Schulte Roth&Zabel

# Employment & Employee Benefits Developments

January 2015

## New Health Care Compliance Considerations for Employers in 2015

Over the past year, the U.S. Departments of Labor (the "DOL"), Treasury and Health and Human Services ("HHS") (collectively, the "Departments"), as well as the Internal Revenue Service ("IRS"), have issued a variety of rules and regulations applicable to group health plans. Employers and other plan sponsors of group health plans (collectively referred to throughout as "plan sponsors") should be reviewing their plan documents, policies and procedures, and participant communications to make sure they are complying with the current rules and regulations.

In this issue, we provide an overview of these rules and regulations. We also summarize the issues at stake in *King v. Burwell*, the case the U.S. Supreme Court will hear on the challenges to tax subsidies available on the Health Insurance Marketplaces ("Exchanges") under the Patient Protection and Affordable Care Act, and we detail some of the key health care reform requirements so that plan sponsors can continue to prepare for the impact these requirements will have on financial and administrative planning, both now and in the coming years.

## Considerations for 2015

- ✔ Begin collecting information for 6055/6056 reporting, if applicable
- ✔ Remit first transitional reinsurance fee payment
- ✔ Begin providing health coverage to avoid employer shared responsibility penalties, if applicable
- ✔ Stop providing HIPAA Certificates of Creditable Coverage

## The Supreme Court and Federal Tax Subsidies

In November 2014, after two federal courts reached conflicting decisions, the U.S. Supreme Court agreed to consider a challenge to the tax subsidies available to certain low-income individuals who purchase health coverage through an Exchange.

By way of background, the Affordable Care Act permits states to either establish their own Exchanges or allow the federal government to operate a federal Exchange within the state's borders. At issue in *King v. Burwell* is language in the Affordable Care Act itself, which provides that individuals may be eligible for subsidies if they purchase coverage through an Exchange "established by the State." The IRS issued subsequent guidance permitting individuals to claim the subsidies regardless of whether the Exchange is operated by the state or the federal government. The appellants in the case that upheld the federal subsidies argue that doing so goes against the plain language of the statute.

If the Supreme Court decides that individuals are not eligible for subsidies if they purchase coverage through a federal Exchange, it will be harmful to the future efficacy of the Affordable Care Act.

To date, only 14 states have established their own Exchanges; the remaining states have incorporated federal Exchanges.

The subsidies available for Exchange coverage are a crucial component of the Affordable Care Act — they make individual coverage accessible, which in turn protects individuals against the individual mandate. If the Supreme Court decides that individuals are not eligible for subsidies if they purchase coverage through a federal Exchange, it will be harmful to the future efficacy of the Affordable Care Act.

## Employer Reporting Under the Affordable Care Act

In 2014, the Treasury Department and IRS released final rules implementing the employer reporting requirements under Sections 6055 and 6056 of the Internal Revenue Code (the "Code"), as added by the Affordable Care Act. Reporting will first be required in early 2016 for the 2015 plan year, which means that employers subject to Sections 6055 and 6056 must now begin to collect the necessary information. The reports will help the IRS determine whether the employer and its employees are complying with both of the Affordable Care Act's "pay-or-play" mandates — the individual mandate and employer shared responsibility provisions.

### Section 6055 Reporting — Minimum Essential Coverage and the Individual Mandate

Section 6055 of the Code requires employers who offer self-insured plans that provide "minimum essential coverage," which includes employer-sponsored health coverage, to report such coverage on an information return filed with the IRS. These employers will also have

to provide a statement regarding such coverage to each "responsible individual" — the individual who enrolls one or more individuals (e.g., the subscriber him- or herself). This means that an employer needs to provide the required statement only to the employee responsible for enrolling his or her family in the employer's health plan to comply with Section 6055.

Employers must provide certain information to both the IRS and employees. This information includes, but is not limited to, the employer's contact information, the responsible individual's (employee's) contact information (including a taxpayer identification number or, if a taxpayer identification number is not available, the responsible individual's birthdate), the name and taxpayer identification number or birthdate of each individual covered under the plan, and the months such individual was covered under the plan.

