Acadia
BENEFITS INC.

UBA ComplianceCenter

Compliance Recap

2015 Year in Review

UBA Compliance Center

Over the course of 2015, federal agencies and the courts provided employers with a significant amount of new guidance, regulation, and FAQs relating to employer benefit plans. This month-by-month guide provides a timeline of these documents, highlighting all the major changes and updates in 2015.

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January 2015

IRS Releases Information and Forms for Satisfying the Individual Mandate and Claiming 2014 Premium Tax Credits

Although employers are not required to offer coverage during 2014, individuals are generally required to have health coverage during 2014 and must report on that coverage through their 2014 federal income tax return. In many cases, the employee will be able to simply state through a "yes/no" question on their federal income tax form that all individuals claimed on the tax form had minimum essential coverage during all of 2014. Individuals will not be required to attach proof of coverage, and employers and insurers are not required to supply proof of coverage provided during 2014. Individuals may wish to maintain evidence of coverage (such as pay stubs showing deductions for premiums or explanations of benefits) in case they are audited, but this is not required.

Individuals who did not have the needed coverage for the entire year, or who are claiming an exemption from the individual mandate, must use Form 8965 to claim an exemption or determine their penalty (which is determined on a month-by-month basis). The penalty for failing to have coverage in 2014 is the greater of 1% of income and $95 per person or $295 per family.

Individuals who received a premium tax credit/subsidy will need to complete Form 8962. Both state and federally-run Marketplaces will provide all individuals who had coverage through the Marketplace with a Form 1095-A. This form will include information the person will need to complete Form 8962, including the employee's monthly premium and tax credit received, so that the employee can reconcile the premium tax credit already applied toward premium payments with the tax credit amount that they are actually due. Individuals who have not received their full premium tax credit will receive the balance as a tax refund, while those who have received a larger estimated subsidy than they were entitled to will owe additional taxes. The amount that must be repaid is capped, and the IRS has said it generally will waive penalties that may be due for late payment of the amount owed or for failing to pay estimated taxes.

Although employers are not obligated to help employees with these new requirements, for those that wish to do so, the IRS has created a summary and issued Publication 5187 to explain the individual mandate requirements and premium tax credit rules.

U.S. Supreme Court to Hear Same-Sex Marriage Cases

On January 16, 2015, the U.S. Supreme Court agreed to decide whether states that do not allow same-sex individuals to marry, or that refuse to recognize marriages of same-sex couples that were legally performed in another state or country, are violating the U.S. Constitution. In June 2013, the Supreme Court ruled that the Defense of Marriage Act (DOMA), which provided that for federal law purposes marriage could only be between a man and a woman, was unconstitutional. Because the 2013 Supreme Court decision only addressed federal laws, over the past year and a half many lawsuits have been filed challenging the legality of state bans on same-sex marriage. Most of the Courts of Appeals that have considered these cases have ruled that state bans violate the U.S. Constitution (which overrides a state constitution), and currently same-sex marriages are recognized in about two-thirds of the states. However, the Court of Appeals for the Sixth Circuit, which governs Kentucky, Michigan, Ohio and Tennessee, found the state bans to be permissible. The Supreme Court has now agreed to decide which interpretation is correct. A decision is expected in late June 2015.

Until that decision is reached, the current laws generally will continue to apply. Based on the 2013 court ruling, employers in all states should be treating both same-sex and opposite-sex spouses equally for purposes of access to tax-free payment of group health premiums – that is, income should no longer be imputed for coverage provided to same-sex spouses and their children. Income should continue to be imputed if domestic partners are covered.

Employers should remember that they need to administer their plans according to the plan's terms. This means that the employer should review the plan or policy to see how "spouse" is defined. Many plans simply state that employee's "spouse" or "lawful spouse" is eligible – in that case, if the employee was legally married to a same-sex spouse in any state, in most cases the spouse is eligible under the plan. If the plan states that only opposite-sex spouses are eligible, and the employee or employer is located in a state that recognizes same-sex spouses, the employer should discuss the situation with local counsel.

2015 Federal Poverty Guidelines

The Department of Health and Human Services has published the 2015 federal poverty level (FPL) guidelines. These numbers are used when determining whether a person is eligible for a premium tax credit. For 2015, in most states FPL is $11,770 for a single person and $24,250 for a family of four. This compares to $11,670 for a single person and $23,850 for a family of four in 2014. FPL in Alaska for 2015 is $14,720 for a single person and $30,320 for a family of four and in Hawaii it is $13,550 for a single person and $27,890 for a family of four.

Qualified Transportation Benefit Adjustments

In December 2014, Congress retroactively increased some of the limits for qualified transportation benefits. Because the increase occurred so late in 2014, questions were raised about how to handle related adjustments to income and FICA. On January 9, 2015, the IRS issued a Notice that provides a streamlined method for employers to handle FICA adjustments. Employees will make income adjustments on their individual tax returns.

Read a summary of this optional process.

February 2015

Regulatory agencies were busy during the month of February, providing information on a variety of topics including reporting, premium payment arrangements, single benefit products and excepted benefits, and benefit parameters. More information was also released on the "Cadillac tax" and on the definition of "spouse" as it relates to the Family Medical Leave Act (FMLA).

Open enrollment in the Patient Protection and Affordable Care Act's (ACA) health insurance Marketplace (or Exchanges) ended on February 15, 2015, however taxpayers will have an opportunity to enroll during a recently announced special enrollment period from March 15 to April 30, 2015. This period is only for individuals who discover (in the process of filing their taxes) that they owe a fee for not purchasing coverage for 2014. The special enrollment period will not affect penalties assessed for 2014, but will allow those who take advantage of it to avoid being assessed the penalty again for this year. It applies only to

people who live in the states that use the federally-facilitated Marketplace, though several states with their own Marketplaces are similarly extending enrollment periods.

2014 Reporting Forms Published

The IRS published final versions of forms and instructions for required reporting by employers and insurers under the ACA's Sections 6055 and 6056. The forms, which are labeled as 2014 forms, are voluntary. The benefits industry anticipates that the 2015 forms will be similar. An employer with fewer than 50 full-time and full-time equivalent employees in its controlled group that sponsors a fully insured medical plan will not have reporting requirements under Sections 6055 and 6056. All other employers will be responsible for some level of reporting, including employers with 50 to 99 employees for 2015.

Read more about the reporting forms and requirements.

IRS Notice 2015-17

The IRS issued a Notice addressing employer payment or reimbursement of individual premiums in light of ACA requirements, and preventing employers from reimbursing or paying premiums for individual coverage on a pre-tax or after-tax basis. The IRS introduced a grace period for small employers, who will not be subject to penalties for 2014 or from January 1 through June 30, 2015. The Notice also addressed reimbursement for Medicare premiums, TRICARE premiums, and premiums of two-percent shareholders.

