent threshold is adjusted annually for cost of living changes. As a result, employees can obtain premium assistance for Marketplace coverage if the cost of employer coverage exceeds 9.56 percent of their household income for the 2015 plan year and 9.66 percent for the 2016 plan year.

Of course, employers do not know their employees' household income, so the IRS provided affordability safe harbors in its Section 4980H regulations. Under these safe harbors, the employer is deemed to provide affordable coverage if the employee's required contribution for single coverage is no more than 9.5 percent of the employee's rate of pay, employee's W-2 wages or the federal poverty line for a single individual. However, unlike the premium tax credit regulation, the employer mandate regulations did not provide any adjustment to the 9.5 percent threshold for the employer safe harbors. This resulted in an inconsistency where premium assistance was available only if the employee's contribution exceeded 9.56 percent of household income for the 2015 plan year, but the affordability safe harbor for employers was capped at 9.5 percent.

Due to this inconsistency, the IRS intends to amend the Section 4980H regulations so that the employer affordability safe harbors are adjusted with the premium assistance threshold annually. Thus, employers can use the 9.56 percent and 9.66 percent for the 2015 and 2016 plan years, respectively, when determining if coverage met the affordability safe harbors. Employers can also use the adjusted amount to determine whether coverage under a multiemployer plan is affordable under the IRS's interim guidance for multiemployer plan contributions.

The IRS also intends to amend the Section 6056 (i.e., Form 1095-C) regulations so that the threshold for qualifying offers of coverage is adjusted. Generally, an employer can use the qualifying offer method for reporting if the employee's required contribution for employee-only coverage does not exceed 9.5 percent of the mainland single federal poverty line. This change will be applicable back to December 16, 2015, and employers can rely on the adjusted amounts in applying the qualifying offer alternative reporting methods.

Q13: Not as good news: Excise taxes (penalties) also increase

The ACA includes a $2,000 "sledgehammer" excise tax based on the employer's total number of full-time employees when an employee obtains a Marketplace subsidy because the employer did not offer minimum essential coverage to the employee and/or dependents (Section 4980H(a)). The ACA also assesses a $3,000 tackhammer tax for each full-time employee who obtains a Marketplace subsidy because the employer did not offer affordable, minimum value coverage (Section 4980H(b)). These penalties are adjusted annually after 2014. Accordingly, the sledgehammer penalty for the 2015 calendar year is $2,080 and $2,160 in 2016. The tackhammer penalty for the 2015 calendar year is $3,120 and $3,240 in 2016.

Leaves of Absence

Notice 2015-87 also includes highly anticipated guidance regarding the calculation of hours of service during a leave of absence.

Q-14: No hours of service credited after termination

When determining if an employee is full time under the employer mandate, employers must include each "hour of service," which means each hour for which an employee is paid, or entitled to payment, for performing services, as well as each hour that the employee is paid, or entitled to payment by the employer, for a period when no duties are performed due to vacation, holiday, illness, incapacity, disability, layoff, jury duty, military duty or a leave of absence under Department of Labor (DOL) Regulation 2530.200b-2(a).

The DOL regulations are typically used to define hours of service for retirement plans, which has resulted in some confusion. The IRS clarified that the employer mandate regulations do not incorporate DOL Regulation 2530.200b-2(a)(2), which

requires hours to be credited for certain periods when no duties are performed "irrespective of whether the employment relationship has terminated." Thus, an hour of service does not include any hours after an individual terminates employment.

Hours of service not required due to payments from certain plans

Moreover, the IRS stated that it intends to incorporate the limitations in DOL Regulation 2530.200b-2(a)(2)(ii) and (iii). An hour of service for Section 4980H purposes does not include:

1) Hours of service associated with payments from a plan maintained solely to comply with workers' compensation, unemployment or disability insurance laws.

2) Hours for payments that solely reimburse employees for medical or related expenses incurred by the employee.

501-hour limit does not apply (except for educational organizations)

However, the IRS said it did not intend to incorporate the 501-hour limit on hours required to be credited during a single continuous period when the employee performs no duties if the hours otherwise qualify as hours of service (although the 501-hour limit still applies to an employee of an educational organization during employment breaks in a calendar year under Treas. Reg. 54.4980H-3(c)(6)(ii)(B)).

