WELLS FARGO INSURANCE

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Legislative update

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Together we'll go far

The IRS releases proposed regulations on ACA reporting requirements under sections 6055 and 6056

The Internal Revenue Service (IRS) recently released two sets of proposed regulations on information reporting requirements under Internal Revenue Code (IRC) sections 6055 and 6056, added by the Patient Protection and Affordable Care Act (ACA). Section 6055 requires providers of minimum essential coverage (MEC), including insurers, self-insuring employers, and certain other health insurance providers that provide MEC, to file an annual report detailing the coverage to the IRS. Section 6055 also requires providers of MEC to distribute a statement to individuals listed on the report to the IRS. Section 6056 requires employers subject to the "play or pay" mandate, known as applicable large employers (ALEs), to file annual reports detailing the terms and conditions of the coverage provided to full-time employees, and also requires distribution of a statement to individuals listed on the report to the IRS. These reporting requirements are intended to facilitate eligibility determinations for the advanced premium tax credit by the Exchange, as well as allow the IRS to verify that taxpayers are complying with the individual mandate. The reporting requirements were originally effective in 2014, but were delayed in conjunction with the "play or pay" delay outlined in IRS Notice 2013-45. The reporting required under sections 6055 and 6056 is now effective for calendar years beginning on or after January 1, 2015. The IRS, however, encourages voluntary compliance in 2014.

Section 6055 MEC reporting

Section 6055 requires information reporting by any person that provides minimum essential coverage to an individual (known as "reporting entities"), which can include employers of any size that provide minimum essential coverage to their employees. The definition of MEC is broadly defined to include any employer-provided group health plan (including any grandfathered plan), but excludes excepted health benefits (such as fixed-dollar indemnity products and limited scope dental and vision benefits).

Information to be reported

Providers of minimum essential coverage must report:

(1) The name, address, and taxpayer identification number (TIN) of the primary insured

(2) The name, dates of coverage, and TIN of each individual covered under a policy

(3) Whether health insurance coverage is a qualified health plan offered through an Exchange

(4) For a qualified health plan the amount of any advance payments of the premium tax credit and cost-sharing reductions

(5) Other information the Secretary requires

Employer group health plan reporting must also include the following information:

(1) The name, address, and employer identification number (EIN) of the employer maintaining the plan

(2) The portion of the premium (if any) paid by the employer

(3) Any other information the Secretary requires for administering the credit under 45R (the tax credit for employee health insurance expenses of small employers)

Time and manner of reporting

The proposed regulations provide that the section 6055 return may be made on IRS Forms 1095-B and 1094-B. These forms are not yet available. The return must be filed on or before February 28 (or March 31 if filed electronically) of the year following the calendar year in which minimum essential coverage was provided. The proposed regulations require electronic reporting for reporting entities that file 250 or more returns during the calendar year.

Statements furnished to individuals

Reporting entities must also furnish a statement to each individual listed on the section 6055 return that shows the name, address, and contact phone number of the reporting entity and information reported to the IRS for that individual. The statements must be furnished on or before January 31 of the year following the calendar year in which minimum essential coverage is provided. If mailed, the statement must be sent to the individual's last known permanent address. A reporting entity may furnish the statement electronically if it meets the requirements set forth in the proposed regulations, including affirmative consent from the recipient in an electronic format.

The first annual statements to individuals must be furnished no later than February 1, 2016 because January 31, 2016 is a Sunday.

Additional information

The proposed regulations provide that insurance issuers are the reporting entity for all insured coverage, including employer provided insured group health plans. Sponsors of self-insured coverage (generally the employer for a self-funded plan established by a single employer) are responsible for reporting under Section 6055. Note that this reporting does not apply on a controlled group basis. Each member of a controlled group that provides MEC is responsible for reporting under section 6055, although one member employer may file on behalf of the other members of the controlled group. For multiemployer plans (commonly referred to as union plans or collectively bargained plans), the responsible reporting entity is the association, committee, or joint board of trustees of the parties who establish or maintain the plan.

Section 6056 ALE reporting

Section 6056 reporting requirements apply to employers that are subject to the "play or pay" mandate, known as applicable large employers (ALEs). An ALE is an employer that employed, on average, at least 50 full-time employees (including "full-time equivalents") during business days in the prior calendar year. "Full-time" employees are those employed on average at least 30 hours per week or 130 hours per month. Although employer size for purposes of the play or pay mandated is determined on a controlled group basis, the reporting requirements apply separately to each employer member of a large employer controlled group. Each ALE member with full-time employees is responsible for reporting under section 6056, even though one employer within a controlled group may file on behalf of other ALE members.

