

## **IRS NOTICE 2015-87: ADDITIONAL GUIDANCE ON HRAS, ACA REPORTING, HEALTH FSA CARRYOVERS AND MORE**

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In December of 2015, the IRS issued IRS Notice 2015-87 (Notice) which provides employers clarifying guidance on Affordable Care Act (ACA) topics ranging from health reimbursement arrangements (HRAs), employer shared responsibility clarifications, information reporting, and additional guidance regarding the health FSA carryover rules. This client alert will highlight certain topics covered in the Notice.

### **Additional Employer Payment Plan Guidance**

With IRS Notice 2013-54 and several FAQs, the IRS has provided a significant amount of guidance on HRAs and other types of employer arrangements that reimburse employees for some or all of the premium expenses or pay directly for an individual health insurance policy (collectively an “employer payment plan”) and the ACA market reforms (e.g. annual dollar limit prohibition and the preventive services requirements). The general position of the IRS is that an employer payment plan cannot pay or reimburse for individual marketplace coverage because such an employer payment plan is a group health plan and does not, on its own, satisfy the ACA market reforms. The following is a summary of the additional guidance provided in the Notice regarding employer payment plans.

#### *Retiree-Only HRAs*

An HRA that covers fewer than two participants who are current employees (such as one covering only retirees or other former employees) is not subject to the ACA market reforms. This includes a retiree-only HRA under which amounts are determined in whole or in part by amounts credited during the period that the individual was a current employee covered by an HRA that was integrated with another group health plan. The Notice clarifies that the retiree-only HRA constitutes minimum essential coverage for any month during which funds are retained in the HRA and, as a result, a participant in an HRA with available funds will not be eligible for a premium tax credit under Code Section 36B for that month.

#### *Unused HRA Balances*

Clarifying Q&A-5 in Notice 2013-54, an unused balance in an HRA cannot be used to purchase individual coverage; even for periods the participant is no longer covered by a group health plan with which the HRA is integrated.

#### *HRA reimbursements for spouse and dependents not enrolled in group health plan*

If the spouse and/or dependents are not enrolled in the employer’s group health plan coverage, the coverage of these individuals under the HRA cannot be integrated with the employer’s group health plan coverage, and the HRA will fail the ACA market reforms.

*Transition relief.* For plan years beginning before January 1, 2016, the IRS will not treat an HRA that is available for the expenses of family members not enrolled in the employer's group health plan as failing to be integrated with the group health plan. Additionally, based on the terms of an HRA as of December 16, 2015, the IRS will not treat an HRA as failing to be integrated with a group health plan for years beginning before January 1, 2017, solely because the HRA covers expenses of family members that are not enrolled in the group health coverage. The Notice does clarify that, notwithstanding this transition relief, the employer is still responsible for Section 6055 reporting for reporting the HRA coverage as minimum essential coverage for each individual covered by the HRA.

*HRA or employer payment plan that only reimburses (or pays directly for) premiums for individual market coverage consisting solely of excepted benefits*

The ACA market reforms do not apply to a group health plan that provides for only HIPAA-excepted benefits (such as limited scope vision or dental coverage). As a result, an HRA or employer payment plan will not be subject to the ACA market reforms if it only reimburses or pays for individual market coverage that covers only HIPAA-excepted benefits.

### **Cafeteria Plans and Individual Market Coverage**

An employer arrangement reimbursing the cost of individual market coverage under a cafeteria plan is an employer payment plan (whether or not funded solely by salary reduction or also including other employer contributions, such as flex credits), which is a group health plan subject to the ACA market reforms. This separate group health plan (in this case, the employer payment plan offered under the cafeteria plan) cannot be integrated with the individual market coverage purchased through that employer payment plan.

### **Affordability Determinations**

#### *HRA Contributions*

An applicable large employer or ALE (an employer that employed 50 or more full-time employees and full-time equivalents during the previous calendar year) may be subject to a penalty under the employer mandate for any month that an employee receives a premium tax credit in connection with his or her enrollment in marketplace coverage because the employer's coverage is not "affordable." The Notice confirms that employer contributions to an HRA count toward an employee's required contribution for purposes of determining "affordability" (i.e. whether the employee's premium is 9.5% (adjusted) or less of the employee's household income) only to the extent the amount of the employer's annual contribution to the HRA is required under the terms of the arrangement or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan. For purposes of reporting under Section 6056 (Form 1095-C), the employer contribution to an HRA (and any resulting reduction in the employee contribution) is treated as made ratably for each month of the period to which it relates.

