AFFORDABLE CARE ACT – 5 THINGS TO KNOW FOR 2015

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I. EMPLOYER RESPONSIBILITIES

A. In general, the date for compliance with the "Pay or Play" health care penalties under the Affordable Care Act ("ACA") became effective for employers with 100 or more full-time equivalent employees ("FTE") in 2015.

B. Under the ACA, employers with 50 or more FTEs are considered to be an Applicable Large Employers ("ALE"). Special rules may delay the "Pay or Play" health care penalties for most ALE that have between 50 and 99 FTE as of January 1, 2015 until 2016. It should be noted that this ALE determination is based on the prior calendar year and not on the health care policy year.

C. Employers with 100 or more FTE as of January 1, 2015 are eligible for certain modifications to the rules for 2015.

D. The determination as to whether an employer is eligible for the delay in the ACA is complex. A summary of the requirements is found below.

II. SPECIAL 2015 TRANSITIONAL RULES FOR EMPLOYERS WITH 50 TO 99 FTES

A. Employers that employed on average at least 50 full-time employees (including full-time equivalents) but fewer than 100 full-time employees (including full-time equivalents) on business days during 2014 will not be liable for the "Pay or Play" penalties for any calendar month during 2015 if they meet the conditions below. For employers with non-calendar-year health plans, the relief applies to any calendar month during the 2015 plan year, including months during the 2015 plan year that fall in 2016.

1. During the period beginning on February 9, 2014 and ending on December 31, 2014, the employer did not reduce the size of its workforce or the overall hours of service of its employees in order to qualify for the transition relief. However, an employer that reduced workforce size or overall hours of service for bona fide business reasons is still eligible for relief.

2. During the period beginning on February 9, 2014 and ending on December 31, 2015 (or, for employers with non-calendar-year plans, ending on the last day of the 2015 plan year), the employer does not eliminate or materially reduce the health coverage, if any,

it offered as of February 9, 2014. An employer will not be treated as eliminating or materially reducing health coverage if:

a) it continues to offer each employee who is eligible for coverage an employer contribution toward the cost of employee-only coverage that either (A) is at least 95% of the dollar amount of the contribution toward such coverage that the employer was offering on February 9, 2014, or

b) is at least the same percentage of the cost of coverage that the employer was offering to contribute toward coverage on February 9, 2014;

c) in the event of a change in benefits under the employee-only coverage offered, that coverage provides minimum value after the change; and

d) it does not alter the terms of its group health plans to narrow or reduce the class or classes of employees (or the employees' dependents) to whom coverage under those plans was offered on February 9, 2014.

B. Employers that are close to the 50 full-time employee threshold in determining if they are subject to the ESR provisions do not have to use the full twelve months of 2014 to measure whether they crossed the threshold. They may measure during any consecutive six-month period (as chosen by the employer) during 2014.

III. EMPLOYERS WITH 100+ FTEs – APPLICATION OF PAY OR PLAY REQURIEMENTS AS OF JANUARY 1, 2015 OR THE FIRST DAY OF THE 2015 POLICY YEAR?

A. The final IRS regulations contained many transitional rules which can delay the application of the Pay or Play penalty rules for employers with 100 or more employees until the first day of the 2015 policy year, if certain requirements are met.

B. The first requirement is that the company must have maintained a non-calendar year health plan as of December 27, 2012, and the plan year was not changed after December 27, 2012 to begin at a later date.

Example:

- **Blue Cross** – Policy was effective June 1, 2011. The policy year was from June 1, 2011 to May 30, 2012.
- **HealthPlus** – Policy was effective December 1, 2011. The initial policy year was from December 1, 2011 to November 30, 2012. This policy was

renewed with the same policy year running from December 1, 2012 to November 30, 2013.

C. Since the company maintained a non-calendar year health plan as of December 27, 2012 and the plan year was not changed after December 27, 2012 to begin at a later date, this requirement has been met. The HealthPlus policy year change to December 1st occurred before December 27, 2012.

D. This employer can delay compliance with the ACA Pay or Play provisions until December 1, 2015, rather than January 1, 2015, **if the additional requirements found below are met**.

IV. DEFERRING COMPLIANCE

A. Since the plan year change hurdle has been met, one of the following requirements will need to be met in order to defer compliance until December 1, 2015 (first day of the 2015 plan year) rather than January 1, 2015.