Information to be reported

Those reports must include:

(1) The name, address, and employer identification number of the ALE member, the name and telephone number of the applicable large employer's contact person, and the calendar year for which the information is reported

(2) A certification as to whether the ALE member offered to its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan

(3) The number of full-time employees for each month during the calendar year

(4) For each full-time employee, the months during the calendar year for which coverage under the plan was available

(5) For each full-time employee, the employee's share of the lowest cost monthly premium (self-only) for coverage providing minimum value offered to that full-time employee under an eligible employer-sponsored plan, by calendar month

(6) The name, address, and taxpayer identification number of each full-time employee during the calendar year and the months, if any, during which the employee was covered under an eligible employer-sponsored plan

(7) Such other information as the Secretary may prescribe or as may be required by the form or instructions

Time and manner of reporting

As with the 6055 reporting, an ALE satisfies its reporting requirements under section 6056 if it files with the IRS a return for each full-time employee using Forms 1095–C and 1094–C, or another set of forms the IRS designates. The return must be filed on or before February 28 (or March 31 if filed electronically) of the year following the calendar year in which minimum essential coverage was provided. The proposed regulations require electronic reporting for reporting entities that file 250 or more returns during the calendar year.

Statements to full-time employees

ALEs required to report under section 6056 must also furnish an annual written statement to each full-time employee identified on the annual IRS return. The statement must include the following information:

(1) The ALE's name, address and EIN

(2) The information required to be shown on the section 6056 return with respect to the employee

Employee statements may be provided either by furnishing to the full-time employee a copy of Form 1095-C or any other form designated by the IRS. A substitute statement may be used if it includes the required information and complies with IRS procedures or other guidance. The statements must be furnished on or before January 31 of the year following the calendar year in which minimum essential coverage is provided. If mailed, the statement must be sent to the individual's last known permanent address. A reporting entity may furnish the statement electronically if it meets the requirements set forth in the proposed regulations, including affirmative consent from the recipient in an electronic format.

The first section 6056 employee statements must be furnished no later than February 1, 2016 because January 31, 2016, is a Sunday.

Additional information

The proposed regulations allow ALEs to use third parties, including third party administrators, to file returns and furnish employee statements, but the employer retains ultimate responsibility for providing the information.

For full-time employees eligible to participate in a multiemployer plan (commonly referred to as a union plan or a collectively bargained plan), the proposed regulations note that one return would be filed by the multiemployer plan administrator, pertaining to the employees eligible to participate in the multiemployer plan. A separate return would be filed by the employer for the remaining full-time employees who are not eligible to participate in a multiemployer plan.

Potential simplified methods

ALEs that sponsor self-insured plans are subject not only to the section 6056 reporting requirements, but also to reporting requirements under section 6055, as well as reporting requirements under 6051, which requires employers to provide Forms W-2. The proposed regulations include provisions designed to simplify reporting such as possibility of using indicator codes on Form W-2s, and allowing self-insured health plans to furnish a single statement to covered individuals for both sections 6055 and 6056. The IRS is also considering a number of additional simplified

reporting methods for plan designs that meet certain requirements, including, but not limited to:

- Replacing section 6056 employee statements with Form W-2 reporting
- Eliminating the need to determine whether particular employees are full-time if adequate coverage is offered to all potentially full-time employees
- Allowing employers to report the specific cost of coverage to an employee only if the cost is above a specified dollar amount
- Limited reporting for certain self-insured employers offering no-cost coverage to employees and their families

The IRS has requested comments on a number of the provisions set forth in the proposed regulation. Comments must be submitted by November 8, 2013.

Update on U.S. Supreme Court decision on same-sex marriages (DOMA)

In *U.S. v. Windsor*, the U.S. Supreme Court struck down Section 3 of the Defense of Marriage Act as unconstitutional. Section 3 stated that for federal law purposes, only opposite-sex individuals could be recognized as married spouses.

On August 29, the IRS released Revenue Ruling 2013-17 and a Same-Sex Spouses FAQ that address most — but not all — federal tax issues with respect to same-sex spouses under the U.S. Supreme Court's decision in *U.S. v. Windsor*. Key points regarding Revenue Ruling 2013-17 include:

- A same-sex marriage is treated as valid for federal tax purposes if the individuals are lawfully married under state law or foreign law, even if the state in which they are domiciled does not recognize the validity of same-sex marriages. This holding will be applied prospectively as of September 16, 2013.
- Employer contributions for a same-sex spouse's coverage under a group health plan maintained by the employer will be treated for federal tax purposes as tax-free (that is, the same tax treatment given to health coverage for opposite-sex spouses), effective September 16, 2013.
- Employee contributions for a same-sex spouse's coverage under a group health plan maintained by the employer will be treated for federal tax purposes as being made on a pretax basis, effective September 16, 2013, if the employee has made a pretax salary-reduction election for health coverage under a cafeteria plan maintained by the employer and the employee currently is making after-tax contributions for the health coverage of the same-sex spouse.
- Beginning September 16, 2013, individuals may file amended tax returns and claims for refund for overpayment of taxes based on the retroactive application of *U.S. v. Windsor* to employer-provided health coverage and fringe benefits that are otherwise excludable from income because of an individual's marital status, but only to the extent that the statute of limitations has not already expired.

