Third Thursday –Crowell & Moring's Employee Benefits Briefing

March 21, 2013

The webinar will begin shortly. Please stand by.

Today's Presenters

Tom Gies

Seth Perretta

Malcolm Slee

Allison Ullman

Overview

- Pay or Play Implementation Issues and Strategies
- Don’t Overlook:
  - New tax reporting requirements
  - Employer actions related to employees’ (and/or their spouse and dependents) application for exchange-based coverage

Pay or Play

- Must offer "minimum essential coverage" to each full-time employee and their child (up to age 26) or pay a penalty [IRC §4980H(a)]
  - Penalty = $2,000 x each full-time employee within the member company (minus first 30 employees)
  - Note: 5% de minimis rule also available

* IRC 4980H only applies to "applicable large employers"

Pay or Play

- Must offer each full-time employee "minimum essential coverage" that provides "minimum value" and is "affordable" [IRC §4980H(b)]
  - Minimum value = 60% AV
  - Affordable = 9.5% of MAGHI (but note safe harbors) based on self-only coverage
  - Penalty = very generally $3,000 per person who gets a PTC (see next slide)

Pay or Play

Condition precedent to employer being subject to any penalties

At least one employee goes to an Exchange and get a premium tax credit or cost-sharing reduction (collectively, PTC)*

*An employee is generally eligible for a PTC with respect to exchange-based coverage if the employee has a MAGHI of between 100/133% and 400% of the Federal Poverty Level (FPL) **AND** the employee is neither (1) eligible for employer-sponsored coverage that is "minimum essential coverage," "affordable," and provides "minimum value," nor (2) enrolled in any employer-sponsored coverage

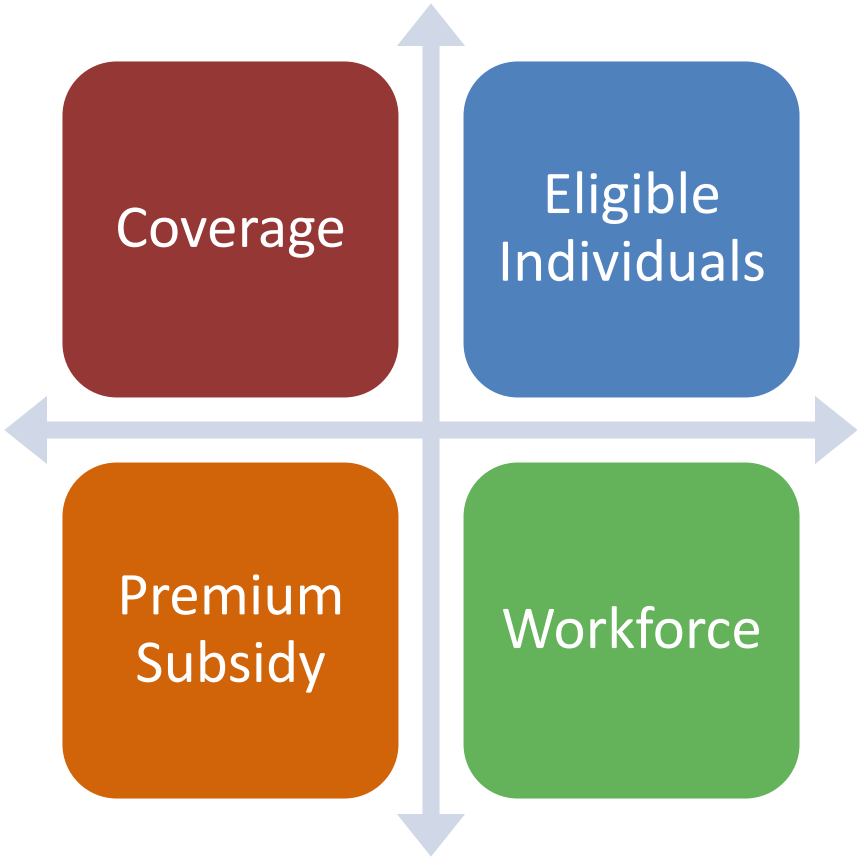
Pay or Play

- Employer-specific considerations
  - Wage demographics
  - Hour demographics
  - Worker turnover
  - Local labor markets
  - Unions
  - Government contractors
  - Value of employer exclusion
  - Expected utilization