Read more about the premium reimbursement restrictions and grace period.

Single Benefit Products and Excepted Benefits

The IRS also issued Frequently Asked Questions (FAQ) on whether supplemental health insurance coverage that provides additional categories of benefits may qualify as excepted health benefits. The IRS has determined that, in addition to the existing criteria for determining if supplemental coverage is excepted, the agency will propose regulations that would classify supplemental coverage as being excepted only if it does not provide coverage of an essential health benefit (EHB) in the state where it is marketed.

Read more about the requirements to be a single product excepted benefit.

Benefit and Payment Parameters Final Rule

On February 20, the Centers for Medicare and Medicaid Services and the Department of Health and Human Services issued a Final Rule with standards for insurers and Marketplaces in 2016, covering topics such as transparency in health insurance rate increases, formulary drug lists, drug mail order opt out provisions, determination of minimum value, and benefits discrimination. Open enrollment for the 2016 benefit year will begin on November 1, 2015, and end on January 31, 2016.

The Final Rule reminds issuers that benefits are not EHBs if the benefit design, or implementation of a benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. The agencies became aware of benefit designs that would discourage enrollment by older individuals or those with health conditions, which it noted were a violation of discrimination prohibitions. Three noted examples of

potentially discriminatory practices include labeling a medically necessary benefit as a “pediatric service,” refusing to cover a single-table drug regimen or extended release regimen that is as effective as a multi-tablet regimen, without appropriate reason for the refusal, and placing most or all drugs that treat specific conditions on the highest cost tiers.

Both fully insured and self-funded plans must pay a transitional reinsurance fee (TRF) for 2014 through 2016. For 2016, the annual contribution for the transitional reinsurance program is $27 per enrollee. The contribution was $44 per enrollee for 2015, and funds reinsurance to the individual market. The contribution is assessed to health insurers and self-insured group health plans providing major medical coverage, although some exceptions exist.

The maximum annual limit on cost-sharing for 2016 has been set. The limit will be $6,850 for self-only coverage and $13,700 for coverage that is not self-only.

Definition of “Spouse” Updated for FMLA

The Department of Labor has issued an updated definition for “spouse” under the Family and Medical Leave Act (FMLA) to make compliance with FMLA easier for both employers and employees. The new regulations will be effective on March 27, 2015, and will define “spouse” as a husband or wife, which refers to a person “with whom an individual entered into marriage as defined or recognized under state law.” The governing state law is that of the “celebration state” or where the marriage took place. Residency of the employee or the state of the employer will no longer have any bearing on the definition of “spouse” for purposes of FMLA. This change means that the same criteria for determining whether an employee is legally married will apply to both benefits and FMLA eligibility determinations.

The updated regulations will allow an employee in a same-sex or common-law marriage to take FMLA leave to care for a child of his or her spouse, or take care of a parent’s same-sex or common-law spouse. For individuals married outside of the United States, the regulations will also apply to any marriages that were legal in the country in which they were performed, as long as the marriage could be legally entered into in at least one state.

Employers may request “reasonable” documentation of a family relationship, but the request cannot interfere with an employee’s rights, and the employer cannot dictate what documentation must be presented. A simple statement by the employee may be sufficient, although the employer may request that a statement be put in writing.

Cadillac Tax Update, Spring 2015

Beginning in 2018, plans that provide coverage that exceeds a threshold will owe an excise tax that is frequently referred to as the “Cadillac tax.” The threshold generally will be $10,200 for single benefits and $27,500 for benefits provided to an employee, retiree, or member of a bargaining unit and dependents. The tax is 40 percent of the value of coverage provided over that threshold level.

The IRS is beginning the process of writing regulations that will provide details on how this tax will operate. On February 23, 2015, the IRS issued Notice 2015-16, which provides some information on the types of benefits that will count toward the tax. It has requested input on how best to value some of these benefits. It also said in the Notice that as part of the process it plans to finally provide guidance on how Consolidated Omnibus Budget Reconciliation Act (COBRA) premiums should be calculated.

Generally, coverage that will count toward the tax includes health flexible spending arrangements (FSAs), health savings accounts (HSAs), governmental plans, retiree coverage, and certain on-site medical clinics. Excluded coverage will include long-term care, stand-alone dental and vision programs, and fixed indemnity coverage. Dollar limits will apply depending on whether the employee has self-only coverage, or other-than-self-only coverage.

Read more about the Cadillac tax proposal.

March 2015

Coming off a busy February, regulatory agencies were noticeably quiet during the month of March. This allowed the Supreme Court to take the spotlight with oral arguments in the Patient Protection and Affordable Care Act (PPACA) related case, *King v. Burwell*. A clarifying FAQ was issued regarding cost-sharing limits for individuals, which was originally announced in February's Final Rule on standards for insurers and Marketplaces in 2016. A Final Rule announcing two pilot programs for employers to provide wraparound excepted benefits was also released. Both Congressional houses have been busy voting on a variety of topics, although nothing has made its way to the President for signature.

The Department of Labor (DOL) also issued an FAQ regarding the time frame during which it intends to finalize changes to regulations regarding summary of benefits and coverage (SBC) requirements. The FAQ confirmed it intends "to finalize changes to the regulations in the near future" which, according to the FAQ, were intended to apply in connection with coverage that would renew or begin on the first day of the first year that begins on or after January 1, 2016. The new SBCs will apply to coverage that would renew or begin on the first day of the first plan year (or, in the individual market, policy year) that begins on or after January 1, 2017 (including open season periods that occur in the fall of 2016 for coverage beginning on or after January 1, 2017).

In February, the DOL issued an updated definition of "spouse" under the Family and Medical Leave Act (FMLA) to make compliance easier, and defined "spouse" as a husband or wife, which refers to a person "with whom an individual entered into marriage as defined or recognized by state law." The governing state law is that of the celebration state or where the marriage took place. This definition was set to go into effect on March 27, 2015. A federal judge in Texas has issued a temporary injunction blocking the ruling from going into effect after the attorneys general in several states that do not recognize same-sex marriage challenged it.

The final outcome of the injunction remains to be seen, and might be affected by an anticipated Supreme Court ruling in one of the same-sex marriage cases pending before it. While employers await a final decision, they should continue to apply the old rule only in the states that are involved in the litigation, which are Texas, Arkansas, Louisiana, and Nebraska. Employers in all other states should apply the new rule.