Employers may claim a refund for excess Social Security taxes and Medicare taxes paid with respect to same-sex spouses, or make an adjustment for the overpayments, by following the instructions for IRS Form 941-X.

There are still unanswered questions for employers with respect to how they design and administer their benefit plans in compliance with the *Windsor* decision. Below are some key additional points:

- **Are employers required to provide health coverage for same-sex spouses as they do for opposite-sex spouses?** For insured plans and non-ERISA self-insured plans, employers will have to treat same-sex marriages the same as opposite-sex marriage for health plan purposes in states that recognize same-sex marriage, presumably without regard as to which state or foreign country that marriage occurred. For ERISA-covered self-insured plans, it is still an open question as to whether ERISA preemption will permit plans to limit their eligibility provisions to opposite-sex spouses (excluding same-sex spouses). This is an issue that will likely be litigated.
- **Midyear enrollment of same-sex spouses and tax implications.** Given the new guidance now allows for pretax treatment of same-sex spouse coverage, this could qualify for a change in status based on a "significant improvement of a benefit package option" and allow employers to permit a midyear election to add the same-sex spouse to coverage. Whether employers are immediately required to affirmatively inform and allow newly eligible same-sex spouses to enroll based on HIPAA special enrollment rights is still not clear. We look forward to further guidance in this area.

Self-insured plans and "essential health benefits"

The Patient Protection and Affordable Care Act (ACA) uses the term "essential health benefits" (EHBs) with respect to two key ACA requirements. First, it arises in 2014 when all individual and small market insured health plans, including those on the public insurance exchanges, must cover all 10 categories of EHBs. Second, it arises in the context of the elimination of all lifetime dollar limits and the phase-out of annual dollar limits on EHBs under all group health plans, grandfathered or not. The prohibition on lifetime dollar limits dates back to plan years starting on or after September 23, 2010. Starting with plan years beginning in 2014, the ACA will fully prohibit plans from having annual dollar limits on EHBs (for plans that have qualified for waivers, current plan year limits cannot be less than $2 million). The ACA lists the following 10 categories of benefits as EHBs:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

With the exception of certain preventive services for nongrandfathered plans, self-insured plans are not required to provide coverage for any of these categories of benefits. However, to the extent they do, plans must meet the prohibition and/or limitation on dollar limits with respect to those benefits. Obviously this is a moot point for plans that apply no direct or indirect dollar limits on any benefits. However, for those that do, questions exist as to whether certain types of medical services fall within any of the above categories. Typical examples of such services are:

- Infertility, particularly more advanced services and procedures
- Chiropractic
- Hearing aids
- Obesity surgery
- Temporomandibular Joint (TMJ)Disorders
- Private duty nursing
- Orthodontia for children

Questions also remain as to whether certain EHBs could be excluded for certain enrollees, such as exclusion of maternity care for dependents only.

Under interim final regulations issued in June 2010 with respect to the lifetime and annual dollar limit prohibitions, regulators did not define what constitutes EHBs, but indicated they would take into account good faith efforts to comply with a reasonable interpretation of the term "essential health benefits" for enforcement purposes. Later regulators indicated that EHBs would generally be determined pursuant to the "benchmark" plans established in various states. More recently, in FAQs issued in February 2012, regulators indicated for self-insured plans, a "permissible definition of EHB . . . is one that is authorized by the Secretary of HHS (including any available benchmark option, supplemented as needed to ensure coverage of all ten statutory categories)." They also indicated their intent "to use their enforcement discretion and work with those plans that make a good faith effort to apply an authorized definition of EHB to ensure there are no annual or lifetime dollar limits on EHB." While an FAQ did indicate that insured plans should use the applicable EHB benchmark for the state in which the related insurance policy is issued and apply that to all participants regardless of the employee's state of residence, guidance has left open the question as to what benchmark or benchmarks self-insured plans can or must select, particularly those plans operating in multiple states and/or territories.