Employer must credit hours for short-term and long-term disability payments

Hours that an employer must credit when no duties are performed must be credited regardless of the payment source. Employees must be credited with hours for short-term or long-term disability payments regardless of whether the employer pays directly or indirectly. For example, an employer must credit hours if it pays disability benefits directly through a trust or if paid by an insurer to which the employer paid premiums. However, the employer does not need to credit hours for payments if the employer did not contribute directly or indirectly. An arrangement that the employee paid for on an *after-tax* basis would be treated as an arrangement the employer did not contribute to and would not result in any hours of service. Moreover, employers need not credit hours to employees receiving workers' compensation payments from a state or local government.

Practice Pointer: The IRS does not require hours of service to be credited when an employee receives disability payments based on his or her previous after-tax contributions. However, pre-tax contributions are considered to be made by the employer. Employers must credit hours of service for disability payments received under coverage that the employer paid for or allowed the employee to obtain on a pre-tax basis through its cafeteria plan.

Q-15: Potential new rules for hours of service for educational organizations

The IRS's employer mandate regulations prohibit most employers from treating a rehired employee as new hire unless the employee had a break in service of at least 13 weeks. However, the IRS provided special rules for educational institutions to account for periods when employees might not be providing services, such as during summer break. Under those rules, employees of educational institutions must have a 26-week break in service before the employer can consider them a new hire under the employer mandate.

However, the IRS is aware of situations where educational institutions are trying to avoid this special rule by using third-party staffing agencies. The IRS intends to propose rules that apply the 26-week break in service requirement in circumstances where services are provided to one or more educational institutions even if the employer is not an educational organization. The IRS intends the rule to apply to employees providing services primarily to educational

organizations who are not given a meaningful opportunity to work during the entire year. For example, the rule would apply to a cafeteria worker who is primarily placed to provide cafeteria services at educational organizations and is not given a meaningful opportunity to provide services during one or more months of the calendar year, such as during summer break. However, an employer that placed cafeteria workers at educational organizations would not apply the special rule to employees who are offered a meaningful opportunity to provide services during all months (for example, by working at a hospital cafeteria during summer break).

The amendments will apply as of the applicability date in the regulations, but not earlier than the first plan year beginning after the date of the proposed regulations.

Q-16: AmeriCorps employees

Notice 2015-87 clarifies that participants in the AmeriCorps program are not employees of AmeriCorps or the grantee receiving assistance through AmeriCorps for which the participant is providing services for purposes of the employer shared responsibility rules of Section 4980H.

Q-17: TRICARE eligibility

The IRS clarified that for determining potential liability under Section 4980H and related information reporting under Section 6056, an offer of coverage under TRICARE for any month based on employment with an employer that results in TRICARE eligibility is treated as an offer of minimum essential coverage by that employer.

Q-18: Applicable large employer (ALE) status or ALE member status

The IRS noted that the aggregation rules under Section 414(b), (c), (m) and (o) that typically apply when determining if an employer is an ALE do not specifically address government entities. As provided in the preamble of the final employer mandate regulations, government entities can use a reasonable, good-faith interpretation of those aggregation rules to determine if it is an ALE or ALE member. The IRS noted this is of little consequence when government entities would independently be ALEs, with one of the few consequences being the allocation of any reduction of assessable payments under Section 4980H(a) or the cap on assessable payments under Section 4980H(b).

Q-19: Separate EINs required for each ALE and ALE member

The IRS clarified that each separate employer entity that is an ALE or ALE member, or that provides self-insured health coverage to employees, must use its own EIN for reporting purposes regardless of the aggregation rules. Thus, separate Forms 1094-C must be filed by each ALE member and each form must have a separate EIN. This is not changed by a government entity's use of a designated government entity (DGE) to file Forms 1094-C and 1095-C.

Example:

A state treats the state executive and its agencies, the judiciary and legislature as three separate employers. The executive, judiciary and legislature must each have separate EINs and file Forms 1094-C and 1095-C with the EIN of the applicable employer.

Example:

Ten counties enter into agreements with a state government entity that the state agency will be the designated government entity for filing on behalf of each county. The state agency must file a 1094-C for each county, as well as itself. Each Form 1094-C will list the name and EIN of the state agency as the designated government entity and the name and EIN of the applicable county as the employer. The Forms 1094-C would be filed with the Forms 1095-C for each employee of that county, which would identify the county as the employer.

Q-20: HSA contributions and VA coverage

Notice 2015-87 addressed the receipt of health care from the Department of Veterans Affairs (VA) and HSA contribution eligibility. As modified by the Surface Transportation Act, an individual receiving VA medical benefits can make HSA contributions if the medical benefits consist only of disregarded coverage, preventive care or hospital care or medical services under any law administered by the VA for service-connected disability. As a rule of convenience, the IRS will consider any hospital care or medical services received from the VA by a veteran who has a VA disability rating to be hospital care or medical services under a law administered by the VA for service-connected disability.