King v. Burwell

On March 4, 2015, the U.S. Supreme Court heard oral arguments in *King v. Burwell*, a case that centers on the meaning of statutory language regarding premium subsidies in the Patient Protection and Affordable Care Act (ACA). This ACA Advisor will give you an overview of the case and the arguments that were made before the Court. A ruling is anticipated from the Court in late May to early June 2015. As

we await the decision, employees will still receive premium subsidies and employers should continue preparations to meet the employer shared responsibility/play or pay requirements.

Read more about the oral arguments in *King v. Burwell*.

Cost-Sharing Limits for Individuals

In the Benefit and Payment Parameters for 2016 Final Rule issued in February 2015, federal agencies included a clarification that annual cost-sharing limitations for self-only coverage apply to all individuals, regardless of whether the individual is covered by a self-only plan or a non-self-only plan. After initial uncertainty over the information, which was not included in the Final Rule's regulatory language, a "Cost-Sharing FAQ" was issued confirming that the self-only limitation will apply to each individual, regardless of the type of plan the individual is enrolled in, beginning in 2016.

Read more about cost sharing limits for individuals, regardless of plan design.

Wraparound Excepted Benefits

Health plan sponsors would be permitted to offer wraparound coverage to employees purchasing individual health insurance in the private market, including the Marketplace, in limited circumstances, under a new Final Rule issued by the Department of Labor and other federal agencies. The Final Rule, published March 18, 2015, sets forth two narrow pilot programs for the limited wraparound coverage. One pilot program allows wraparound benefits only for multi-state plans (MSPs) in the Health Insurance Marketplace. The second pilot program allows wraparound benefits for part-time workers who enroll in an individual policy or in Basic Health Plan coverage for low-income individuals, which was established under the Patient Protection and Affordable Care Act (ACA).

Read more about wraparound excepted benefits.

April 2015

Regulatory agencies were quiet during the month of April. The most significant guidance came from a variety of federal agencies that issued various documents regarding wellness programs. In addition to a Proposed Rule (discussed below) issued by the Equal Opportunity Employment Commission (EEOC) to align wellness program requirements with Title I of the Americans with Disabilities Act (ADA), other agencies released documents on the same topic. The Department of Health and Human Services (HHS) Office of Civil Rights (which enforces HIPAA privacy rules) released an FAQ on wellness programs and HIPAA privacy and security. Additionally, HHS and the Department of Labor (DOL) issued an FAQ on wellness programs. Finally, HHS released an FAQ on the relationship between insurance reforms under the Patient Protection and Affordable Care Act (ACA) and wellness programs.

A recent audit report from the Treasury Inspector General indicated that the IRS will likely increase its enforcement of entities that are noncompliant in regard to paying the Patient-Centered Outcomes Research Institute (PCORI) fee.

UBA published information and guidance on penalties under the ACA, focusing on excise tax penalties and penalties that large employers must pay if they do not meet their employer shared responsibility/play or pay obligations.

Read more about potential employer penalties under PPACA.

Medicare Part D 2016 Defined Standard Set

The Centers for Medicare & Medicaid Services (CMS) set the 2016 parameters for the defined standard Medicare Part D prescription drug benefit. Most group health plan sponsors offering prescription drug coverage to Part D eligible individuals must disclose to Part D eligible individuals and to CMS whether the plan coverage is creditable or non-creditable. To be creditable, the actuarial value must equal or exceed the actuarial value of standard Medicare Part D coverage under CMS. Practically speaking, a group health plan must offer coverage that is at least as good as standard Part D coverage to be determined creditable. For 2016, the standard deductible is set at $360, the initial coverage limit is $3,310, and the out-of-pocket threshold is $4,850. For further benefit parameters and more, read the full announcement from CMS.

Further Information on DOL's Definition of "Spouse" Under FMLA

As previously reported, in February the Department of Labor (DOL) issued an updated definition of "spouse" under the Family and Medical Leave Act (FMLA) to make compliance easier, and defined "spouse" as a husband or wife, which refers to a person "with whom an individual entered into marriage as defined or recognized by state law." The governing state law is that of the celebration state, or where the marriage took place. This definition was set to go into effect across the United States on March 27, 2015. A federal judge in Texas has issued a temporary injunction blocking the ruling from going into effect after the attorneys general in several states that do not recognize same-sex marriage challenged it. The final outcome of the injunction remains to be seen, and might be affected by an anticipated Supreme Court ruling in one of the same-sex marriage cases pending before it. Although it was originally thought that until litigation concluded employers in all states should apply the old rule, in April the DOL made it clear that **the new rule applies in all states except those involved in litigation, which are Texas, Arkansas, Louisiana, and Nebraska**.

EEOC Proposed Rule for Wellness Programs

On April 20, 2015, a Proposed Rule to amend regulations and provide guidance on implementing Title I of the Americans with Disabilities Act (ADA) as it relates to employer wellness programs was published by the Equal Employment Opportunity Commission (EEOC). To accompany the Proposed Rule, the EEOC also released a Fact Sheet for Small Businesses and an FAQ for the general public.

Title I of the ADA applies to employers with 15 or more employees, prohibits discrimination against people with disabilities, and requires equal opportunity in promotion and benefits, among other things. Under the Proposed Rule, wellness programs that are part of or are provided by a group health plan or by a health insurance issuer (carrier) offering group health insurance in conjunction with a group health plan are required to provide a notice and describe the use of incentives. In the Proposed Rule, "group health plan" refers to both insured and self-insured group health plans. All of the other proposed changes relate to "health programs," which include wellness programs regardless of whether they are offered as part of or

outside of a group health plan or group health insurance coverage. The term "incentives" includes financial and in-kind incentives for participation, such as awards of time off, prizes, or other items of value.

Read more about the EEOC's Proposed Rule on wellness programs.

Vanpooling Benefits

The IRS issued an information letter regarding one of the pieces of criteria used in determining whether a vanpooling benefit is a qualified transportation plan benefit. The IRS did not provide a definitive answer on the matter as a whole, but indicated that the question of who "operates" a vanpool should focus on control – who drives the van, who determines the route, and who determines the pick-up and drop off. Employees receiving transit passes to pay for vanpool rides do not necessarily indicate that a vanpool is private or public transit-operated. Determining who operates a vanpool will help an employer determine whether the related 80/50 rule applies or whether cash reimbursements are available.

May 2015

After a few quiet months, regulatory agencies have picked up steam, leaving employers with a significant amount of new information to digest and work through. The Internal Revenue Service (IRS) was busy updating FAQs relating to reporting under the Patient Protection and Affordable Care Act (ACA) and setting the 2016 high deductible health plan (HDHP) limits. The Department of Labor (DOL) updated all of its model forms and notices relating to the Family and Medical Leave Act (FMLA), and issued FAQs on a variety of topics. The Center for Consumer Information & Insurance Oversight (CCIIO) also released a technical guidance to assist with medical loss ratio rebates and calculations.