1. Pre-2015 Eligibility. The "Pay or Play" penalty will not be imposed on the company between January 1, 2015 and the first day of the 2015 plan year (December 1, 2015) for any employee who was eligible to participate in the plan under its terms as of February 9, 2014 (even if the employee did not enroll or it cost more than 9.5% of pay for single coverage). This exemption from the "Pay or Play" penalty will apply for any employee who was eligible to participate in the health plan under its terms as of February 9, 2014 (even if the employee did not enroll).

   This delayed effective date only applies if, no later than the first day of the 2015 plan year (December 1, 2015), the employer offers affordable coverage (9.5% of pay for single coverage) that provides minimum value to at least 70% of the full-time employees (30 hours per week is full-time).

   If the health plan on February 9, 2014 required full-time employees to work more than 30 hours per week in order to be eligible for coverage, this special relief will not apply with respect to those employees who worked more than 30 hours per week in 2014, but worked less than the employer's threshold for health insurance eligibility or were otherwise excluded.

   It should be noted that the use of the 70% test rather than the 95% coverage test normally required may subject the company to the $3,000 per year penalty for the failure to pay a specific amount (IRC 4980H(b)) if such excluded full-time employees (30 hours per

week or more) obtain health coverage on the government exchange and receive government subsidies.

2. Significant Percentage of All Employees Test. No "Pay or Play" penalty will be imposed on the company between January 1, 2015 and the first day of the 2015 plan year (December 1, 2015 in the example) if:

a) No later than the first day of the 2015 plan year (December 1, 2015), the company offers affordable coverage (9.5% of pay for single coverage) that provides at least minimum value to at least 70% of the full-time employees (30 hours per week); and one of the following two tests are met:

(1) **All Employees Test:**

aa) The health plan covered at least 25% of **all** employees (full and part-time) on any date in the prior 12 months ending on February 9, 2014, **or**

bb) Offered coverage to 1/3 or more of all employees (full and part-time) during the most recent open enrollment before February 9, 2014; **or**

(2) **Significant Percentage of Full-Time Employees:**

aa) Covered at least 1/3 of the full-time employees (30 hours per week) on any date in the prior 12 months ending on February 9, 2014, **or**

bb) Offered coverage to 50% or more of its full-time employees (30 hours per week) during the most recent open enrollment before February 9, 2014.

Note: You should have documentation that this coverage was actually offered to full-time employee for the policy year beginning December 1, 2013.

The best documentation would be signed waivers from the employees that coverage was offered and waived. If such employees have signed the Waiver of Health Insurance/Notice of HIPAA Special Enrollment Rights or something similar, this would be the best proof.

B. A large ALE (100+) that meets either the "All Employee" test or the "Significant Percentage" test, will be eligible for the fiscal year transition

relief. However, in order to get the benefit of the relief, the company must offer health insurance coverage that is affordable and meets certain requirements to at least 70% of its full-time employees (30 hours per week or more) by the first day of the 2015 plan year (December 1, 2015 in the example). If the company does not meet this condition, the penalties will apply retroactively to January 1, 2015.

C. It should be noted that the use of the 70% test rather than the 95% coverage test normally required under the ACA may subject the company to the $3,000 per year penalty for the failure to pay a specific amount (IRC 4980H(b) if such excluded full-time employees (30 hours per week or more) obtain health coverage on the government exchange and receive government subsidies.

V. "APPLICABLE LARGE EMPLOYER" DETERMINATION

A. The ACA defines an "applicable large employer" for a calendar year as an employer that employed an average of at least 50 full-time employees on more than 120 business days during the preceding calendar year. For this purpose, the term "full-time employees" means the sum of the employer's full-time employees and full-time equivalent employees ("FTEs"). For this determination, employees working less than 30 hours per week are combined to determine the number of FTEs.

B. The ACA does not require employers to provide health insurance coverage to its employees. However, employers that do not provide minimum "essential health benefits" as defined by the U.S. Department of Health and Human Services ("HHS"), may be liable for an additional tax. The two new taxes ("Pay or Play") are:

1. Failure to Provide Health Insurance Coverage (IRC 4980H(a)) - Full-time (30 hours per week) employees must be offered health insurance. The additional tax for any month is $166.67 multiplied by the number of actual full-time employees employed by the employer during such month ($2,000 per year). In calculating this monthly tax, the first 30 full-time employees are subtracted from the penalty.