It is important to note that if an employer sponsors a fully-insured health plan, the health insurance issuer, and not the employer, will be required to report under Section 6055. In addition, if an employer offers a self-insured plan and has fewer than 50 full-time employees (generally employees who work an average of at least 30 hours per week), it will need to file a report only under Section 6055; if, however, the employer has 50 or more full-time employees ("large" employers), it will need to file reports under both Sections 6055 and 6056. Please see the next section, "Section 6056 Reporting — Employer Shared Responsibility Penalty," for information on this combined reporting obligation for large self-insured employers.

Employers subject to the Section 6055 reporting requirement must file the forms electronically if they are required to file at least 250 Forms 1095-B or 1095-C (forms relating to the employer's offering of health coverage). Employers must mail the statements to the responsible individuals' last known address but may furnish the statements electronically if the responsible individuals affirmatively consent to electronic delivery. Employers may also retain a third party to fulfill the reporting requirement, although the employer will remain ultimately liable for accurate and compliant reporting.

## Section 6056 Reporting — Employer Shared Responsibility Penalty

Large employers must file a return with the IRS and provide statements to their full-time employees about the health coverage the employer offers under Section 6056 of the Code. This applies regardless of whether the employer offers a self-insured or fully-insured health plan. Generally, large employers will be required to provide certain information to both the IRS and employees that includes, but is not limited to, the employer's contact information and for each full-time employee, information about the coverage offered to the employee, if any, including the lowest-cost option for self-only coverage that the employer offers.

Large employers that offer self-insured plans can take advantage of streamlined reporting by using a single form for both Section 6055 and Section 6056 reporting requirements. The form will have two sections, one for each of the reporting requirements. Large employers that offer fully-insured plans will use the same form as employers offering self-insured plans but will complete only the section required for compliance with Section 6056.

Employers subject to the Section 6056 reporting requirement must file the forms electronically if they are required to file at least 250 reports under Section 6056. Employers must mail the statements to their employees' last known addresses but may furnish the statements electronically if the employees affirmatively consent to electronic delivery. Employers may retain a third party to fulfill the reporting requirement, and the plan administrator of a multiemployer plan can prepare the return and provide the employee statements on behalf of a large contributing employer. Ultimately, however, the employer will remain liable for accurate and compliant reporting.

For the 2015 plan year, if an employer certifies that it made a qualifying offer to at least 95 percent of its full-time employees it can take advantage of the simplified employer reporting option for its entire workforce.

### Simplified Employer Reporting

Employers who make "qualifying offers" to any of their full-time employees may be eligible for a simplified method of reporting under Section 6056. A "qualifying offer" is an offer of health coverage that: (1) provides minimum value (i.e., the plan's share of the total allowed cost of benefits provided under the plan is at least 60 percent of such cost); (2) provides employee-only coverage at a cost of no more than 9.5 percent of the Federal Poverty Level (about $1,100 for 2015); and (3) is extended to the employee's family. If an employee receives a qualifying offer for all 12 months of the year, the employer extending the qualifying offers must report only the employee's name, address and taxpayer identification number or birthdate, and the fact that the employee received a qualifying offer. The employee's statement must simply indicate that the employee received a qualifying offer.

If an employee did not receive a qualifying offer for all 12 months of the year, the employer can enter a code for each month that a qualifying offer was made.

For the 2015 plan year, if an employer certifies that it made a qualifying offer to at least 95 percent of its full-time employees (including an offer of coverage to its full-time employees' families) it can take advantage of the simplified employer reporting option for its entire workforce, even for employees who did not receive qualifying offers for the full plan year. These employers will also be required to provide their employees with a standardized statement informing them of the possibility that they may be eligible for premium tax credits on an Exchange.

## Employer Shared Responsibility Payments

Large employers should now be collecting data to ensure that they will not be liable for an employer shared responsibility payment under Section 4980H of the Code (a "4980H penalty"). Generally, a large employer may be liable for a 4980H penalty for 2015 if: (1) it does not offer at least 70 percent of its full-time employees and their dependents the opportunity to enroll in an employer-sponsored plan, and at least one full-time employee receives a premium tax credit or cost-sharing subsidy through an Exchange; or (2) it does offer its full-time employees and their dependents the opportunity to enroll in an employer-sponsored health plan, but the coverage is either unaffordable (e.g., the employee's share of the premium would cost the employee more than 9.5 percent of the employee's household income, determined, for example, by reference to the employee's Form W-2) or does not provide minimum value, and at least one full-time employee receives a premium tax credit or cost-sharing subsidy. Note that for employers with between 50 and 99 full-time employees, the penalties have been further delayed until 2016.

