WELLS FARGO INSURANCE

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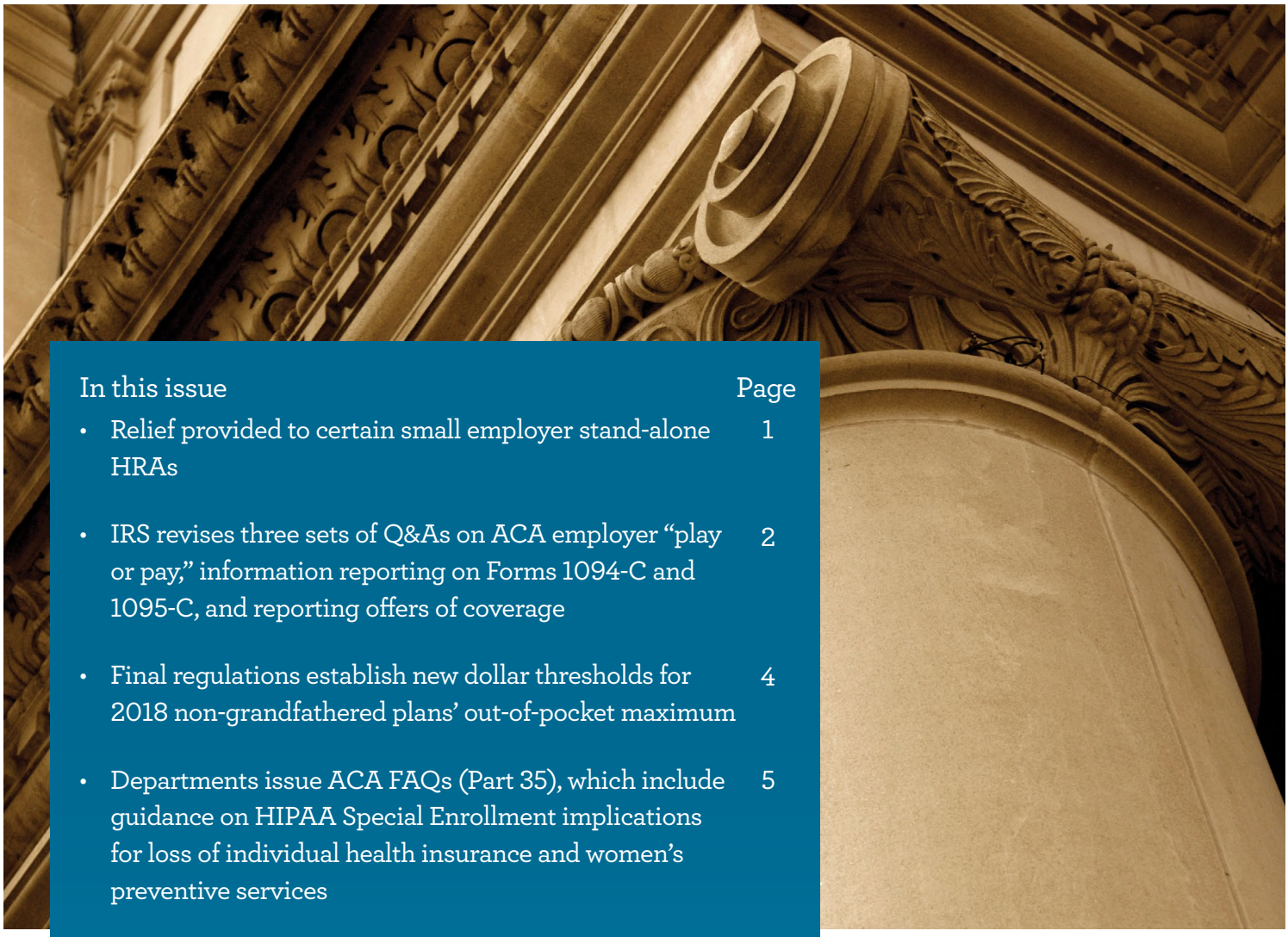
Employee Benefits Compliance Update

Wells Fargo Insurance Employee Benefits Compliance Practice



In this issue

Together we'll go far

Relief provided to certain small employer stand-alone HRAs

In brief:

- Certain small employers are now allowed to provide a new specialized form of stand-alone health reimbursement arrangement (HRA) to help employees with their medical expenses (including the purchase of individual health insurance coverage) in a manner previously prohibited under the Affordable Care Act (ACA).
- Relief is subject to various limitations and requirements, including one that allows only employers with less than 50 full-time and full-time equivalent employees that do not provide group health plan coverage to its employees to offer such an arrangement.
- Subject to certain transition rules, these new arrangements are available starting on or after January 1, 2017.