2016 High Deductible Health Plan Limits

The IRS has announced that for calendar year 2016 the annual limitation on contributions for individual self-only coverage with an HDHP is $3,350. The annual limit on contributions for an individual with family coverage under an HDHP is $6,750. For 2016 a health plan with an annual deductible cannot be less than $1,300 for self-only coverage, or $2,600 for family coverage and the annual out-of-pocket expenses cannot exceed $6,550 for self-only coverage or $13,100 for family coverage.

Preventive Services FAQ

On May 11, 2015, the Department of Labor (DOL), along with other federal agencies, issued an FAQ regarding the implementation of the Patient Protection and Affordable Care Act (ACA) that focused on coverage of preventive services. Non-grandfathered group health plans and health insurance offered in the individual or group markets must provide certain listed benefits with no cost-sharing to the beneficiary. The FAQ provided information on some commonly confusing or ambiguous requirements including BRCA testing, contraception coverage, and colonoscopy related anesthesia charges.

Read more about the DOL's Preventive Services FAQ.

Cost-Sharing Limits and Provider Discrimination FAQ

On May 26, 2015, federal agencies including the Department of Labor (DOL) issued a short, five-question FAQ on two ACA-related issues: limitations on cost-sharing and provider discrimination. The FAQ further confirmed the self-only maximum annual limitation on cost sharing applies to each individual, regardless of the type of coverage they are enrolled in (self only, family, high deductible, etc.). The FAQ also confirmed that enforcement of the ACA's provider non-discrimination requirements are delayed, assuming plans use a good faith interpretation of the statute as it stands.

Read more about the FAQ on cost-sharing limits and provider discrimination.

IRS FAQs and Webinars

On May 20, 2015, the IRS updated all of its FAQs relating to reporting under ACA sections 6055 and 6056. These FAQs provided more information on reporting COBRA coverage and offers, qualifying offers, when employees must be provided with forms, how governmental units should report, reporting on terminated employees, and third-party reporting.

The IRS also held a webinar on reporting, going over key points on counting employees and properly reporting coverage that is offered.

Read more about the FAQs and IRS webinar.

The Center for Consumer Information & Insurance Oversight (CCIIO) issued a technical guidance covering two topics: (1) limited circumstances in which a health insurance issuer may exclude agent and broker fees or commissions from earned premium; and (2) premium rebate applicability for policy holders who use a premium tax credit.

The medical loss ratio (MLR) requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, and requires them to issue rebates to enrollees if the percentage does not meet minimum standards. The regulations state that a premium means "all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan" including reporting "agents and brokers fees and commissions" as non-claims costs. The Centers for Medicare & Medicaid Services (CMS) has become aware of issuers seeking ways to exclude agent and broker fees from premium. Recognizing there are some instances where a policyholder retains an agent or broker and pays the agent or broker's fee or commission, CMS set the following seven conditions that must all be met in order to exclude agent or broker fees and commissions from premium:

1. The law of the state in which the policy is issued does not deem the agent or broker to be a representative of the issuer;
2. The policyholder is not required to utilize an agent or broker to purchase insurance and may purchase a policy directly from the issuer;
3. The policyholder selects, retains, and contracts with the agent or broker on his or her own accord;
4. The policyholder negotiates and is responsible for the fee or commission separate and apart from premium;
5. The issuer does not include these agent or broker commissions and fees in rate filings submitted to the applicable regulatory agency;

6. The policyholder voluntarily chooses to pass the fee or commission through the issuer and is not required to do so, or the policyholder pays the fees or commission directly to the agent or broker; and,
7. The policyholder issues the 1099 to the agent or broker, if a 1099 is required.

The guidance also confirmed that, in regard to the MLR rebate, when a policyholder is owed an MLR rebate and a portion or all of the premium was paid the premium tax credit, the issuer must provide the rebate to the policyholder.

June 2015

June was a busy month, with multiple updates from regulatory agencies as well as two important Supreme Court opinions that impacted the world of employer benefits. As the Supreme Court wrapped up the October 2014 term, it has granted petitions for the October 2015 term, which will ultimately impact ERISA plans. The IRS updated its PCORI fee instructions on Form 720, provided guidance on expatriate health plan compliance under the Patient Protection and Affordable Care Act (ACA), and released draft reporting forms for reporting relating to the ACA for 2015. The government is also accepting public comments relating to health plan identifier numbers (HPID) requirements, which are currently delayed.

PCORI Fee Instruction Update

The IRS quietly updated the instruction form for Form 720, which is used to pay the Patient Centered Outcomes Research Institute (PCORI) fee, paid by all plans that provide medical coverage to employees. The fee is due by July 31 of the year following the calendar year in which the plan or policy ends. The fee is adjusted every year for medical inflation and paid per covered life. The updated instructions provide for the most recent applicable rate of $2.08 per covered life for policy and plan years ending on or after October 1, 2014, and before October 1, 2015.

HPID Update

The ACA originally set requirements for large and small health plans to obtain a health plan identifier number (HPID), but this requirement was delayed indefinitely in October 2014. The Department of Health and Human Services (HHS) has published a request for information seeking public comments on the requirements of HPIDs, including the requirement to use the HPID in electronic health care transactions. Comments should be submitted by July 28, 2015. A request for comments often indicates the government's desire to move forward with proposed or final regulations on a subject.

IRS Reporting under ACA Sections 6055 and 6056

The IRS has given instructions (in webinars) that when filling out Line 16 on Form 1095-C you may only use one code and you should follow the "code hierarchy" provided in the instructions. The instructions do not have a specific table or listed hierarchy, but when going through the instructions line by line, the following hierarchy emerges:

- 2C trumps all if the employee enrolls in minimum essential coverage
- 2E trumps 2D, 2F, 2G, and 2H

The IRS has also issued draft 2015 reporting forms, which include a few changes from the 2014 forms. The biggest difference between the 2014 and 2015 versions are on Form 1095-C, which in 2015 will likely include (assuming the draft forms are finalized as they currently appear) a "plan start month" field, allowing a filer to indicate the first month of the applicable large employer's (ALE's) plan year. The draft instructions indicate this would be optional for 2015. ALEs could use the 2014 format instead of filling out the information, or in the alternative may either fill out the first month of the plan year or fill in "00" rather than the actual first month. Beginning in 2016 this field will be required. Currently it is unclear if employers can use the 2014 forms if they choose to use the 2014 format, or if they should use the 2015 format and leave the field blank.