To avoid liability for a 4980H penalty, employers that think they may be "large" employers under the Affordable Care Act should establish a system whereby they can count their employees and track their hours. Employers should also review their health plans to ensure the coverage they offer is both affordable and provides minimum value.

## Cafeteria Plan Amendments

The IRS released guidance permitting plan sponsors to amend their cafeteria plans to add certain "special enrollment" rights. These amendments must be adopted by the last day of the 2015 plan year (e.g., Dec. 31, 2015 for calendar-year plans).

### Reduction of Hours

Plan sponsors of cafeteria plans can amend their plans to permit employees to prospectively revoke their elections outside of open enrollment if they fall below 30 hours of service per week (and thus become part-time employees under the Affordable Care Act), even if the reduction in hours does not cause a loss of coverage, as long as the employee's revocation corresponds to the employee's intent to enroll him- or herself, and any family member whose coverage is also terminating as a result of the election change, in another plan that provides minimum essential coverage. This new coverage must take effect no later than the first day of the second month following the month that includes the effective date of the revocation.

### Exchange Plan

If an employee is eligible for a special enrollment right for a qualified health plan offered on an Exchange and the employee wishes to enroll in such plan during the employer's open enrollment period but the Exchange's open enrollment period does not coincide with the employer's open enrollment period, the employee may nevertheless revoke his or her election of coverage under the employer's group health plan as long as the employee's revocation corresponds to the employee's intent to enroll him- or herself, and any family member whose coverage is also terminating as a result of the election change, in the qualified plan. Coverage under the qualified plan must take effect no later than the day immediately following the last day of coverage under the employer's group health plan.

### *'Spouse' after* Windsor

Plan sponsors should review their cafeteria plan documents to ensure that "spouse" no longer excludes same-sex spouses.


For more information on the effect of the Supreme Court's decision in *U.S. v. Windsor*, please see SRZ's Employment & Employee Benefits Developments health care compliance newsletter at **www.srz.com/Employment_Employee_Benefits_Developments_Fall_2013_Year-End_Action_Items**.

## Health FSA Contribution Increase and Amendments

Effective Jan. 1, 2015, the maximum amount that employees who participate in Health Flexible Spending Accounts ("FSAs") can contribute is increasing from $2,500 to $2,550.

In addition, employers that sponsor FSAs may wish to consider amending their plan documents to permit employees to carry over up to $500 of their unused account balance that remains at the end of the plan year and use that amount during the following plan year. Employers that adopt the carryover cannot also incorporate a "grace period" (i.e., a period of usually two and a half months in the subsequent plan year during which an employee can use his or her unused account balance from the preceding plan year). Just as with any unused account balances used during a grace period, the carryover amount will not count towards the participant's contribution amount. This means that if an employer sponsors an FSA and adopts the carryover, an employee participating in the FSA can elect to contribute $2,550 to the FSA and use up to $500 that the employee did not use during the preceding plan year.

## New Excepted Benefits

The IRS, DOL and HHS amended the "excepted benefit" regulations to add Employee Assistance Programs to the list of excepted benefits. They also modified the rules for determining whether dental and vision benefits are considered "excepted." Excepted benefits are exempt from numerous provisions of a variety of health-related federal statutes, including, but not limited to, ERISA, the Code and the Affordable Care Act. The amended regulations also include proposed rules regarding when "wraparound" coverage may be considered an excepted benefit.

### Employee Assistance Programs ('EAPs')

Prior to 2015, an EAP was considered a limited excepted benefit if it did not provide significant benefits that are medical in nature. Beginning Jan. 1, 2015, EAPs must also comply with the following requirements in order to be considered a limited excepted benefit:

- Employee premiums and/or contributions are not allowed for participation in the EAP;
- There can be no cost-sharing for benefits offered under the EAP; and
- EAP benefits cannot be coordinated with benefits offered under another group health plan (e.g., participants cannot be required to exhaust EAP benefits before being eligible for other group health plan benefits, and participants must be eligible for EAP benefits regardless of their eligibility for other group health plan benefits).