2. Failure to Pay a Specific Amount (IRC 4980H(b)) - Full-time (30 hours per week) employees cannot be required to pay more than 9.5% of their W-2 income for individual coverage. The employer penalty for requiring employees to pay more than 9.5% of their W-2 income is $250.00 per month ($3,000 per year). This penalty only applies to those full-time employees that use the government health exchange and receive the government health credit.

The total tax penalty may not be greater than the tax penalty that would apply if the employer offered no coverage at all.

VI. FULL-TIME EMPLOYEE ANALYSIS

A. The Pay or Play provisions of the ACA impose tax penalties (described above) on an "applicable large employer" that either fails to offer its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage, or fails to offer affordable coverage or coverage that provides minimum value where one or more full-time employees is certified to receive a premium tax credit or cost-sharing reduction.

B. Although the new Pay or Play requirements are generally effective for health plan years beginning on or after January 1, 2015, the determination of "full-time" for 2015 is based on an employee's hours in 2014.

C. The guidance from the IRS defines an applicable large employer for a calendar year as an employer that employed on average at least 50 full-time "equivalent" employees on more than 120 business days during the preceding calendar year. For this purpose, the term "full-time equivalent employees" means the sum of the employer's full-time employees and full-time equivalent employees ("FTE's"). "Full-time" is defined as working 30 hours or more per week or 120 hours or more during a month. Monitoring the 30/120 hour requirement each month during a calendar year will create administrative complexity for large employers, especially employers with employees whose hours vary on a daily, weekly or monthly basis. In order to ease this administrative burden, the IRS issued an IRC 4980H Safe Harbor. The IRS Safe Harbor contains rules for dealing with new and existing full-time and part-time employees.

1. 4980H Safe Harbor - Determining the Full-Time Status of Hourly Employees

The IRS provided a notice of proposed rulemaking on December 28, 2012 relating to the shared responsibility requirements. Also included in this notice was a new safe harbor. The 4980H Safe Harbor is an optional method that large employers may use in determining the full-time status of its hourly employees. In order to avoid penalties, large employers will establish a measurement period during which an employee's hours are measured. Each employee who averages 30 hours of service per week during the measurement period will then be treated as full-time for health care purposes, regardless of the hours actually worked during the subsequent period. In addition, such employee must also be offered qualifying health care coverage during the subsequent stability period. The 4980H Safe Harbor works differently

depending on whether the employee is a new employee or an existing employee.

2. New Employees and the 4980H Safe Harbor

The Safe Harbor looks at two types of new employees: (i) Employees who are reasonably expected on their date of hire to work full-time ("New Full-Time Employees"); and (ii) Employees in which it cannot be determined on the date of hire whether they are reasonably expected to work full-time during the "measurement period" ("New Hourly Employees").

New Full-Time Employee: For an employee determined to be a New Full-Time Employee, the employer must offer health insurance coverage to such employee that begins after a waiting period determined by the employer that is no more than 90 days.

New Hourly Employees: For employees determined to be New Hourly Employees, the employer may establish an initial measurement period during which the new employee's hours are measured. Health insurance coverage does not need to be offered to such new employees during the initial measurement period, which may range from 3 to 12 months, as determined by the employer. The initial measurement period can begin on the date of hire, or the employer can establish an administrative period before the initial measurement period begins. A likely beginning date would be the first day of the month following the date of hire.

If the New Hourly Employee is determined during the initial measurement period to be working full-time (30 hours), then the employee's stability period must be no shorter than the initial measurement period used, but in no event less than 6 months. The health insurance coverage would be required to begin as soon as the initial measurement period ends, or following an administrative period.

If the New Hourly Employee is determined during the initial measurement period to not be working full-time, the employee may then be treated as not working full-time during the stability period. No 4980H penalty would apply for failing to offer such employee health insurance. The stability period for a new employee who is determined not to be a full-time employee cannot be more than 1 month longer in duration than the initial measurement period. Furthermore, the stability period for the New Hourly Employee cannot be longer than the "standard measurement period" (discussed below) that is applicable to ongoing employees.

In establishing an administrative period before or after the initial measurement period, the total administrative period cannot exceed 90 days. Furthermore, the administrative period and the initial measurement period cannot extend beyond the last day of the first calendar month after the employees date of hire.