Read more about the IRS draft forms.

IRS Provides Expatriate Plan Guidance

The IRS released a notice providing further guidance on expatriate health coverage. The guidance generally provided for:

- Temporary relief allowing taxpayers to apply the requirements of the Expatriate Health Coverage Clarification Act (EHCCA) using a reasonable and good faith interpretation of the EHCCA while issuers, employers, and plan sponsors modify their current arrangements to comply with the EHCCA.

- Clarification that the EHCCA exemption from ACA provisions does **not apply** to requirements of sections 6055 and 6056 (play or pay reporting). However, statements to individuals reporting an offer of minimum essential coverage may be furnished electronically (unless the recipient refuses consent).

- PCORI fee calculations may exclude lives covered under a specified health insurance policy that is issued or renewed on or after July 1, 2015, or under an applicable self-insured health plan for plan years starting on or after July 1, 2015, if the facts and circumstances demonstrate that the policy or plan

  (1) was designed and issued specifically to cover primarily employees

    (a) who are working and residing outside the United States, or

    (b) who are not citizens or residents of the United States but who are assigned to work in the United States for a specific and temporary purpose or who work in the United States for no more than six months of the policy year or plan year; or

  (2) was designed to cover individuals who are members of a group of similarly situated individuals for purposes of § 3(d)(3)(C) of the EHCCA under the explained special rule for groups of similarly situated individuals.

The IRS will consider an individual to be a member of a group of similarly situated individuals if

- the group of individuals satisfies the standards under §§ 3(d)(3)(C)(i) and (ii) of the EHCCA;

- in the case of a group organized to travel outside the United States, each member of the group is expected to travel or reside outside the United States for at least six months of the policy year (or, in the case of a policy year that is less than 12 months, for at least half of the policy year), and in the case of a group organized to travel within the United States, each member of the group is expected to travel or reside in the United States for not more than 12 months; and
- the group of individuals meets the test for having associational ties under § 2791(d)(3)(B) through (F) of the PHS Act (42 U.S.C. 300gg-91(d)(3)(B) through (F)).

U.S. Supreme Court Upholds ACA Subsidy Eligibility on Federal Exchanges

The Supreme Court issued its opinion in *King v. Burwell*, holding that the Internal Revenue Service (IRS) may issue regulations to extend tax-credit subsidies to coverage purchased through Exchanges established by the federal government under the Patient Protection and Affordable Care Act (ACA). The six-to-three opinion was authored by Chief Justice John Roberts, who was joined by Justices Kennedy, Ginsburg, Breyer, Sotomayor, and Kagan.

Read more about *King v. Burwell*.

U.S. Supreme Court Finds Same Sex Marriage Is Protected by the 14th Amendment

The Supreme Court ruled in *Obergefell v Hodges*, that the 14th Amendment requires a state to license a marriage between two people of the same sex, and to recognize a marriage between two people of the same sex when their marriage was lawfully licensed and performed out of state. The decision was reached five to four. Justice Kennedy delivered the majority opinion and was joined by Justices Ginsburg, Breyer, Sotomayor, and Kagan.

As a result, group health plans that offer spousal benefits must extend these benefits to any individual who is validly married in any state, regardless of the sex of his or her spouse. Although the ruling does not explicitly extend to same-sex marriages performed out of the country, other federal regulations on the issue would indicate that employers should also recognize same-sex marriages performed validly wherever the marriage took place. It is likely that the Department of Labor and other agencies will issue guidance on this issue, but employers should be prepared to change spousal policies excluding same-sex marriages as soon as practicably possible.

Read more about *Obergefell v. Hodges*.

July 2015

July brought the benefits industry increased fines relating to the Patient Protection and Affordable Care Act (ACA) as well as some much-anticipated updates and information on a variety of subjects. A trade bill passed in early July increased penalties for employers that fail to file IRS forms relating to the ACA's play or pay provision, while a Final Rule brought clarity to requirements regarding preventive services that must be offered by all non-grandfathered group health plans. The Department of Labor (DOL) issued guidance on how to properly determine if a worker is an employee or an independent contractor, and the

IRS issued further information on potential methods of implementing the 2018 Cadillac tax. Finally, in a bill aimed at assisting veterans, changes were made to the way some veterans are included in the headcount for determining applicable large employer (ALE) status under the ACA, and health savings account (HSA) eligibility rules were relaxed for individuals with healthcare from the Department of Veterans Affairs.

Trade Bill Increases ACA Penalties

Most employers are familiar with the penalties assessed to applicable large employers (ALEs) that fail to offer minimum essential coverage that is minimum value and affordable. In addition to being required to offer coverage, employers (all applicable large employers and all employers with self-funded plans regardless of size) are required to complete IRS reporting forms under sections 6055 and 6056 of the Patient Protection and Affordable Care Act (ACA). These forms are used to inform the IRS and employees about the coverage that was offered and enrolled in, allowing employees to satisfy the individual mandate and allowing employers to confirm they met the requirement to offer coverage.

On June 29, 2015, President Obama signed the Trade Preferences Extension Act of 2015. The bill included significant increases for failure to file a number of required tax reporting forms, including the forms required under sections 6055 and 6056. The Trade Preferences Extension Act of 2015 also restored the Health Coverage Tax Credit (HCTC) for all eligible coverage months beginning before January 1, 2020.

Read more about the Trade Preferences Extension Act of 2015 and its impact.

Preventive Services and Closely Held Corporations

Federal agencies released final regulations on the preventive services mandate of the Patient Protection and Affordable Care Act (ACA) that requires non-grandfathered group health plans to provide coverage without cost-sharing for specific preventive services, which for women include contraceptive services. The 2015 Final Rules (applicable for plan years beginning on or after September 14, 2015) provide the following:

- Formalizes prior guidance requiring a plan to cover out-of-network services without cost sharing if the plan does not have an in-network provider who can provide a required preventive service.
- Provides for midyear plan changes if a recommended preventive service is downgraded (by task force or advisory body) to a "D" rating or is subject to a safety recall or other significant safety concern.
- Provides contraceptive coverage accommodations for eligible organizations.

Read more about the Final Rules and preventive services coverage.

Cadillac Tax Notice

The IRS has issued its second notice regarding the upcoming implementation of the Patient Protection and Affordable Care Act's (ACA's) excise tax on high cost employer-sponsored health coverage, also known as the "Cadillac tax." Beginning in 2018, plans that provide coverage that exceeds a set threshold will owe the tax. On July 30, 2015, the agency released Notice 2015-52, which addresses IRS thoughts on: (1) the definitions of applicable coverage; (2) the determination of the cost of applicable coverage;

and (3) the application of the dollar limit on the cost of applicable coverage to determine any excess benefit subject to the excise tax. The IRS is seeking public comment on all of these issues.