With the enactment of the 21st Century Cures Act on December 13, 2016, certain small employers received an early holiday gift by the inclusion of a provision that created a new type of tax-preferred medical reimbursement arrangement. Qualified Small Employer Health Reimbursement Arrangements (QSEHRAs) allow eligible employers to pay or reimburse employees for qualified medical expenses up to certain amounts, including reimbursing employees for the cost of individual health insurance premiums, which was previously prohibited by the ACA.

As reflected in the following highlights, however, QSEHRAs are subject to various design and administrative requirements. As a result, the relief is limited in scope, will not be applicable at all to larger employers, and may not even be that attractive for many smaller employers.

Which employers can offer QSEHRAs?

QSEHRAs may only be offered by an employer that is not an applicable large employer (ALE) as defined under the ACA. This means that an eligible employer generally must have employed an average of less than 50 full-time and full-time equivalent employees in the prior calendar year. In addition, the small employer may not offer a group health plan to any of its employees.

What expenses can be paid or reimbursed under a QSEHRA?

The arrangement may pay or reimburse eligible employees for qualified medical care expenses (as defined under Internal Revenue Code section 213(d)), including premiums for individual health insurance and other unreimbursed medical expenses. Note, however, documentation of the expenses must be presented to the employer prior to payment or reimbursement.

In addition, the arrangement must be provided on the same terms to all eligible employees (although certain variations are permitted if they are consistent with the variation in the price of an individual insurance policy based on age or number of family members). Thus, an eligible small employer essentially must offer the same scope of coverage to all of its eligible employees.

Who are eligible employees under a QSEHRA?

Generally, QSEHRAs must be offered to all employees of an eligible employer, except for:

- employees who have not completed 90 days of service;
- employees who have not attained age 25;
- part-time employees (defined as employees who customarily work less than 35 hours per week, if other employees performing similar work have substantially more hours; or anyone customarily working less than 25 hours per week);
- seasonal employees (defined as employees who customarily work less than nine months per year, if other employees performing similar work have substantially more months of work; or anyone customarily working less than seven months per year);
- collectively bargained employees (provided that such employees are not covered under the plan); and
- nonresident aliens with no U.S. source income.

How are QSEHRAs funded, and what are the contribution limits?

These arrangements must be funded solely by the eligible employer, and no employee contributions or salary reduction contributions are allowed. The amount of payments or reimbursements for any year allowed under a QSEHRA is limited to $4,950 ($10,000 for families) with these amounts indexed to inflation.

How will QSEHRAs affect individuals who receive subsidized Marketplace exchange coverage?

For any month in which an employee is covered under a QSEHRA that is considered "affordable," an employee who obtains individual health insurance through a Marketplace exchange is not eligible for any federal subsidies. Moreover, for any month in which the coverage is considered unaffordable, the federal Marketplace subsidy is reduced pro-rata (but not below zero) by the amount made available under the QSEHRA.

Since employees who obtain individual health insurance through a Marketplace exchange must report the amount credited to them under the QSEHRA to the exchange if they apply for federal subsidies as noted below, the Marketplace exchange (rather than the employer) will make the affordability determinations and any pro-rata subsidy reduction calculations.

What administrative requirements are imposed on employers that maintain QSEHRAs?

Employers must provide written notice to every eligible employee 90 days before the start of the plan year indicating (i) the amount of the QSEHRA benefit, (ii) that employees applying for federal subsidies must notify the Marketplace exchange of that amount, and (iii) the tax consequences if the individual fails to obtain minimum essential coverage. In addition, employers must include the amount of the QSEHRA benefits on their employees' Forms W-2 at the end of the year. However, since QSEHRAs are statutorily excluded from the definition of group health plan, employers are not required to offer COBRA coverage or comply with ERISA's reporting and disclosure requirements with respect to its QSEHRA.