*Example.* EE contribution for health coverage under the plan is \$200 per month. For the current plan year, the employer makes \$1,200 available that the employee may use to pay the employee share of contributions for the major medical coverage, pay cost-sharing, or pay towards the cost of vision or dental coverage. In this example, the Notice concludes that the \$1,200 employer contribution to the HRA reduces the employee's required contribution. For reporting and the employer mandate "affordability" requirements, the employee's required contribution for major medical is \$100 (\$200-\$100) per month because 1/12 of the \$1,200 HRA amount per month is taken into account as an employer contribution whether or not the employee uses the HRA to pay the employee share of the contributions for the major medical coverage.

### *Employer flex contributions*

Under a cafeteria plan, the employee's enrollment in a group health plan is funded by salary reduction but may also be funded by employer flex contributions. An employer's flex contribution may reduce the amount of an employee's required contribution for purposes of determining whether an ALE has made an offer of affordable minimum value coverage under Code Sections 36B and 5000A and any related potential penalties under 4980H(b), provided that the employer contribution constitutes a health flex contribution. A health flex contribution is defined as an amount that an employee (1) may not opt to receive as a taxable benefit; (2) may use to pay for minimum essential coverage; and (3) may use exclusively to pay for medical care, within the meaning of Code Section 213. For purposes of the employer mandate "affordability" requirements and Code Section 6056 reporting, the health flex contribution is treated as made ratably for each month of the period to which it relates. However, if an employer flex contribution is also available to pay for non-health care benefits under the cafeteria plan (e.g. dependent care or life insurance premiums) or that could be received in cash, that contribution will not be treated as a health flex contribution and, as a result, will not reduce the required employee contribution.

*Transition relief.* For plan years beginning before January 1, 2017, solely for purposes of 4980H(b), an employer flex contribution that is not a health flex contribution because it may be used for non-health benefits will be treated as reducing the amount of an employee's required contribution. This relief is not available with respect to a flex contribution arrangement offering non-health benefits that is adopted after December 16, 2015 or that substantially increases the amount of the flex contribution after December 16, 2015. Additionally, for plan years beginning before January 1, 2017, an employer may reduce the amount of the employee's required contribution by the amount of a non-health flex contribution for purposes of information reporting under Code Section 6056 (line 15 of the 1095-C). Due to the fact that treating a non-health flex contribution as reducing an employee's required contribution may affect the employee's eligibility for a premium tax credit under Code Section 36B, the IRS is encouraging employers not to reduce the required contribution for these purposes. If the employer does not reduce the employee's contribution and is contacted by the IRS about an assessable payment under 4980H(b), the employer can then show that they were eligible for the relief described in the Notice.

### *Opt-out payments*

The Notice provides that the IRS intends on proposing regulations that will provide that an unconditional "opt-out" payment (i.e. an arrangement providing for a payment conditioned solely on an employee declining coverage under an employer's health plan and not due to any other "meaningful" requirement related to the provision of health care to employees, such as a requirement to provide proof of coverage provided by a spouse's employer) will be treated as an additional employee cost for purposes of determining whether an employee required contribution under Code Section 36B and 5000A and any related consequences under Code Section 4980H(b).

The IRS anticipates that the regulations will apply only for periods after the issuance of the final regulations except for *non-relief-eligible* opt-out arrangements. *Non-relief-eligible* opt-out arrangements are opt-out payments that are adopted after December 16, 2015. An opt-out arrangement will be treated as adopted after December 16, 2015 unless (1) the employer offered the opt-out arrangement (or a substantially similar opt-out arrangement) with respect to health coverage provided for a plan year including December 16, 2015; (2) the employer adopted the opt-out arrangement before December 16, 2015; or (3) the employer 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. For the period prior to the proposed regulations, employer are not required to increase the amount of an employee's required contribution by the amount of an opt-out (other than a non-relief-eligible opt-out arrangement), and an opt-out payment will not be treated as increasing an employee's required contribution for purposes of any potential assessable payment under 4980H(b). Prior to the issuance of regulations, the Notice indicates that employers can rely on the language in the Notice to treat opt-out payments as increasing the employee's required contribution and, with respect to any individual who could demonstrate that the individual meets a condition (in addition to declining the employer's health coverage) that must be satisfied

to receive an opt-out payment (such as demonstrating that the employee has coverage under a spouse's group health plan) the individual may treat the opt-out payment as increasing the employee's required contribution for purposes of Sections 36B and 5000A.