3. Ongoing Employees and the 4980H Safe Harbor

An ongoing employee is an employee who has been employed for one entire "standard measurement period." A "standard measurement period" is defined as a period determined by the employer for measuring hours of service for existing employees. This period may range from 3 to 12 months.

Once an employee is determined to work full-time during the standard measurement period, the stability period for such employee must be no shorter than the standard measurement period, but not less than 6 months. The stability period must begin immediately after the standard measurement period or an administrative period of not more than 90 days.

An ongoing employee who is determined to not be a full-time employee during the standard measurement period can be treated as not being a full-time employee during the following stability period.

VII. PEO AND STAFFING COMPANY ISSUES

A. The final IRS Pay or Play regulations determine an individual's status as an "employee" by applying the "common law" standard. When an employer obtains workers through a PEO or staffing company, it must be determine who is the proper employer for purposes of the Affordable Care Act.

1. Employees from Short-Term Staffing Companies

In the preamble to the final regulations, the IRS drew a distinction between "temporary staffing firms" and "staffing firms." In the preamble, the IRS referenced workers from temporary staffing firm as the common law employee of the temporary staffing firm. This may be due to short-term staffing companies normally exercises greater control over the employee than is normally seen in the PEO context. Thus, it appears that when workers are obtained for short periods of time the IRS seems agreeable that the workers are the common law employees of the temporary staffing firm, leaving the temporary staffing firm responsible for offering coverage and liable for paying penalties if coverage is not offered.

2. Employees from PEOs

Later in the final regulation preamble, the IRS references professional employer organizations and other staffing agencies and states that, in the typical case, the professional employer organization or staffing firm is not the common law employer.

The IRS appears to imply that if you use a worker from a staffing firm or PEO for anything other than a short-term, temporary assignment, the IRS will view that worker as the common law employee of the worksite employer. Thus, the worksite employer would have to count that worker in determining if the worksite employer is subject to the play or pay requirements and whether it owes any penalties for the failure to cover the requisite percentage of employees.

3. IRS Safe Harbor

The preamble to the regulations provides that if certain conditions are met, an offer of coverage to an employee performing services for an employer that is a client of a professional employer organization or other staffing firm made by the staffing firm on behalf of the client employer under a plan established or maintained by the staffing firm, is treated as an offer of coverage made by the client employer for purposes of section 4980H ("Pay or Play" requirements).

For this purpose, an offer of coverage is treated as made on behalf of a client employer only if the fee the client employer would pay to the staffing firm for an employee enrolled in health coverage under the plan is higher than the fee the client employer would pay to the staffing firm for the same employee if the employee did not enroll in health coverage under the plan.

a) Frequency of Additional Fee. No guidance has been provided as to the amount of the additional fee or its frequency. Informally, the IRS has indicated that the fee should be a specified health care fee on periodic invoices for each employee receiving health coverage. Some commentators have stated that a lesser permissible method would be to have an aggregate charge for the employees that have elected health coverage.

b) Amount of Additional Fee. No guidance has been provided as to the amount or calculation of an appropriate fee. In theory, this could be a nominal amount or it could be the full employer share of the cost of the health care with the employee paying the remaining amount.

c) Playing it Safe. It may be advisable to structure agreements with PEOs and longer term staffing companies to comply with the IRS safe harbor if the employees would put the employer over the 50 person threshold or if it would reduce the employer's coverage to fall below the 70% offer threshold.

VIII. EMPLOYEE DISCLOSURES

A. Insurance Marketplace

1. General Information. The ACA amends the Fair Labor Standards Act ("FLSA") to require that employers provide all new hires and current employees with a written notice about the health benefit Exchange and some of the consequences if an employee decides to purchase a qualified health plan through the Exchange in lieu of employer-sponsored coverage.

   Employers were required to provide the notice to each new employee at the time of hiring beginning October 1, 2013. For 2014, the Department of Labor permitted the notice to be provided within 14 days of an employee's start date. The notice is required to be provided automatically. For 2015 and thereafter, the 14 day period does not apply and the notice should be provided on or before the hire date.

   The notice must be provided in writing in a manner calculated to be understood by the average employee. It may be hand delivered or provided by first-class mail. Alternatively, the notice may be provided electronically if the requirements of the DOL electronic disclosure safe harbor are met.