When do the QSEHRA rules become effective?

The QSEHRA rules generally become effective for years beginning after December 31, 2016. However, for employers who want to establish a QSEHRA effective as of January 1, 2017, there is a special transition rule with respect to the otherwise applicable 90-day advance notice requirement that allows employers to provide the notice by March 12, 2017. In addition, the law extends previously issued administrative transition relief to stand-alone HRAs that provided reimbursement for individual health insurance premiums for periods between July 1, 2015, and December 31, 2016.

IRS revises three sets of Q&As on ACA employer "play or pay," information reporting on Forms 1094-C and 1095-C, and reporting offers of coverage

In brief:

- Updated Q&As on employer "play or pay" primarily reiterate established principles for determining ALE status and an "offer of coverage," while eliminating Q&As on expired transition rules.
- Updated Q&As on Form 1094-C and Form 1095-C reporting for ALEs primarily reiterate separate reporting by entity in controlled group situations, and special rules for HRAs.
- Updated Q&As on reporting offers of coverage primarily reiterate when ALE members can file multiple Forms 1094-C, but cannot provide more than one Form 1095-C for a single employee.

On December 22, 2016, the Internal Revenue Service (IRS) released three updated sets of previously issued questions and answers (Q&As) covering employer responsibilities under the Affordable Care Act (ACA).

Employer "play or pay" rules

The IRS issued an initial set of Q&As on the employer shared responsibility "play or pay" rules in early 2014, which were updated in early 2015, and have now been updated a second time. The most recent update reiterates many concepts discussed in earlier versions while adding on additional information from new developments in the past two years. These rules apply to "applicable large employers" (ALEs), which, for a particular calendar year, generally had 50 or more full-time and full-time equivalent employees in the prior calendar year. Here are some highlights from these Q&As:

- **TRICARE/VA coverage.** Employees who have coverage under TRICARE or a Veterans Administration health program are not taken into account in determining if an employer is an ALE. This rule was created in legislation passed in late 2015 and discussed in our September 2015 Employee Benefits Compliance Update.
- **Controlled groups.** Related business entities are combined for counting employees and determining ALE status, but once ALE status is established, each entity is separately an "ALE Member" and is separately subject to the applicable ACA reporting requirements and liable for "play or pay" penalty payments.
- **Counting all employees for ALE status.** To determine ALE status, employers should count all employees, even those who are eligible for coverage elsewhere (such as Medicare, Medicaid, or another employer's plan) and those exempt from the individual mandate (such as members of a Health Care Sharing Ministry or of a Federally-recognized Indian tribe). However, employees working abroad are generally not counted.
- **Interns and hours of service.** Interns are treated like all other employees. If they have hours of service (generally, hours for which they are paid), they could be full-time employees with respect to the employer "play or pay" rules.
- **"Offer of coverage."** Coverage is offered for a month only if coverage would cover every day in the calendar month, it must be offered at least once per plan year, and an offer must provide "an effective opportunity to enroll . . . based on all the relevant facts and circumstances." For example, there is not an offer of coverage if the employer will terminate the employee if the employee enrolls the employee and/or dependents.
- **Employee required contribution.** To avoid certain penalties, an "employee required contribution" must be "affordable." The Q&As remind employers that an employee required contribution is not necessarily the same as what the employee actually pays, such as when the employee chooses a plan option that is more expensive than the lowest cost employee-only coverage that provides minimum value, or when the employer has arrangements in place that change an employee's cost, such as HRA contributions, wellness program incentives, flex credits, and opt-out payments.
- **Dependent to end of month of reaching age 26.** While the ACA mandate for coverage for dependents only requires such coverage to a child's 26th birthday, the employer "play or pay" mandate essentially requires coverage to the end of the month in which the child attains age 26. See our FAQ in our January 2016 Employee Benefits Compliance Update.
- **"Play or pay" penalty payments.** The IRS will begin to send letters to ALEs regarding potential liability for 2015 "play or pay" penalties (from Forms 1094-C and 1095-C filed in 2016) in early 2017. For future years, such letters are expected in the latter part of the calendar year for which reporting was due (e.g., late 2018 for 2017 forms filed in 2018). More guidance on penalty payments and procedures will be forthcoming.
- **Transition relief.** Most "play or pay" transition relief ended in 2015, with the exception of certain relief that may apply to plan years beginning in 2015 that carry over into 2016 and will end at the end of that plan year.