*Fringe benefit payments made pursuant to McNamara – O'Hara Service Contract Act (SCA), the Davis-Bacon Act or the Davis Bacon Related Acts (collectively the "DBRA")*

The IRS recognizes that an employer that is subject to the SCA or DBRA fringe benefit requirements (both the SCA and DBRA generally require that workers employed on certain federal contracts be paid prevailing wages and fringe benefits), may have difficulty complying with the Notice's requirements that employer flex contributions (see above) only be used for health care benefits for purposes of affecting the affordability calculation. Until any further guidance is issued, employer fringe benefit plans (including flex credits or flex contributions) under the SCA or DBRA will be treated as reducing the employee's required contribution for participation in that group health plan for purposes of 4980H(b), but only to the extent that amount of the payment does not exceed the amount required to satisfy the requirement to provide fringe benefit payments under the SCA or DBRA. In addition, the employer may treat these employee fringe benefit payments as reducing the employee's required contribution for purposes of reporting under Section 6056 (line 15). Employers are, however, encouraged to treat these fringe benefit payments as not reducing the employee's required contribution so that an employee may still be treated as potentially eligible for a premium tax credit. For purposes of Sections 36B and 5000A, individual taxpayers are not required to take these amounts into account as reducing the employee's required contribution.

For employers that are using the Section 6056 relief described above, the Notice encourages employers to notify employees that they may obtain accurate information about their required contribution taking into account the modifications permitted in the Notice using the employer contact telephone number provided to the employee on the 1095-C. Without regard to how the employee obtains that information, if the modified required contribution is not affordable for purposes of Section 36B and the employee is otherwise entitled to the premium tax credit, the employee may claim it on Form 8692, Premium Tax Credit.

### **Adjusting Affordability**

The Notice clarifies that the reference to 9.5 percent for purposes of the affordability safe harbors under the employer mandate and certain other ACA provisions is adjusted to reflect the affordability adjustments under Code Section 36B, so that employers may rely upon 9.56 percent for plan years beginning in 2015 and 9.66 percent for plan years beginning in 2016 for purposes of determining "affordability."

### **Adjusting Employer Mandate Penalties**

Under Code Section 4980H(c)(5), in the case of any calendar year after 2014, the applicable dollar amounts of \$2,000 and \$3,000 under Section 4980H(c)(1) and (b)(1) are increased based on the premium adjustment percentage as defined in Section 1302(c)(4). For calendar year 2015, the adjusted \$2,000 amount in 4980H(c)(1) is \$2,080 and the adjusted \$3,000 amount in section 4980H(b)(1) is \$3,120. For 2016, the adjusted \$2,000 amount in 4980H(c)(1) is \$2,160 and the adjusted \$3,000 is \$3,240 for the 4980(b)(1) penalty. Future adjustments will be posted on [www.irs.gov](http://www.irs.gov).

### **Hours of Service**

Hours of service under the employer mandate generally reference and parallel hours of service under DOL regulation 2530.200b-2(a). However, there are certain rules in the DOL regulation that do not fit within the structure of the hours of service requirements under the employer mandate. The Notice clarifies that the 4980H regulations do not incorporate the provisions of 29 CFR 2530.200b-2(a)(2) that require hours of service to be

credited for certain periods of time during which no duties are performed “irrespective of whether the employment relationship has terminated” because the purpose of 4980H is to determine whether a current employee is a full-time employee (and to accumulate the hours of service of current non-full-time employees to calculate an employer’s number of full-time equivalent employees) and an hour of service does not include an hour of service after the employee has terminated. Additionally, an hour of service does not include (1) an hour for which an employee is directly or indirectly paid, on account of a period during which no duties are performed, under a plan maintained solely for purposes of complying with applicable workers’ compensation, or unemployment or disability insurance laws; and (2) an hour of service for a payment which solely reimburses an employee for medical or medically related expenses incurred by the employee.

Furthermore, the Notice clarifies that there is no 501-hour limit on the hours of service required to be credited to an employee on account of any single continuous period during which the employee performs no duties if the hours of service would otherwise qualify as hours of service. For purposes of determining whether an hour of service must be credited, a payment is deemed to be made by or due from an employer regardless of whether the payment is made by or due from the employer directly, or indirectly through, among others, a trust fund or insurer to which the employer contributes or pays premiums, and regardless of whether contributions made or due to the trust fund, insurer, or other entity are for the benefit of particular employees or are on behalf of a group of employees in the aggregate. Accordingly, periods during which an individual is not performing services but is receiving payments pursuant to a short-term disability or long-term disability program result in hours of service for any part of the period during which the recipient retains status as an employee of the employer, unless the payments are made from an arrangement to which the employer did not contribute directly or indirectly. A disability arrangement for which the employee paid with after-tax contributions (so that the benefits received under the arrangement are excluded from income) would be treated as an arrangement to which the employer did not contribute and the payments from the arrangement would not give rise to hours of service. Additionally, periods during which the employee is not performing services but receiving payments in the form of workers’ compensation benefits under a state or local government program do not result in hours of service.