The Center for Consumer Information & Insurance Oversight (CCIIO, a division of HHS) has created a Web site that provides helpful information on the EHB-benchmark plans for each of the 50 states, the District of Columbia and U.S. territories. That information includes a summary of various benefits that are EHBs under each benchmark. There is a notable variance between states as to what benefits are and are not EHBs, particularly with respect to the services listed above. For example, Utah appears to be a state with a benchmark where a significant number of benefits are not considered EHBs, while New Jersey's benchmark has numerous benefits that are considered EHBs. Some commentators have taken the position that self-insured plans can elect a benchmark from any state, including a state to which the plans sponsor has no ties. However, a more conservative position might involve selecting the benchmark of the state in which the sponsor has ties such as a principle place of business or a significant number of employees.

The CCIIO website also includes a "Guide to Reviewing Essential Health Benefits Benchmark Plans," which provides some overriding guidance on state benchmarks. Most significantly, it notes regulations where certain benefits are excluded from EHB, even though an EHB-benchmark plan may cover them. These include:

- Routine nonpediatric dental services
- Routine nonpediatric eye exam services
- Long-term/custodial nursing home care benefits, and/or
- Nonmedically necessary orthodontia

The CCIIO guidance also highlights regulations that plans may not exclude an enrollee from coverage in an entire EHB category, regardless of whether such limits exist in the EHB-benchmark plan. For example, even though a benchmark might exclude dependent children from the category of maternity and newborn coverage, a self-insured plan cannot do so (with the exception of pediatric services). For example, if a plan provides maternity coverage, it must include dependent maternity coverage.

Nondollar limits on EHBs do appear to be permissible. The February 2012 FAQs stated that "plans are permitted to impose nondollar limits, consistent with other guidance, on EHB as long as they comply with other applicable statutory provisions." The CCIIO guidance goes on to state that "[a]nnual and lifetime dollar limits can be converted to actuarially equivalent treatment or service limits."

Ultimately, self-insured plans that impose any dollar limits on benefits should work with their third party administrators in going over the following steps:

1. Identify each covered benefit to which an annual and/or lifetime dollar limit currently applies.
2. Evaluate what states have benchmarks that exclude those benefits from their list of benefits.
3. Evaluate whether a state with a benchmark that excludes some or all of the limited benefits might be a reasonable choice; to the extent there are little or no ties between the sponsor and that state, perhaps consider another state with closer ties, or consult with outside legal counsel as to the propriety of selecting such state benchmark.
4. Consider converting any benefit that is an EHB under the selected state benchmark into a nondollar limit such as a treatment or service limit.

The IRS issues proposed regulations on the small employer tax credit

The IRS issued proposed regulations on the small business health care tax credit, which provides a tax credit for eligible small employers that offer health insurance coverage to their employees. See our April 2010 Legislative Alert for a more in depth discussion about this tax credit. An eligible small employer is an employer with no more than 25 full-time equivalent (FTE) employees whose average annual wages are less than $50,000, adjusted for inflation starting in 2014. This tax credit has been available since 2010, but the proposed regulations outline important changes for 2014:

- The coverage must be offered through a Small Business Health Options Program (SHOP)
- Employers must contribute a uniform percentage of at least 50% of premiums for each employee enrolled in SHOP coverage
- The maximum credit amount increases from 35% to 50% of premiums paid (from 25% to 35% for eligible small tax-exempt employers)
- The credit can be claimed for only two consecutive years beginning on or after 2014
- Cost-of-living adjustments may be made to the average annual wage phase-out amounts

For purposes of determining eligibility for the small employer health care tax credit, an employer generally counts all employees, but excludes independent contractors, sole proprietors, partners in a partnership, more-than-2% shareholders in an S corporation, and more-than-5% owners of other businesses. In addition, seasonal workers are not counted for determining the number of FTE employees and wages, but premiums paid on behalf of a seasonal worker are counted in determining the amount of the credit.

Distribution of Medicare Part D notices

As a reminder, plan sponsors of a prescription drug plan are required to notify covered participants whether their prescription drug coverage is creditable coverage (coverage is expected to pay on average as much as the standard Medicare prescription drug coverage). The notice is intended to help Medicare-eligible individuals determine whether they should enroll in Medicare Part D instead of their employer-provided prescription drug plan. A Medicare-eligible individual who foregoes Part D coverage for a noncreditable employer prescription drug plan could be subject to a Medicare Part D late enrollment penalty.

The plan sponsor is required to issue the Medicare Part D disclosure notice to all Medicare eligible individuals covered under its prescription drug plan including all Medicare-eligible employees and their dependents, Medicare-eligible COBRA participants and their dependents, Medicare-eligible disabled individuals and any retirees and their dependents covered under the prescription drug plan. This notice must be distributed no later than October 15 each year. The notice must also be distributed to all Medicare-eligible individuals when they enroll in the prescription drug plan. A sample copy of the notice of Creditable or Noncreditable Medicare Prescription Drug Coverage is available at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html,