Form 1094-C and Form 1095-C reporting for ALEs

- **Each ALE member entity files one 1094-C "authoritative transmittal."** Each business entity that is an ALE, or is part of a controlled group where the combined controlled group is an ALE, is separately designated as an "ALE member" with its own responsibility to file Forms 1094-C and 1095-C (for its own employees). Each ALE member can file Forms 1095-C and a Form 1094-C in "batches," but only one Form 1094-C filing can be the "authoritative transmittal." More importantly, the Q&As remind employers that ALE members that otherwise combine to form a single employer as an "Aggregated ALE Group" do not file just a single authoritative transmittal for all ALE members in the group. For more information, see our July 2015 Employee Benefits Compliance Update article on controlled group situations.
- **Reporting new employees.** For Form 1095-C, Part II purposes, a new employee with a start date (and any

insurance coverage date) other than the first day of the month should always be reported on line 14 as code 1H (No offer of coverage), and on line 16 as 2D (Employee in a section 4980H(b) Limited Non-Assessment Period). However, for Part III purposes (for an ALE member with a self-insured health plan), a person should be reported has having coverage for a month if the person was covered for one or more days of that month.

- **Qualifying offers.** An ALE member that makes a "qualifying offer" to any employee for any month may use code 1A on line 14 of the Form 1095-C, with no entry required for either line 15 or line 16 for that month.
- **Reporting COBRA situations.** The Q&As provide details for reporting COBRA situations for both termination of employment and reduction in hours situations. Other offers of non-COBRA post-employment coverage are treated similar to COBRA situations. For more information, see our March 2016 Employee Benefit Compliance Update.
- **HRA reporting.** ALE members should report coverage under a health reimbursement arrangement (HRA) to the extent an employee is not also enrolled in a non-HRA plan of the same ALE member.

Reporting offers of coverage

- **Providing employee statements electronically.** Furnishing Form 1095-C electronically to employees requires satisfying notice, consent, and hardware and software specifications. See our December 2015 Employee Benefits Compliance Update. Expatriate plan coverage can be furnished electronically by default, unless the recipient explicitly refuses to consent to electronic delivery.
- **One Form 1095-C per employee from ALE member.** An ALE member should not provide more than one Form 1095-C to an employee (for example, due to the employee working for two divisions of the same ALE member). However, an employee who works full-time in a calendar year for two separate ALE members in the same controlled group should receive a separate Form 1095-C from each ALE member.
- **Due dates for 2016 forms (due in early 2017) extended.** The Q&As reiterate the extensions provided under IRS Notice 2016-70. See our November 21, 2016 Employee Benefits Compliance Alert.

Please contact your Wells Fargo Insurance Services representative for any questions regarding the employer "play or pay" mandate or Form 1094-C/1095-C reporting.

Final regulations establish new dollar thresholds for 2018 non-grandfathered plans' out-of-pocket maximum

In brief:

- The 2018 out-of-pocket maximum for non-grandfathered plans will be $7,350 for self-only coverage, and $14,700 for all coverage tiers other than self-only.

On December 22, 2016, the Department of Health and Human Services published a final rule that includes the finalized 2018 health plan out-of-pocket maximums (OOPM). Under the Affordable Care Act (ACA), the annual out-of-pocket maximum applicable to non-grandfathered group health plans became effective for plan years beginning in 2014. The final regulations provide that the limits for 2018 are $7,350 for self-only coverage and $14,700 for tiers other than self-only.

Employers need to be mindful of new regulations that began in 2016 requiring that all non-grandfathered health plans apply the self-only out-of-pocket maximum to any individual, regardless of whether the individual participates in a self-only tier of coverage or any other tier of coverage, such as family coverage. Thus, for example, in 2018, if several individuals are enrolled in family coverage with a family out-of-pocket maximum of $10,000, if any one of those individuals incurs out-of-pocket expenses exceeding $7,350, all remaining eligible claims incurred by that individual for the balance of the plan year must be paid at 100% by the plan.