Pay or Play

- Is the field set?
  - Nondiscrimination rules
  - Permissibility of corporate restructuring
  - Collectively-bargained plan issues
  - Use of defined contribution health arrangements
  - Safe harbor rules
  - ACA whistleblower provisions
  - Wellness incentives
  - State of the post-2013 individual insurance markets

Pay or Play Strategies



Pay or Play Strategies

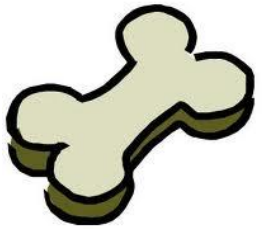
Status Quo

Skinny Down

Egg Timer

Inoculate/Targeted

Supplement



Incentive

Pay or Play Strategies

- Characteristics
  - Affordable, MV, MEC only for PTC-eligibles  
  - Skinny down the MV, MEC for PTC-eligibles 
  - Provide non-MV, MEC, i.e., 40% plan, for PTC-eligibles (consider providing reduced employee premium contributions) 
  - Richer coverage for higher-paids (insured only) 
  - Perhaps more robust employer premium subsidies for higher-paids as well (insured only) 

  =

  - Provide coverage for no one else 

Additional Issues for Employers Related to Exchanges

- New employer Exchange notice requirement
- New IRS reporting obligations
- New Exchange-based employer activities and audit risks

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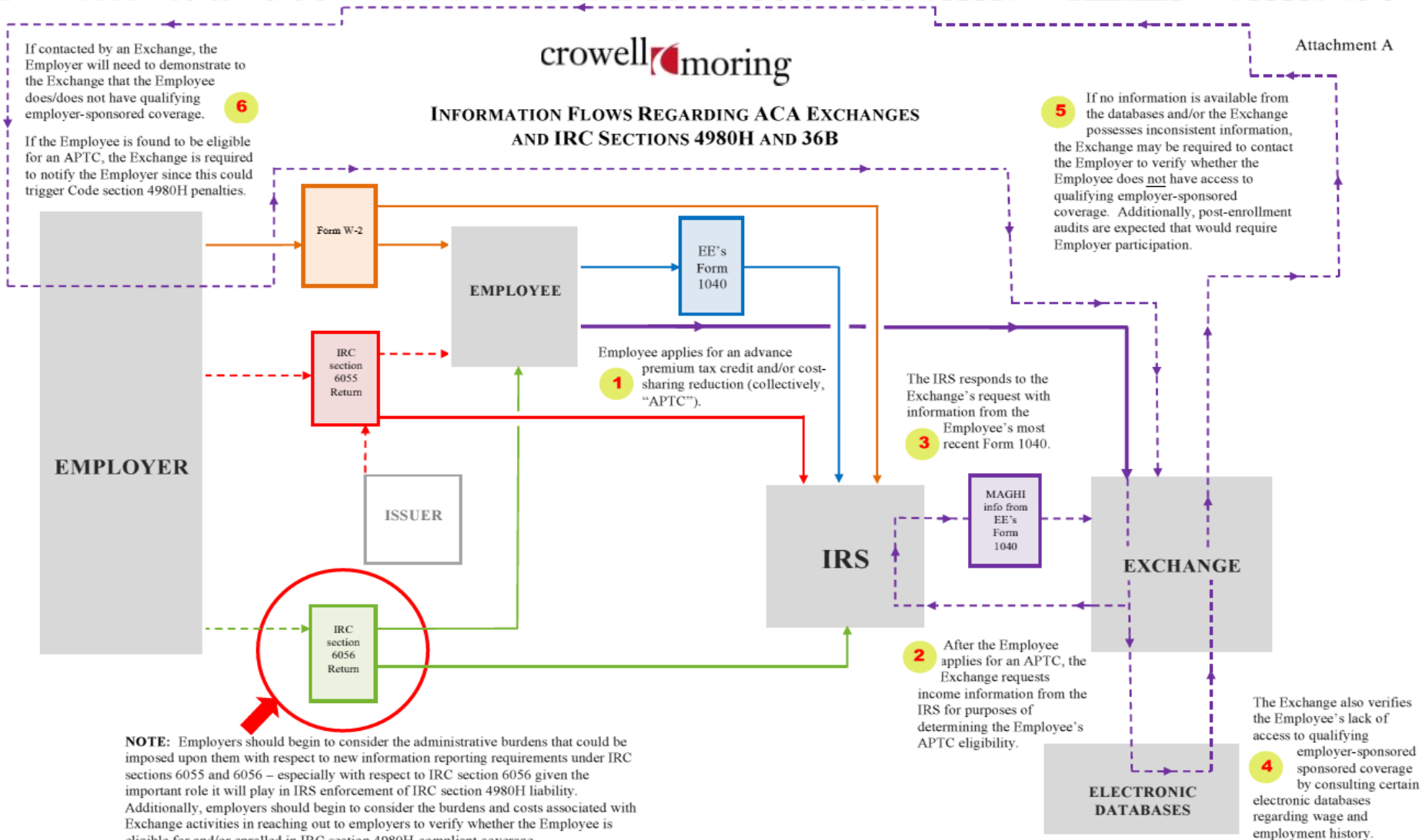
INFORMATION FLOWS REGARDING ACA EXCHANGES AND IRC SECTIONS 4980H AND 36B