2. Content Requirements. The DOL has issued a model notice for the employer to complete. The Notice:

   a) Informs the employees of the existence of an Marketplace and how to contact the Exchange to request assistance,

   b) Informs the employees that they may be eligible for a premium tax credit (under Code § 36B) or a cost-sharing reduction (under ACA § 1402) through the Marketplace if the employer plan's share of the total cost of benefits under the plan is less than 60%; and

   c) If the employees purchase a qualified health plan through the marketplace they may lose any employer contribution toward the cost of employer-provided coverage and that all or a portion of employer contributions to employer-provided

coverage may be excludable for federal income tax purposes.

B. 60 Day Advance Notice

The ACA requires plans and issuers to provide at least 60 days' advance notice of any material modification in plan terms or coverage that are not described in the most recent SBC. The DOL's proposed regulations offer additional guidance on when plans and issuers must provide the 60-day advance notice to enrollees.

1. The proposed regulations state that plans and issuers are required to issue the 60-day advance notice when:

   A material modification is made that would affect the content of the SBC;

   The change is not already included in the most recently provided SBC; and

   The change is a mid-plan year change (that is, it does not occur in connection with a renewal of coverage).

Note: Under the proposed regulations, plans and issuers must provide the SBC before the beginning of each plan year. Changes that occur in connection with a new plan year should be described in an updated SBC provided before the beginning of the plan year.

When a plan timely provides the 60-day advance notice in connection with a material modification, the proposed regulations state that the plan will also satisfy ERISA's requirement to provide an SMM.

2. Guidance on Material Modifications. The proposed regulations describe a "material modification" as any change to a plan's coverage that independently, or in connection with other changes taking place at the same time, would be considered by the average plan participant to be an important change in covered benefits or other terms of coverage.

   A material modification may include:

   An enhancement in covered benefits or services or other more generous plan or policy terms (for example, reduced cost-sharing or coverage of previously excluded benefits); or

   A reduction in covered services or benefits or more strict requirements for receiving benefits (for example, a new referral requirement or increased premiums or cost-sharing).

C. Summary Plan Description ("SPD") Issues

ERISA health and welfare benefit plans (other than governmental plans and church plans) must distribute an SPD to each participant covered under the plan.

The documents distributed by most employers sponsoring health and welfare plans to its employees do not meet the ERISA requirements for and SPD.

The plan administrator generally must furnish the SPD within 90 days after a participant first becomes covered under the plan. For new plans, the plan administrator must furnish the SPD to covered participants within 120 days after the plan's establishment.

The summary plan description (SPD) is the primary vehicle for informing participants and beneficiaries about their rights and benefits under the employee benefit plans in which they participate. Consequently, ERISA is quite specific about the content requirements for an SPD and establishes extensive and detailed requirements regarding the information that must be disclosed.

Some of the required information that must be contained in the SPD or in related documents for health and welfare plans that we see missing include the following:

1. Name of the plan

2. Sponsor Information including full name and address, EIN, Plan Number and the Plan Year.

3. Type of Plan (ex. group health plan, disability, prepaid legal services, etc.).

4. Administration (ex. contract administration, insurer administration, etc.).

5. Plan Administrator information such as the name, business address, and telephone number of the plan administrator. This is usually the plan sponsor.

6. Service of Process - Name and address of the person designated as agent for service of legal process, and a statement that service can be made on a plan trustee or the plan administrator.

7. Collective-Bargaining Agreement - For collectively bargained plans, a statement referencing the collective-bargaining agreement, and a

statement that the collective-bargaining agreement is available for examination and that a copy may be obtained by written request to the plan administrator.

8. Eligibility - A description of the plan's requirements for eligibility to participate and to receive benefits, such as waiting periods, class or classes of eligible participants, and how variable hour employees under the ACA may become eligible for participation.

9. Amendment and Termination information.

10. COBRA Continuation Rights information.

11. Funding Medium - The SPD must disclose the identity of the funding medium used to accumulate assets and pay benefits, along with the name of any insurance company, trust fund, or other institution which maintains the fund. If a health insurance issuer is responsible, in whole or in part, for the financing or administration of a group health plan, the SPD must disclose the name and address of the insurer, whether and to what extent benefits under the plan are guaranteed under the policy or contract, and the nature of any administrative services provided (for example, contract administrator or claims payer).