Remember that HSA-eligible high-deductible health plans (HDHPs) must comply with minimum deductible and maximum out-of-pocket requirements and that the maximum out-of-pocket requirement for an HSA-eligible HDHP is now different than the maximum out-of-pocket limit permissible under the ACA for all types of non-grandfathered plans. In turn, employers maintaining an HSA-eligible HDHP will need to comply with both sets of rules. Thus, for example, a family HDHP should be able to comply with both out-of-pocket limits if it applies a self-only out-of-pocket maximum that is no higher than the self-only ACA limit and, in all

events, pays all expenses for all family members once the group's expenses reach the family out-of-pocket maximum under the HSA-eligible rules (or the family limit established for the plan, if lower).

Year	ACA OOPM – self only	ACA OOPM – other than self only	HSA OOPM – self only	HSA OOPM – other than self only
2016	$6,850	$13,700	$6,550	$13,100
2017	$7,150	$14,300	$6,550	$13,100
2018	$7,350	$14,700	TBD	TBD

Departments issue ACA FAQs (Part 35), which include guidance on HIPAA Special Enrollment implications for loss of individual health insurance and women's preventive services

In brief:

- Employer sponsored health plans must allow mid-year HIPAA Special Enrollment for individuals who lose eligibility for individual health insurance, including Marketplace coverage.
- Updated Women's Preventive Services Guidelines must be covered by non-grandfathered group health plans, without cost sharing, for plan years beginning on or after December 20, 2017.

On April 20, 2016, the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the "Departments") released FAQs about Affordable Care Act Implementation (Part 35), consisting of three questions and answers relating to HIPAA Special Enrollment rules, women's preventive services under the Patient Protection and Affordable Care Act (ACA), and small group health reimbursement arrangements (HRAs). Small group HRAs are addressed within a separate article in this Update.

HIPAA Special Enrollment rules

The first FAQ addresses loss of individual health insurance coverage and implications under HIPAA Special Enrollment rules. Presumably, the FAQ was driven by the fact that some carriers have recently chosen to cease offering some or all of their individual insurance products on public Marketplace exchanges effective January 1, 2017, with most carriers providing advance notice. For individuals with access to employer-sponsored coverage with a plan year that started January 1, 2017, there was little problem in transitioning over to the employer coverage during the relevant open enrollment period. However, when employer-sponsored coverage is on a non-calendar plan year, the issue arises as to whether loss of Marketplace coverage allows an individual to go to his or her employer and enroll in the employer coverage mid-year.

HIPAA Special Enrollment rules require employer plans to allow for a special enrollment when an individual loses individual coverage, including Marketplace coverage. However, the loss of coverage must be due to a loss of eligibility for such coverage. Merely choosing to not renew individual coverage (e.g., due to a sharp increase in cost) would not qualify, and losing eligibility due to failure to pay premiums on a timely basis or termination of coverage for cause, such as making a fraudulent claim or an intentional misrepresentation of a material fact, would also not qualify. The FAQ essentially confirms this rule and seems to indicate that a Special Enrollment is required when an individual merely ceases to be eligible for the policy the individual was enrolled in, even though that individual might be eligible to enroll in other individual market coverage, whether inside or outside of a Marketplace.

Note that any mid-year election change pursuant to a HIPAA Special Enrollment event should also qualify as a permissible mid-year election change under cafeteria plan rules, but would require that an employer's relevant cafeteria plan document expressly allow for such changes (which most do).

Women's preventive services

The second FAQ provides information on the effective date of new updated guidelines for women's preventive services. Guidelines were updated on December 20, 2016, and the FAQ provides that non-grandfathered health plans must cover such services, without cost sharing, for plan years beginning on or after December 20, 2017 (i.e., as of January 1, 2018, for calendar year plans). Until then,

plans must continue to provide services as prescribed in earlier guidance from the Health Resources & Services Administration. The updated guidance extends on the earlier guidance, including certain screenings, in the following areas:

- Breast cancer screening for average-risk women
- Breastfeeding services and supplies
- Cervical cancer screening
- Screening for gestational diabetes mellitus
- Screening for HIV infection
- Screening for interpersonal and domestic violence

These FAQs included a third FAQ pertaining to health reimbursement arrangements (HRAs) for small employers. That FAQ is further addressed in a related article in this Update.