Read more about the potential process for implementing the 2018 Cadillac tax.

Veteran Exception to ALE Status; New HSA Eligibility Rule

The Surface Transportation and Veterans Health Care Choice Improvement Act (STVHCC) of 2015 was signed into law by President Obama on July 31, 2015. The Act is focused on surface transportation programs but has impact on rules regarding how to count employees under the Patient Protection and Affordable Care Act (ACA) as well as health savings account (HSA eligibility) for individuals receiving care through the Veterans Administration. The STVHCC allows employers (effective months beginning after December 31, 2013), solely for purposes of determining ALE status, to disregard in any month an employee that has medical coverage for that month through TRICARE or under a federal health care program through the Department of Veterans Affairs. The STVHCC also provides that individuals who receive hospital care or medical services under any law administered by the Secretary of Veterans Affairs for service-connected disability are still HSA eligible for any months after December 31, 2015.

Read more about the Surface Transportation and Veterans Health Care Choice Improvement Act.

August 2015

August was a generally slow month with a few important updates for the benefits industry. Notably the Internal Revenue Service (IRS) issued draft instructions for its reporting forms relating to the Patient Protection and Affordable Care Act's (ACA) employer-shared responsibility requirements. The draft instructions, although generally unremarkable, did contain new language regarding reporting on health reimbursement accounts (HRAs) that raises more questions than answers. Finally, the Department of Labor (DOL) issued an FAQ regarding reporting rulemaking for non-qualified health plan coverage.

2015 Draft 6055/6056 Reporting Instructions

Under the Patient Protection and Affordable Care Act (ACA), individuals are required to have health insurance while applicable large employers (ALEs) are required to offer health benefits to their full-time employees. Reporting on this coverage is done in large part through IRS Forms 1094-B, 1095-B, 1094-C, and 1095-C. The IRS has issued draft 2015 instructions, which include a variety of changes from the 2014 instructions. For the 1094-C and 1095-C forms, the following important clarifications were provided: (1) who must file, (2) information on extensions and waivers, (3) how to correct returns, (4) an example and further information on the 98% offer method, (5) information on the new plan start month box, (6) multiemployer plan reporting, (7) offers of COBRA coverage, (8) reporting on employee premiums, and (9) break in service information.

Read more about the draft instructions.

The new draft instructions relating to section 6055 had new language that affects reporting on HRAs. Beginning in 2013, during the proposed rulemaking stage, the government was clear that health savings accounts (HSAs) and HRAs that supplement minimum essential coverage (MEC) are not required to report

under the 6055 requirements. This obligation, or lack thereof, was repeated in the final regulations and in related IRS FAQs. The new draft instructions contain new and contradictory information on page three.

Supplemental Coverage

Providers aren't required to report the following minimal essential coverage that is supplemental to other minimum essential coverage.

- Coverage that supplements a government-sponsored program, such as Medicare or TRICARE supplemental coverage.
- Coverage of an individual in more than one plan or program provided by the same plan sponsor (the plan sponsor is required to report only one type of minimum essential coverage).

Coverage isn't provided by the same plan sponsor if they aren't reported by the same reporting entity. **Thus, an insured group health plan and a self-insured health reimbursement arrangement covering the employees of the same employer aren't supplemental.** (Emphasis added)

Taken at face value, this language in the draft instructions would require employers of all sizes to greatly increase their reporting obligations if they offer an HRA to employees. Employers with HRAs should reach out to their carriers, third-party administrators, and any vendor they rely on for reporting to discuss the approach or approaches these entities are taking. Until the instructions are finalized, it is unclear what the reporting obligations for HRAs will be.

Read more about the 6055 reporting on HRAs.

Transparency Reporting Rulemaking for Non-QHP Coverage

The DOL announced that it will propose transparency reporting for non-QHP (Qualified Health Plan) issuers and non-grandfathered group health plans in the future. Federal agencies intend to streamline reporting under multiple reporting provisions of the ACA and reduce unnecessary duplication.

September 2015

After a slow summer, federal agencies picked up the pace in September, with a large assortment of guidance, proposed rules, and updated forms and instructions. Nondiscrimination regulations were proposed, a temporary safe harbor was announced for summary and benefits of coverage, and the 2015 6055/6056 reporting forms and instructions were finalized, among other things.

In addition the larger updates, the American Bar Association's Committee on Employee Benefits released the minutes of a presentation from the IRS, with questions 21 through 24 pertaining to the employer shared responsibility provisions and related IRS reporting. The IRS also released the special per diem rates used to substantiate business expenses incurred during travel on or after October 1, 2015.

The Center for Consumer Information and Insurance Oversight (CCIIO) released technical guidance on the limited circumstances under which a health insurance issuer will not be out of compliance with regulatory deadlines for 2014 reporting year medical loss ratio (MLR) rebate distributions.

Exchange and Marketplace Notifications

The Centers for Medicare & Medicaid Services (CMS), through the CCIIOO, released an FAQ providing that all Exchanges on Healthcare.gov will notify certain employers if one or more employees received a subsidy on the Exchange. The notification process will be phased in, with the Exchanges first sending notices to employers with employees who received a subsidy for at least one month in 2016 and who provided a complete employer mailing address. CMS will be working to determine the next stage of the phase-in. For now, notifications will come via mail, but CMS is considering using email notifications in the future. An employer has 90 days from the notice to appeal, and the appeal request form will be available on Healthcare.gov.

Non-Discrimination Regulations Proposed

The Department of Health and Human Services (HHS) has issued the first of the anticipated nondiscrimination rules, which sets forth proposed regulations to implement Section 1557 of the Patient Protection and Affordable Care Act (ACA). Section 1557 provides that individuals shall not be excluded from participation, denied the benefits of, or subjected to discrimination under any health program or activity that receives federal financial assistance, on the basis of race, color, national origin, sex, age, or disability. The proposed regulations also apply to any program administered by an agency of the federal government or an entity established under Title I of the ACA. These applicable entities are "covered entities" and include a broad array of providers, employers, and facilities. State-based Marketplaces are covered as Title I entities, as are Federally-Facilitated Marketplaces.

Although the proposed regulations are aimed primarily at preventing discrimination by health care providers and insurers, it would also apply to the employee benefits programs of an employer that is principally or primarily engaged in providing or administering health services or health insurance coverage, or employers who receive federal financial assistance to fund their employee health benefit program or health services. Employee benefits programs include fully insured and self-funded plans, employer-provided or sponsored wellness programs, employer-provided health clinics, and longer-term care coverage provided or administered by an employer, group health plan, third party administer, or health insurer.