12. Maternity or Newborn Coverage - The SPD must contain a statement describing the federal or state law requirements applicable to the plan (or any health insurance coverage offered under the plan) relating to hospital length-of-stay in connection with childbirth for the mother or newborn child.

13. Foreign Language Statement - An employer subject to a foreign language disclosure requirement should include a statement, prominently displayed and in the appropriate, non-English language, telling how, when, and where participants can receive an oral, non-English explanation of the plan.

14. HIPAA Special Enrollment Rights - for medical and other HIPAA plans, the SPD must include an explanation of events that trigger a special enrollment right and the time limits that apply to such enrollment rights.

15. Mastectomy Reconstruction - Health plan SPDs must contain a statement regarding the limits of the mastectomy reconstruction benefit.

16. Qualified Medical Child Support Orders (QMCSOs) - Health plan SPDs must contain either the procedures for handling QMCSOs or

a statement indicating that participants and beneficiaries can obtain, free of charge, a copy of the procedures.

17. ERISA Rights - All SPDs must include the statement of ERISA rights.

D. Insurance Refunds

1. General Information. The ACA established medical loss ratio (MLR) standards for health insurance issuers. Issuers are required to provide rebates when their spending for the benefit of policyholders on reimbursement for various health care services, in relation to the premiums charged, is less than the MLR standards established pursuant to the statute. Rebates are based upon aggregated market data in each State and not upon a particular group health plan's experience.

   To the extent that distributions, such as premium rebates, are considered to be plan assets of employer-sponsored health care plan, they become subject to the requirements of Title I of ERISA. Anyone with authority or control over plan assets is a "fiduciary," and subject to, among other things, the fiduciary responsibility and prohibited transaction provisions of ERISA. The DOL issued Technical Release 2011-04 to provide employers and plan fiduciaries guidance on handling any insurance company rebates received.

2. Who is Entitled to the Refund? Under ERISA section 401(b)(2), if the health care plan is the policyholder, the policy would be an asset of the plan, and in the absence of specific plan or policy language to the contrary, the employer would have no interest in the distribution. The policy for most small plans is in the name of the employer.

   It is the DOL's position that the employer named as the policyholder or the owner of the policy would not, by itself, indicate that the employer may retain the distributions. In determining who is entitled to the distribution, the DOL requires a careful analysis of terms of the governing plan documents and the parties' understandings and representations.

   Under ordinary notions of property rights, if a contract is ambiguous, other evidence may be used to determine the intent of the parties. In the absence of more direct evidence, the DOL has looked to the sources of the insurance policies' premium payments. For example, where the premium is paid entirely out of trust assets,

it is the view of the Department that the entire amount received from the insurer by the policyholder constitutes plan assets.

3. Allocating the Refund. Assuming the plan documents and other extrinsic evidence do not resolve the allocation issue:

   a) the portion of a rebate that is attributable to participant contributions would be considered plan assets. Thus, if the employer paid the entire cost of the insurance coverage, then no part of the rebate with respect to this particular policy would be attributable to participant contributions.

   b) if participants paid the entire cost of the insurance coverage, then the entire amount of the rebate would be attributable to participant contributions and considered to be plan assets.

   c) if the participants and the employer each paid a fixed percentage of the cost, a percentage of the rebate equal to the percentage of the cost paid by participants would be attributable to participant contributions.

   d) if the employer was required to pay a fixed amount and participants were responsible for paying any additional costs, then the portion of the rebate under such a policy that does not exceed the participants' total amount of prior contributions during the relevant period would be attributable to participant contributions.

   e) if participants paid a fixed amount and the employer was responsible for paying any additional costs, then the portion of the rebate under such a policy that did not exceed the employer's total amount of prior contributions during the relevant period would not be attributable to participant contributions.

   f) In any case, employers that sponsor group health plans that use insurance policies to provide benefits would be prohibited by ERISA section 403(c)(1) from receiving a rebate amount greater than the total amount of premiums and other plan expenses paid by the employer. To the extent that an employer's portion of the rebate exceeds the amount of such employer's total amount of premiums and other plan expenses paid, that excess amount must be held in trust for the exclusive benefit of participants and beneficiaries.