### Dental and Vision Benefits

Prior to 2015, participants had to pay an additional premium or contribution for dental or vision benefits in order for them to be considered excepted benefits. Under the amended regulations, dental and vision benefits are now considered "limited excepted benefits" if they are provided under a separate policy, certificate or contract of insurance or they are not otherwise an integral part of a group health plan. Dental and vision benefits are not considered "integral" to a group health plan if participants can elect not to receive dental or vision benefits or claims for dental or vision benefits are administered under a claims contract that is separate from the claims administration for any other benefits offered under the group health plan.

## At a minimum, essential health benefits must include:

- ✔ 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

### Wraparound Coverage

By way of background, the Affordable Care Act requires certain plans, including qualified plans offered on an Exchange, to cover "essential health benefits." The essential health benefits package limits cost-sharing and provides certain levels of coverage. The Departments have tasked states with the responsibility of defining the specific benefits that will constitute essential health benefits; for reference, New York has chosen the Oxford EPO plan, which is the largest small group plan in the state, as its benchmark plan for purposes of determining the essential health benefits package.

The Departments recognize that employer-sponsored coverage may offer benefits in addition to the essential health benefits package offered by an Exchange plan (e.g., home health care, infertility treatment, long-term care, etc.), or may provide larger networks than are provided through an Exchange plan, but that such coverage may be unaffordable for some employees. The Departments are therefore considering whether employer-sponsored "wraparound" coverage for an Exchange plan could be considered a limited excepted benefit. The Departments recognize that permitting such wraparound coverage would enable employees to receive health benefits comparable to those offered under the plan sponsored by their employer at a price that is affordable to everyone.

The proposed rules apply to wraparound coverage offered under a group health plan when offered to employees who could receive employer-sponsored coverage if they could afford the premiums, but instead the employees choose to enroll in an Exchange plan because the premium for the employer-sponsored plan is unaffordable. Under the proposed rule, the wraparound coverage would be considered a limited excepted benefit only if certain conditions are met:

- The coverage must wrap around non-grandfathered health insurance coverage offered in the individual market that provides more than just the essential health benefits package.
- The wraparound coverage must be designed to provide benefits beyond those offered by the individual health insurance coverage.
- The wraparound coverage must not otherwise be an integral part of a group health plan. This means that the plan sponsor offering the wraparound coverage must also sponsor another group health plan that provides minimum value and is affordable for a majority of the employer's employees. Only individuals eligible for this other group health plan, referred to as the "primary plan," can be eligible for the wraparound coverage.

- The total cost of coverage under the wraparound plan cannot exceed 15 percent of the cost of coverage under the primary plan. Both the employer's contributions and the employee's contributions are considered when determining this amount.
- The wraparound coverage cannot discriminate in favor of certain individuals regarding eligibility, benefits or premiums and cannot impose any preexisting condition exclusions.

The Departments note that as a limited excepted benefit, a wraparound plan will not protect a large employer from a 4980H penalty. As such, large employers that are considering offering a limited excepted benefit wraparound plan must still offer a plan to substantially all of their full-time employees, and their dependents, that provides minimum value and is affordable, or else potentially face a 4980H penalty.

## HIPAA Certificates of Creditable Coverage

Effective Jan. 1, 2015, HIPAA certificates of creditable coverage no longer need to be provided because the Affordable Care Act banned preexisting condition exclusions for all individuals. Individuals who lose employer-sponsored coverage therefore no longer need HIPAA certificates of creditable coverage to protect themselves against a new plan's preexisting condition exclusions.

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## Health Plan Identifiers

Plan sponsors of group health plans should be aware that the Centers for Medicare & Medicaid Services has indefinitely delayed the requirement for obtaining a Health Plan Identifier, or "HPID." An HPID is a unique identifier that is intended to increase standardization within HIPAA standard transactions. Without the delay, group health plans would have been required to obtain an HPID by Nov. 5, 2014.

## Transitional Reinsurance Fee

Health plans will be required to submit their first transitional reinsurance fee payment for the 2014 plan year in January of 2015. The 2014 fee is $63 per covered life. The 2015 fee will be $44 per covered life, and the 2016 fee has not yet been announced. Health plans that are both self-administered and self-insured are exempt from paying the fee for both 2015 and 2016.