Additional Guidance on Health FSA Carryovers

The IRS modified the cafeteria plan rules to permit health FSA carryovers of up to $500 from year-to-year in Notice 2013-71. Notice 2015-87 provides updates based on common questions.

Q-21: Carryover is included when determining if a health FSA is underspent for COBRA

The IRS clarified that the carryover must be included in determining whether COBRA coverage must be offered because the health FSA is underspent.

Example:

An employee can elect to contribute up to $2,500 to a calendar year health FSA and carries over $500 in unused benefits from the prior year. Thus, the maximum amount the employee can receive under the health FSA for the entire year is $3,000. When the employee terminates employment on June 30, he had submitted $1,100 of reimbursable expenses under the health FSA. As a result, the maximum benefit the employee receives for the remainder of the year is $1,900 (i.e., [$2,500 + $500] – $1,100]).

Practice Pointer: The determination seems to hinge on when the qualifying event occurs. If it occurs prior to the end of the run-out period from the prior year, then it would appear that the carryover amount, which is not yet known, would not be a factor. However, if it occurs after the end of the run-out period, when the carryover is known, the carryover amount would be a factor. Additional guidance on the intended application of this rule would be welcome.

Q-22: Health FSA COBRA premium only includes salary reductions and employer contributions

The IRS also clarified that the COBRA premium for a health FSA can only include the salary reduction election and nonelective employer contributions for the year, plus a 2 percent administrative fee. In other words, carryovers are not included when calculating the COBRA premium for a health FSA.

Q-23: If COBRA is elected, carryover continues until exhausted or COBRA expires

Qualified beneficiaries who elected continuation coverage for their health FSAs must be provided with carryovers if similarly situated non-COBRA beneficiaries receive carryovers. However, the health FSA is not required to allow a COBRA beneficiary to elect additional salary reductions for the carryover period or provide employer contributions during the carryover period. The ability to carry over amounts is limited to the applicable COBRA continuation period (for example, 18 months due to termination of employment). The health FSA cannot charge a premium for the carryover in later years.

Practice Pointer: Employers that provide carryovers in their health FSAs should revise their COBRA notices to describe how the carryover impacts the premium and that amounts carried over will be available until exhausted or the COBRA period ends.

Q-24: Carryover not required if employee does not elect health FSA for next year

The IRS also clarified that a health FSA can limit carryovers to individuals who elected to participate in the health FSA in the next year, even if a minimum salary reduction is required.

Example:

An employer sponsors a health FSA that permits carryovers, but only if the employee participates in the health FSA during the next year. To participate in the health FSA, an employee must contribute at least $60 per year ($5 per month). At the end of 2015, Lou and Maureen each have $26 left in their health FSAs. Lou elects to contribute $600 to the FSA for 2016. Lou's $26 is carried over to the health FSA next year, giving Lou a $626 health FSA balance for 2016. However, Maureen does not elect to contribute to the health FSA in 2016, so she forfeits her $26 and has no health FSA balance for 2016.

Q-25: Health FSAs can have a maximum carryover period

The IRS stated that a health FSA can limit carryovers to a maximum period. For example, a health FSA can limit the ability to carry over unused amounts to one year.

Practice Pointer: If an employer wants to provide a maximum carryover period, it should check to see if a plan amendment is required and notify employees accordingly.

Deadline Delayed for 2015 Forms 1094-C and 1095-C

Finally, the IRS noted that it provided delayed deadlines to submit Forms 1094-C and 1095-C. Employers now have until March 31, 2016, to provide employees with the 1095-C (it was due February 1, 2016). It also extends the due date for electronic filing of the 2015 Forms 1094-C and 1095-C with the IRS from March 31, 2016, to June 30, 2016 (paper submissions by employers filing less than 250 Forms 1095-C are now due May 31, 2016).

The good news for employees is that they can file their income tax return before they receive their 1095-C and *will not* need to amend their returns if they rely on coverage information they received from their employer previously.

The IRS will not allow additional extensions. Employers must show a good-faith effort to comply, as well as file and furnish the statements by applicable deadlines, to qualify for relief from accuracy penalties. Otherwise, the employer must satisfy the IRS's standards for reasonable cause to receive relief. The IRS provided more information on this relief in Notice 2016-4.

If you would like to receive future *Employee Benefits & Executive Compensation Advisories* electronically, please forward your contact information to **employeebenefits.advisory@alston.com**. Be sure to put "**subscribe**" in the subject line.

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