E. W-2 Reporting

The ACA requires employers to report the cost of coverage under an employer-sponsored group health plan on Form W-2. Until further guidance is issued, this requirement will only apply to employers that issue 250 or more Forms W-2 for the calendar year. All employers of the controlled group are aggregated for this 250 Forms W-2 requirement.

1. What is Required to Be Reported?

Code Section 6051(a)(14) provides that the aggregate cost of employer-sponsored health insurance coverage must be included on the Form W-2. The reported costs are generally as used for COBRA purposes for "Applicable Employer-Sponsored Coverage".

Applicable Employer-Sponsored Coverage does not include:

a) Coverage only for accident, or disability income insurance, or any combination thereof;

b) Stand-alone dental and vision coverage (ex. Employees can choose dental and/or vision and not health coverage);

c) Coverage issued as a supplement to liability insurance;

d) Liability insurance, including general liability insurance and automobile liability insurance;

e) Workers' compensation or similar insurance;

f) Automobile medical payment insurance;

g) Credit-only insurance;

h) Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

i) Coverage for specific diseases or illness (ex. cancer insurance); or

j) Hospital indemnity or other fixed indemnity insurance.

2. Calculating the Cost of Coverage.

a) Insured Plans – Use the premium charged by the insurance company rate for the employee's selected coverage. The costs reported on the Form W-2 are calendar year payments and not the payments for the insurance policy year.

b) Self-Insured Plans – Use the method currently used for COBRA purposes for the employee's selected coverage, except that the reported costs must be determined on a calendar year basis. The costs reported on the Form W-2 are calendar year payments and not the payments based on the self-insured plan's fiscal year. You will need to discuss this issue further with Employee Benefit Concepts.

c) Mid-Year Employee Coverage Changes - If an employee changes coverage during the year, the reportable cost under the plan for the employee for the year must take into account the change in coverage by reflecting the different reportable costs for the coverage elected by the employee for the periods for which such coverage is elected.

d) Controlled Group Rules – Until further guidance is provided, the 250 Form W-2 count is determined without application of any entity aggregation rules for related employers.

F. Summary of Benefits and Coverage

The ACA mandates the creation and distribution to health plan participants of a document entitled Summary of Benefits and Coverage ("SBC").

Non-compliance with SBC regulations can result in a civil penalty of up to $100 per day per affected individual; an excise tax of $100 per day per affected individual; and fines of up to $1,000 per affected individual for willful violations.

1. Plans Covered

Government regulations provide that the SBC requirements apply to the following types of plans:

a. Self-funded and insured medical plans

b. Individual plans

c. Limited benefit plans

d. Student health insurance

e. Expatriate plans (U.S.-based benefits only)

f. Certain other plan types (e.g., HRAs, pharmacy and EAP if considered a group health plan)

The purpose of the SBC is to give eligible employees and beneficiaries information about a health insurance plan's benefits in "plain language," so they can make appropriate purchasing,

enrollment and coverage decisions. All customers and insurers must use the SBC document format prescribed by the final DOL regulations.

2. Who needs to provide the SBC?

   All group health plans and health insurance issuers are required to provide an SBC. The requirement also applies to grandfathered health plans.

   Responsibility for the preparation of the SBC depends on the nature of the plan. For self-insured group health plans, the plan (including the plan administrator) will be responsible for providing an SBC.

   For fully-insured plans, both the insurer and the plan are jointly responsible. Generally, SBCs will be drafted by insurers and third-party administrators. The plan or insurer is not liable for enforcement if they have an arrangement with a TPA, they monitor the TPA, and they take action in the event of a violation.

   The rules also apply to health reimbursement arrangements. However, if the health reimbursement arrangement is coordinated with another major medical plan, two separate SBCs will not be required.

   The SBC requirements will also not apply to stand-alone retiree health plans.

3. When must SBCs be provided?

   For group health plan coverage, the regulations provide that, for disclosures with respect to participants and beneficiaries who enroll or re-enroll through an open enrollment period (including late enrollees and re-enrollees), the SBC must be provided beginning on the first day of the first open enrollment period that begins on or after September 23, 2012.

   For disclosures with respect to participants and beneficiaries who enroll in coverage other than through an open enrollment period (including individuals who are newly eligible for coverage and special enrollees), the SBC must be provided beginning on the first day of the first plan year that begins on or after September 23, 2012.