### **Breaks in Service - Staffing Agencies and Educational Organizations**

The 4980H regulations provide for certain breaks in service rules that generally provide that an employee who is rehired after at least 13 weeks (or 26 weeks for educational organizations) can be treated as a new hire under the special rehire rules under 4980H and the look-back measurement method. The IRS is aware of arrangements where educational organizations are attempting to avoid the 26-week break in service rule by using third-party staffing agencies for certain individuals providing services to the educational organization. By utilizing the third-party agency, employees of the staffing agency that are utilized by an educational organization-client are covered by the 13-week break in service rule (as opposed to the 26-week rule for employees of educational organizations). The IRS intends to propose amendments to the regulations under Section 4980H to provide that the 26-week break in service will apply to not only employees of education organizations, but also to any employee providing services primarily to one or more educational organizations for whom a meaningful opportunity to provide services during the entire year (to an educational organization or any other type of service recipient) is not available.

*Example.* This new special rule would apply to a bus driver who is primarily placed to provide bus-driving services or a cafeteria worker who is primarily placed to provide services in a cafeteria at one or more educational organizations and who is not provided a meaningful opportunity to provide services during one or more months of the calendar year (for example, the summer recess period). In contrast, an employer that primarily places bus drivers or cafeteria workers at educational organizations would not apply the special rule to an employee if the individual was offered a meaningful opportunity to provide services during all months of the year (for example, the case of a cafeteria worker, by working at a hospital cafeteria during the summer recess period of the educational organization at which the individual generally is placed).

The amendments under these breaks in service rules will apply as of the applicability date specified in the regulations.

### **Governmental Entities and ACA Reporting**

The Notice clarifies that, due to the fact that controlled group rules under Code Section 414(b), (c), (m) and (o), does not directly address governmental entities, such entities can apply a good faith standard in applying these controlled group rules for purposes of determining whether the government entity is an ALE.

The Notice also clarifies that each separate governmental employer entity that is an ALE or that provides self-insured coverage to its employees must use its own EIN for purposes of the ACA reporting requirements.

*Example.* A state treats the state executive and executive agencies, the state judiciary, and the state legislature as three separate employers that are ALE members of the applicable employer group that reflects the state government. Each of the three employees is required to have a separate EIN and file the Forms 1094-C and 1095-C reflecting the EIN of the employer.

If the government employer(s) use a designated government entity or (DGE), the government employers have transferred the responsibility for reporting to the DGE, but the DGE is still reporting on behalf of the government entity that retains its separate status as an applicable large employer (or ALE member) subject to the employer shared responsibility provisions.

*Example.* If ten counties that are ALEs enter into agreements with a state government entity that the state will be the DGE for each of the counties, the state government entity should file a Form 1094-C on behalf of each of the counties (as well as a Form 1094-C on behalf of itself as an employer of its own employees). Each Form 1094-C would list the name and EIN of the state government entity as the DGE, and the name and EIN of the county as the employer. The Form 1094-C for each county would be accompanied by the Forms 1095-C for each employee of each county and would identify the county as the employer.

### **Good Faith Compliance with ACA Reporting**

The IRS has provided certain relief from the information reporting penalties under Code Sections 6721 and 6722 for the ACA information reporting under Code Sections 6055 and 6056 for the 2015 calendar year. The relief generally extends to incomplete or incorrect returns where the employer can demonstrate that it operated in good faith in completing the forms; provided that the incorrect or incomplete forms were filed timely. The Notice reiterates that an employer may still be eligible for relief where the forms are not filed timely if the employer can demonstrate that “reasonable cause” exists under Code Section 6724.

### **Health FSA Carryovers**

Health FSAs can now permit the carryover of up to \$500 of unused amounts remaining at the end of the plan year. The Notice clarifies that any carryover amount is included in determining the amount of the benefit that a qualified beneficiary is entitled to receive during the remainder of the plan year in which a COBRA qualifying event occurs.