IRS delays guidance on opt-out arrangements

In brief:

- Final rules on the treatment of opt-out arrangements under the Affordable Care Act have been delayed.
- Until final rules are issued, employers can continue to rely on previous guidance for the proper treatment of opt-out arrangements under the ACA.

On December 19, 2016, the IRS published final regulations (on premium tax credits for individuals) which state that final rules on the treatment of opt-out arrangements under the Affordable Care Act have been delayed. In an opt-out arrangement, the employer makes an opt-out payment to an employee if the employee declines coverage under a group health plan offered by the employer. Employers have been waiting for the IRS to clarify how opt-out arrangements affect the "required employee contribution" disclosed on line 15 of IRS Form 1095-C, which applicable large employers are required to distribute annually to ACA full-time employees.

According to the final regulations, employers can continue to rely on previous guidance (discussed in the January 2016 and September 2016 Employee Benefits Compliance Updates) for the proper treatment of opt-out arrangements under the ACA. The IRS anticipates that final guidance on opt-out arrangements will apply only for periods after the guidance has been issued.

Below is a summary of existing guidance on what needs to be included in the "required employee contribution" for purposes of line 15 on IRS Form 1095-C, for an ACA full-time employee who is eligible for coverage under the employer's group medical plan:

Topic	Effect on line 15 ("required employee contribution") of IRS Form 1095-C
Salary reduction contribution by an employee (whether pre-tax or after-tax).	Included
Opt-out payment available to the employee under an opt-out arrangement adopted on or before December 16, 2015, which meets at least one of the following requirements: • The employer offered the opt-out arrangement (or a substantially similar arrangement) with respect to health coverage provided for a plan year that included December 16, 2015; or • A board, committee, or similar body, or an authorized officer of the employer, specifically adopted the opt-out arrangement before December 16, 2015; or • The employer had provided written communications to employees on or before December 16, 2015, indicating that the opt-out arrangement would be offered to employees at some time in the future. An example would be an opt-out payment required under the terms of a collective bargaining agreement that was in effect before December 16, 2015.	Excluded

Topic	Effect on line 15 ("required employee contribution") of IRS Form 1095-C
Opt-out payment available to the employee under an "eligible opt-out arrangement" which meets all of the following requirements: • The employee must provide reasonable evidence that he/she and all individuals in the employee's tax family (i.e., those for whom he/she expects to claim a personal tax exemption) have minimum essential coverage from an acceptable alternate source; • The employee must provide reasonable evidence of the alternate coverage at least annually; and • The opt-out payment may not be paid if the employer knows that the employee or a member of his/her tax family does not have minimum essential coverage from an acceptable alternate source.	Excluded
Opt-out payment available to the employee under an opt-out arrangement adopted after December 16, 2015, that is not an "eligible opt-out arrangement".	Included
Flex dollars available to the employee that are "health-flex contributions" meeting all of the following requirements: • Employee may not opt to receive this amount as cash (i.e., a taxable benefit); • Employee may use the flex dollars to pay for coverage under an employer-provided group health plan; and • Employee may use the flex dollars exclusively to pay for health care.	Excluded
Flex dollars available to the employee that are "non-health-flex contributions" because they meet at least one of the following requirements: • Employee may opt to receive this amount as cash (i.e., a taxable benefit); • Employee may use the flex dollars to pay for coverage under an employer-sponsored plan that is not health-care related; or • Employee may use the flex dollars to pay for something other than health care.	Included

One-page flyer and posters available for employers to explain 1095 forms to employees

Wells Fargo Insurance has developed a one-page flyer for customers to provide to their employees explaining the Forms 1095 that employees may receive by March 2nd. "What you need to know about the new IRS forms" will explain the three primary forms, 1095-C, 1095-B, and 1095-A, which employees will need to complete their 2016 income tax returns. Information on these forms is used to administer the individual health coverage mandate and the tax credits for which some employees may qualify in the event they and/or some family members enrolled in public Marketplace coverage for 2016.

Prudent employers are advised to continue to comply with ACA statutory and regulatory requirements. Among other things, this means complying with the ACA reporting requirements for the 2016 calendar year, which have deadlines in early 2017. Please contact your Wells Fargo Insurance representative for a copy of the flyer and/or posters.

How can we help?

To learn more about current benefits compliance issues, please visit us online or contact your local Wells Fargo Insurance Services representative.