Read about the proposed nondiscrimination regulations.

Minimum Value Rule Change

Beginning in 2015, under the ACA, large employers must offer affordable, minimum value coverage to their full-time employees or potentially pay a penalty. Some companies have or had been marketing a plan that they state satisfies the minimum value requirement (an actuarial value of 60 percent), based upon a calculator provided by the Department of Health and Human Services (HHS), even though the plan does not cover inpatient hospital charges. New information provided by the IRS and HHS in 2014 and recently in 2015 should be considered as employers review their benefit offerings.

On September 1, 2015, the Department of the Treasury issued a supplemental notice of proposed rule making that would modify its current rule regarding the ACA minimum value standards to ensure that to meet minimum value requirements, a group health plan must meet or exceed an actuarial standard value of

at least 60 percent and provide substantial coverage of inpatient hospital services and physician services. The purpose of the proposal is to incorporate the substance of the earlier HHS rules into IRS regulation.

Read about the minimum value rule change.

Summary of Benefits and Coverage Safe Harbor

A Summary of Benefits and Coverage (SBC) is four-page (double-sided) communication required by the federal government under the ACA. It must contain specific information, in a specific order and with a minimum size type, about a group health benefit's coverage and limitations. An SBC is required whenever application or open enrollment materials are provided to new hires or current employees. If no application or open enrollment materials are given, an SBC must be provided when the person can first enroll in the plan.

The Department of Health and Human Services (HHS) has announced that, due to difficulties for some issuers that have hundreds of documents that must be posted to comply with the requirement for both individual and group coverage, it will not take enforcement action against issuers that make available individual coverage policy or group certificate of coverage documents no later than November 1, 2015. HHS expects all group and individual health insurance issuers to provide an Internet address for the group certificate of coverage or individual policy documents by the date on which the SBC is otherwise required.

Read about the summary of benefits and coverage safe harbor.

2015 IRS Reporting Forms and Instructions Finalized

Under the ACA, individuals are required to have health insurance while applicable large employers (ALEs) are required to offer health benefits to their full-time employees. In order for the Internal Revenue Service (IRS) to verify that (1) individuals have the required minimum essential coverage, (2) individuals who request premium tax credits are entitled to them, and (3) ALEs are meeting their shared responsibility (play or pay) obligations, employers with 50 or more full-time or full-time equivalent employees and insurers will be required to report on the health coverage they offer. Final instructions for both the 1094-B and 1095-B and the 1094-C and 1095-C forms were released in September 2015, as were the final Forms 1094-B, 1095-B, 1094-C, and 1095-C.

Guidance was provided on reporting offers of COBRA coverage, when to report health reimbursement arrangement (HRA) coverage, and when extensions or waivers might be available.

The IRS also updated its corresponding FAQ on 1094-C and 1095-C reporting.

Read about the 2015 IRS reporting forms and instructions.

Minimum Essential Coverage Reporting

Minimum essential coverage (MEC) is the type of coverage that an individual must have under the Patient Protection and Affordable Care Act (ACA). Employers that are subject to the ACA's shared responsibility provisions (often called play or pay) must offer MEC coverage that is affordable and provides minimum value.

The IRS has issued Notice 2015-68 stating that it intends to propose regulations relating to reporting on MEC that would:

- Provide that health insurance issuers must report coverage in catastrophic health insurance plans, as described in section 1302(e) of the Affordable Care Act, provided through an Affordable Insurance Exchange (Exchange, also known as a Health Insurance Marketplace),
- Allow electronic delivery of statements reporting coverage under expatriate health plans unless the recipient explicitly refuses consent or requests a paper statement,
- Allow filers reporting on insured group health plans to use a truncated taxpayer identification number (TTIN) to identify the employer on the statement furnished to a taxpayer, and
- Specify when a provider of minimum essential coverage is not required to report coverage of an individual who has other minimum essential coverage.

Read about minimum essential coverage reporting.

October 2015

October was a relatively quiet month, although it began with a big shift for employers with the Protecting Affordable Coverage for Employees (PACE) Act becoming law, which amended the Patient Protection and Affordable Care Act (ACA) and redefined small employers as those with 50 or fewer employees and gave states the option to expand the definition to include employers with up to 100 employees. The IRS proposed straightforward regulations to implement the Supreme Court's holding in *Obergefell v Hodges*, which recognized same sex marriage as a civil right.

Same Sex Marriage Proposed Regulations

In June 2015, the Supreme Court ruled in *Obergefell v Hodges* that the 14th Amendment requires a state to license a marriage between two people of the same sex, and to recognize a marriage between two people of the same sex when their marriage was lawfully licensed and performed out of state. The IRS has issued proposed regulations to reflect that holding, which will impact married couples, employers, sponsors, and administrators of employee benefit plans and executors.

The Proposed rule would require that terms indicating sex, such as "husband," "wife," and "husband and wife," will be interpreted in a neutral way to include same-sex and opposite-sex spouses.

Read about the proposed regulations on the definition of "spouse" under IRS code.

November 2015

As 2015 winds down, federal agencies are working to provide updates and proposed or final regulations. The Patient Protection and Affordable Care Act's (ACA) auto-enrollment requirement was repealed, implications of the PACE Act were clarified, a proposed rule relating to the Genetic Information Nondiscrimination Act (GINA) and wellness programs was released, and a final rule on grandfathered health plans was issued, to name a few.

FAQ on Mental Health Parity and the ACA

In October 2015, the Department of Labor (DOL) provided an informational FAQ relating to the Mental Health Parity and Addiction Equity Act (MHPAEA) and ACA market reform provisions.

Non-grandfathered group health plans and individual or group market health insurance must cover a variety of preventive services without any cost-sharing requirements. Required preventive services include "breastfeeding comprehensive support and counseling from trained providers, and access to breastfeeding supplies," obesity screening and weight management services for certain individuals, colonoscopies for certain age groups, and contraception coverage for women.

Read more about the DOL's FAQ.

ACA Auto Enrollment Requirement Repealed

The ACA initially required employers with more than 200 full-time employees and that offer employees one or more health benefit plans to automatically enroll (and re-enroll existing) full-time employees into one of the health plans (subject to any waiting period authorized by law), in accordance with DOL regulations.

Following delays in the DOL regulation, the "Bipartisan Budget Act of 2015," which was signed by President Obama on November 2, 2015, repealed the auto-enrollment requirement.

Employers are still free to use default or negative elections for employee enrollment, but employers with more than 200 employees are not longer required to do so.