   The SBC is going to be a part of the annual enrollment processes going forward.

There are basically five circumstances in which the document and the glossary will need to be provided:

a) At enrollment (i.e., initial enrollment) - with any written enrollment application materials the plan provides. If no such materials are provided, then no later than the first date the participant is eligible to enroll himself or any beneficiary in coverage.

b) If there are changes to the SBC - no later than the first day of coverage

c) HIPAA special enrollees - no later than 90 days following enrollment. This time period is coordinated with the requirement for providing the group health plan SPD.

d) Early delivery required upon enrollee's request.

e) Upon renewal (i.e., annual enrollment) - if applicable, only for those benefit options in which the participant or beneficiary is enrolled, by either the date the written renewal application materials are distributed to the plan sponsor or, in the case of automatic renewal, no later than 30 days prior to the first day of the new plan year.

A participant or beneficiary can also request an SBC during renewal for an option in which they are not enrolled.

f) Upon request – no later than seven business days.

IX. FORM 1094/1095 REPORTING AND DISCLOSURES

A. General Information

The Affordable Care Act imposes significant information reporting responsibilities on employers starting with the 2015 calendar year. This new reporting requirement is the most significant increase in employer reporting since W-2 reporting began.

The new reporting requirement will be similar to the current Form W-2 reporting since an information return (IRS Forms 1095-B or 1095-C) will be prepared for each applicable employee. These Forms will be filed with the IRS using a single transmittal form (Form 1094-B or 1094-C).

Employers must report information to the IRS about the health care coverage provided to full-time employees no later than February 29, 2016, or March 31, 2015, if filed electronically). Electronic filing with the IRS is required for 250 or more Forms 1095-B or 1095-C

A copy of the Form 1095, or a substitute statement, must be given to the employee by January 31, 2016 and can be provided electronically with the employee's consent. Employers will be subject to penalties of up to $200 per return for failing to timely file the returns or furnish statements to employees.

B. Full-Insured Health Plans

The filing requirements are based on an employer's health plan and number of employees. Form 1095-B (Health Coverage) and Form 1094-B (Transmittal of Health Coverage Information Returns) will be filed by insurance companies to report individuals covered by insured employer-sponsored group health plans.

C. Small Self-Insured Health Plans

Small employers with self-insured health plans will also use Form 1095-B and Form 1094-B to report the name, address, and Social Security number (or date of birth) of the employees and their family members who have coverage under the self-insured plan. Employees who are offered coverage, but decline the coverage, are not reported on this form.

D. Large Employers – Full-Insured and Self-Insured Plans

Form 1095-C (Employer-Provided Health Insurance Offer and Coverage) and Form 1094-C (Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns) will be filed by applicable large employers. These forms will be required if the employer offers an insured or self-insured health plan, or does not offer any group health plan.

Applicable large employers are those that had, on average, at least 50 full-time employees (including full-time equivalent employees) during the preceding calendar year. Full-time employees are those who work, on average, at least 30 hours per week. The controlled group/affiliated service group rules apply.

Applicable large employer group members must prepare a Form 1095-C for each full-time employee regardless of whether the employee is participating in an employer-sponsored group health plan. In addition, the employer will complete a Form 1095-C for each non-full-time employee who is in the plan. The employer will not prepare Form 1095-C for non-full-time employees who are not in the plan.

Form 1095-C will report the following information to the IRS:

- The employee's name, address and Social Security number

- The employer's name, address and employer identification number
- Whether the employee and family members were offered health coverage each month that met the minimum value standard
- The employee's share of the monthly premium for the lowest-cost minimum value health coverage offered
- Whether the employee was a full-time employee each month
- The affordability safe harbor applicable for the employee
- Whether the employee was enrolled in the health plan
- If the health plan was self-insured, the name and Social Security number (or birth date if the Social Security number is unavailable) of each employee and family member covered by the plan by month

Members of an applicable large employer group that has fewer than 100 full-time employees are generally eligible for transition relief from the employer shared responsibility penalty for their 2015 plan year. Nonetheless, these employers are required to file Forms 1095-C and 1094-C for the 2015 calendar year.

Each applicable large employer group member is required to file Forms 1095-C and 1094-C for its own employees, even if it participates in a health plan with other employers (e.g., when the parent company sponsors a plan in which all subsidies participate).