*Example.* During the open enrollment an employee elects \$2,500 to contribute to employee’s health FSA. In addition, the employee carries over \$500 in unused benefits from the prior year. Thus, the maximum benefits that the employee can become entitled to receive under the health FSA for the entire year is \$3,000. The employee experiences a COBRA “qualifying event” that is a termination of employment on May 31. As of the date, the employee had submitted \$1,100 of reimbursable expenses under the health

FSA. The maximum benefit that the employee could become entitled to receive for the remainder of the plan year as a benefit under the health FSA is \$1,900 (\$2,500 plus \$500) minus \$1,100).

The COBRA rules provide that the maximum amount that a group health plan is permitted to charge for COBRA coverage is 102 percent of the applicable premium for the period of the COBRA continuation coverage. For health FSAs, an employer may base its reasonable estimate of the cost of providing coverage for similarly situated non-COBRA beneficiaries on the maximum amount available under the health FSA for the period, taking into account both the employee salary reduction and any additional employer contribution. The Notice clarifies that the maximum amount that a health FSA is permitted to require to be paid does not include unused amounts carried over from prior years. Instead, the applicable premium is based solely on the sum of the employee's salary reduction election for the year and any nonelective employer contribution.

*Example.* An employee elects salary reduction with respect to a health FSA of \$2,000. The employer provides a matching contribution of \$1,000. In addition, the employee carries over \$500 in unused benefits from the prior year. The employee experiences a COBRA qualifying event that is a termination of employment on May 31. The maximum amount the health FSA is permitted to require to be paid for COBRA continuation coverage for the remainder of the year is 102 percent of 1/12 of the applicable premium of \$3,000 (\$2,000 of employee salary reduction election plus \$1,000 of employer contributions) times the number of months remaining in the year after the qualifying event. The \$500 of benefits carried over from the prior year is not included in the applicable premium.

If a health FSA allows carryovers of unused amounts for similarly situated non-COBRA beneficiaries, the health FSA must allow carryovers by similarly situated COBRA beneficiaries, subject to the same terms applicable with respect to non-COBRA beneficiaries. However, the health FSA is not required to allow a COBRA beneficiary to elect additional salary deduction amounts for the carryover period, or to have access to any employer contributions to the health FSA made during the carryover period. In addition, the carryover is limited to the applicable COBRA continuation period.

*Example.* An employee elects to contribute \$2,500 under the health FSA. The employee experiences a COBRA qualifying event that is a termination of employment on May 31. As of that date, the employee had submitted \$400 of reimbursable expenses under the health FSA. The employee elects COBRA continuation coverage and pays the required premiums for the rest of the year. As a qualified beneficiary, the former employee submits additional reimbursable payments in the amount of \$1,600. At the end of the plan year, there is \$500 of unused benefits remaining. The former employee/qualified beneficiary is allowed to continue to submit expenses under the same terms as similarly situated non-COBRA beneficiaries in the next year, for up to \$500 in reimbursable expenses. The maximum amount that can be required as an applicable premium for the carryover amount for periods after the end of the plan year is zero. The maximum period the carryover is required to be made available is the period of COBRA continuation coverage. In this case, the period is 18 months and terminates at the end of November of the next year. Thus, the health FSA need not reimburse any expense incurred after that November.

A health FSA may limit the availability of the carryover of unused amounts (subject to the \$500 limit) to individuals who have elected to participate in the health FSA in the next year, even if the ability to participate in that next year requires a minimum salary reduction election to the health FSA for that next year.

*Example.* An employer's health FSA permits up to \$500 of unused health FSA amounts to be carried over to the next year, but only if the employee participates in the health FSA during that next year. To participate in the health FSA, the employee must contribute a minimum of \$60 (\$5 per calendar month). As of December 31, 2016, Employee A and Employee B each have \$25 remaining in their health FSAs. Employee A elects to participate in the health FSA for 2017, making a \$600 salary reduction election. Employee B elects not to participate in the health FSA for 2017. Employee A has \$25 carried over to the health FSA for 2017, resulting in \$625 available in the health FSA. Employee B forfeits the \$25 as of December 31, 2016 and has no funds available in the health FSA thereafter. This is a permissible carryover feature.

A health FSA may limit the ability to carryover unused amounts to a maximum period (subject to the \$500 limit). For example, a health FSA can limit the ability to carry over unused amounts to one year. Thus, if an individual carried over \$30 and did not elect any additional amounts for the next year, the health FSA may require forfeiture of any amount remaining at the end of that next year.

### **Next Steps**

The Notice has a lot of moving parts and certain guidance will apply to different employers. If there is a topic addressed in this Notice that might apply to you and you would like additional information or have questions, please feel free to reach out to Gabe Marinaro at (231) 486-4540 or [gmarinaro@shrr.com](mailto:gmarinaro@shrr.com).



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