EEOC Proposes Rule Relating to GINA and Wellness Programs

On October 30, 2015, the Equal Employment Opportunity Commission (EEOC) issued a proposed rule to amend the regulations implementing Title II of the Genetic Information Nondiscrimination Act (GINA) as they relate to employer wellness programs that are part of group health plans. The proposed rule would allow employers to offer financial incentives and inducements to spouses who offer information about current or past health status as part of a wellness program.

Read about the EEOC's proposed rule.

Final Rule on Grandfathered Health Plans

On November 13, 2015, federal agencies issued a final rule that essentially combined a variety of interim final rules and non-regulatory guidance on a variety of ACA initiatives such as grandfathered health plans, preexisting condition exclusions, internal and external appeals, rescissions of coverage, lifetime and annual limits, emergency care access and dependent coverage. The final rule was very similar to the previous guidance it consolidated. The final rule goes into effect on January 1, 2017. At that time all of the prior interim rules will be superseded.

The final rule also noted that various transitional rules are now void, such as the allowance of grandfathered health plans to exclude children under age 26 who were eligible for other group health plan

coverage, and rules that provided a special enrollment period for children under age 26 who had been excluded from coverage.

Read more about the final rule on grandfathered health plans and more.

PACE Act Clarifications from CMS

The Providing Affordable Coverage for Employees (PACE) Act amended the ACA and redefined small employers as those with 50 or fewer employees; it also gives states the option to expand the definition to include employers with up to 100 employees (or, practically speaking, those with 51 to 100 employees, also called "mid-size employers"). Prior to the ACA, all states defined small employers as those with 1 to 50 or 2 to 50 employees; however, many have passed legislation redefining the group size up to 100 employees beginning in 2016. States are now in the process of determining what they define as "small employer."

The Centers for Medicare & Medicaid Services (CMS), in response to the PACE Act, issued an FAQ on the impact of the PACE Act on small group expansion. CMS clarified that states that choose to expand the definition up to 100 employees beginning January 1, 2016, were required to notify CMS of the decision by October 1, 2015. States with other effective dates should notify CMS of the decisions as soon as is practical. A state's definition is legally binding on health insurance issuers.

December 2015

2015 went out with a bang, as federal agencies and the White House issued a number of major delays relating to employee benefits. Most significantly, IRS reporting for the Patient Protection and Affordable Care Act's play or pay requirement has been delayed, for both forms being sent to employees and forms being sent to the IRS. The Cadillac tax was also delayed two years, and commuter transit benefit parity was permanently achieved.

Omnibus Legislation

President Obama has signed the omnibus legislation that includes the Consolidated Appropriations Act for 2016 and a tax extenders package. The agreement will keep the federal government running through September 2016. Within the legislation is language that significantly impacts provisions of the Patient Protection and Affordable Care Act (ACA), largely through delays of upcoming taxes.

The most significant delay contained in the omnibus bill is a two-year delay on the "Cadillac tax" or the 40 percent excise tax on high-cost health insurance.

The omnibus bill also put a moratorium on the Health Insurance Provider (HIP) fee for 2017, which went into effect in 2013 and will return in 2018. The HIP fee imposes an aggregate annual tax apportioned among health insurers of "United States health risks" whose annual net premiums written exceed $25 million based on relative market share.

Read more about the omnibus legislation.

6055 and 6056 Reporting Delay

On December 28, 2015, the IRS issued Notice 2016-4, delaying the ACA's employer shared responsibility reporting deadlines.

The reporting requirements are in Sections 6055 and 6056 of the ACA. Forms 1094-C, 1095-C, 1094-B, and 1095-B were originally due to the IRS by February 28 if filing on paper (by February 29 in 2016, because February 28 falls on the weekend), or March 31 if filing electronically. The 1095-C form was due to employees by January 31 of the year following the year to which the Form 1095-C relates (February 1 in 2016, because January 31 falls on a weekend). The 1095-B was due to the individual identified as the "responsible individual" on the form by January 31 (February 1 in 2016, because January 31 falls on a weekend).

The transition relief provided by Notice 2016-4 **extended the due date for furnishing Form 1095-B and 1095-C to individuals to March 31, 2016. The due date for filing all forms (1094-C, 1095-C, 1094-B, and 1095-B) to the IRS is moved from February 29, 2016, to May 31, 2016, if filing by paper. If filing electronically, the date is moved to June 30, 2016.**

	Paper Filing	Electronic Filing
1095-B or 1095-C Forms to Employee	Originally: February 1, 2016 **Delayed: March 31, 2016**	**N/A**
1094-B, 1095-B, 1094-C, and 1095-C Forms to IRS	Originally: February 29, 2016 **Delayed: May 31, 2016**	Originally: March 31, 2016 **Delayed: June 30, 2016**

Read more about the delay.

IRS Notice 2015-87

On December 16, 2015, the Internal Revenue Service (IRS) and other federal agencies released IRS Notice 2015-87, which is a "potpourri" update that covers many different topics relating to the ACA, including some relating to market reforms.

The Notice generally covers health reimbursement arrangements (HRAs) and other employer payment plans, the impact of HRAs, flex credits, opt-out incentives or fringe benefit payments on affordability calculations relating to applicable large employers (ALEs), IRS reporting that is required for ALEs, rules for health savings accounts (HSAs) for individuals eligible for benefits administered from the Department of Veterans Affairs (VA), COBRA rules in relation to unused health flexible spending arrangement (HFSA) funds and a reiteration of safe harbors relating to good faith reporting for ALEs.

Read more about IRS Notice 2015-87.

Commuter Benefit Parity

The omnibus legislation that was signed into law also equalized commuter benefits between benefits for public transit passes and vanpools versus benefits for qualified parking. In 2015 the maximum tax-exclusion for public transit and vanpool went from $250 to $130 and remained at $250 for qualified parking. The omnibus legislation updates the 2016 maximum monthly tax exclusion for both public transit

passes, vanpools, and qualified parking benefits to $255. It retroactively raises the 2015 maximum for public transit passes and vanpools from $130 to $250. Employers who provided taxable transit benefits above $130 and up to $250 in 2015 will need to make adjustments to quarterly tax returns and refund employees that had over withholdings.

IRS Final Rule on Minimum Value

In December 2015, the Internal Revenue Service (IRS) issued a final rule that clarifies various topics relating to the Patient Protection and Affordable Care Act (ACA) and premium tax credit eligibility provisions. The rule finalizes regulations that were proposed years earlier on topics such as inclusion of a child's income in household income, factoring in wellness incentives for affordability, and mid-month enrollment of newborns and other dependents due to adoption, foster placement and similar situations.

Read more about the IRS rule.

1/11/2016