## Participant Communications

### Summary of Benefits and Coverage

Plan administrators of self-insured group health plans and health insurance issuers of fully-insured group health plans must continue to provide a Summary of Benefits and Coverage ("SBC") to participants and beneficiaries. Though SBCs generally must be provided to new hires and upon request, the SBC must also be distributed during open enrollment for the next plan year. For most calendar-year plans, open enrollment occurs during October. The Departments have recently provided a streamlined template SBC that plans and issuers should use on and after Sept. 15, 2015.

### Revised COBRA Notices

The Departments modified their model COBRA notices to include language informing participants that, in addition to COBRA, they may be eligible for coverage on the Exchange. Plan administrators should review their COBRA notices and other relevant plan documents to ensure that they include this updated language.

## ACA Implications for Plan Years Beginning in 2015 and Beyond

Plan sponsors of group health plans should be aware of the following provisions of the Affordable Care Act that may impact their plans in the coming years:

### 90-Day Waiting Period

Effective for plan years beginning on or after Jan. 1, 2014, group health plans cannot apply "waiting periods" in excess of 90 days. A "waiting period" is defined as the period of time that must pass before coverage for an eligible employee or dependent becomes effective. The Departments issued final and proposed regulations concerning the ACA's prohibition on waiting periods in excess of 90 days. Though the final regulations mostly track the proposed regulations, they differ from the proposed regulations in that they permit employers to require employees to successfully complete a reasonable and bona fide employment-based orientation as a condition for eligibility for coverage under a plan. The final regulations do not specify the circumstances under which the duration of an orientation period would not be considered reasonable or bona fide, but the proposed regulations propose one month as the maximum length of any orientation period.

The preamble to the proposed regulations also clarifies that in adding successful completion of an orientation period as a permissible condition for eligibility for coverage under a plan, the Departments envision that the purpose of such orientation period is to determine

whether the employment situation is satisfactory to both the employer and the employee, and that standard orientation and training would begin during the orientation period.

Under the proposed regulations, it now appears that a group health plan can condition eligibility on the successful completion of a reasonable and bona fide employment-based orientation period if the maximum 90-day waiting period begins on the first day after the orientation period (e.g., if an employee's start date is May 3, and the employee is otherwise eligible for coverage, the employer can require the employee to successfully complete an orientation period that can end no later than June 2 and the maximum 90-day waiting period must begin no later than June 3).

### Nondiscrimination for Fully-Insured Health Plans

The Affordable Care Act extends the current requirement that self-insured plans not discriminate in favor of highly compensated individuals to fully-insured plans. This requirement, however, has been delayed pending further regulations from the IRS that will detail the specifics of the rule. The rule is expected to become effective beginning the first plan year after such regulations are issued.

### Excise Tax on Cadillac Plans

Effective Jan. 1, 2018, high-cost, or "Cadillac" health plans will be assessed a 40-percent non-deductible excise tax on the value of health coverage that exceeds $10,200 for an individual and $27,500 for a family, indexed for inflation. Insurers of fully-insured plans will be responsible for the payment of the tax.

## Action Items

- ✔ **COUNT** employees and track hours to determine large employer status and potential liability for a 4980H penalty
- ✔ **TRACK** offers of health coverage to employees to aid compliance with Section 6055 and Section 6056 reporting
- ✔ **COLLECT** information necessary for Section 6055 and Section 6056 reporting, especially taxpayer identification numbers and/or birthdates
- ✔ **REVIEW** cafeteria plan documents and timely adopt any discretionary plan amendments
- ✔ **PREPARE** and distribute updated SBCs
- ✔ **REVIEW** summary plan descriptions and plan documents to reflect health care reform changes being made under the Affordable Care Act
- ✔ **REMIT** transitional reinsurance fee payment
- ✔ **ELIMINATE** HIPAA certificates of creditable coverage from participant communications effective Jan. 1, 2015
- ✔ **REVISIT** EAPs and limited excepted benefit dental and/or vision plans to ensure they still qualify as excepted benefits
- ✔ **PREPARE** for Cadillac Plan excise tax for 2018
- ✔ **UPDATE** COBRA notices
- ✔ **REVIEW** plan documents and amend as necessary to ensure that "spouse" does not exclude same-sex spouses

# **Schulte Roth & Zabel** Contacts

For additional information on the reminders and highlights in this newsletter, or if you would like assistance with implementing any of the requirements and recommendations or preparing participant communications, amendments or other plan materials, please contact your Schulte Roth & Zabel attorney or one of the following authors:


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