NOTE: Employers should begin to consider the administrative burdens that could be imposed upon them with respect to new information reporting requirements under IRC sections 6055 and 6056 – especially with respect to IRC section 6056 given the important role it will play in IRS enforcement of IRC section 4980H liability. Additionally, employers should begin to consider the burdens and costs associated with Exchange activities in reaching out to employers to verify whether the Employee is eligible for and/or enrolled in IRC section 4980H-compliant coverage.

New Employer Notice Requirements

- Employer Exchange Notice
  - Employers are required to provide to all new employees at time of hire (and current employees by no later than [?], 2013) a written notice:
    - About the existence of the state exchanges post-2013;
    - That the employee may be eligible for federal premium assistance and cost-sharing reductions if the plan's share of the cost of the benefits is less than 60%; and
    - That if the employee chooses coverage through a state Exchange, the employee may lose the employer's contribution to coverage, all or part of which might be excludable from the employee's income
  - No meaningful guidance or model notice issued to date
    - Where is it? What's holding it up?
    - No more March 1, 2013 deadline for current employees, but when?

New Tax Reporting Burdens

- Two new tax reporting requirements for employers:
  - IRC sections **6055** and **6056**
    - Serving two distinct purposes
    - Issuers also have (share?) 6055 reporting burden
  - Returns to IRS due in following year (exact date TBD) and written statements to employees are due by January 31 of next year
  - Regulations due out VERY SOON!

New Tax Reporting Burdens

- IRC section **6055**
  - Notice to IRS and enrollee about whether the coverage provided qualifies as "minimum essential coverage"
  - Reporting requirement applies to issuers AND employer plan sponsors . . . for the time being at least . . .
    - Possibility the burden may fall solely to issuers by regulation

New Tax Reporting Burdens

- IRC section **6055**
  - Generally, must report the following information:
    - Name, address, and EIN of employer plan sponsor
    - Name, address, and TIN of the primary insured and of each other individual obtaining coverage under the policy or plan
    - Dates during which the individual was covered during the calendar year
    - The portion of the premium (if any) required to be paid by the employer
    - For insured minimum essential coverage, information regarding whether or not the coverage is a qualified health plan offered through an Exchange and, in the case of a qualified health plan, the amount (if any) of the advance payment of any cost-sharing reduction, or of any premium tax credit with respect to such coverage
    - If the health insurance is a qualified health plan in the small group market offered through an Exchange, such other information as the IRS may require for administering the tax credit for employee health insurance expenses of small employers

New Tax Reporting Burdens

- IRC section **6056**
  - Notice to IRS and employee about whether the employer provided IRC section 4980H-compliant coverage
  - Only applies to "applicable large employers"
  - No reporting obligation for issuers
  - Basis for IRS enforcement of IRC section 4980H

New Tax Reporting Burdens

- IRC section **6056**
  - Generally, must report/notice the following information:
    - Name and EIN of the applicable large employer
    - Date the return is filed
    - Certifications as to whether the applicable large employer offers its full-time employees (and their children up to age 26) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan and, if so:
      - The duration of any waiting period with respect to such coverage
      - The months during the calendar year when coverage under the plan was available
      - The monthly premium for the lowest cost option in each enrollment category under the plan
      - The employer's share of the total allowed costs of benefits provided under the plan
    - The number of full-time employees for each month of the calendar year
    - For each full-time employee, the name, address, and TIN of the employee and the months (if any) during which the full-time employee (or any dependents) were covered under the eligible employer-sponsored plan
    - Such other information as may be required by the Secretary of the Treasury

New Exchange-Based Employer Activities and Audit Risks

- Exchanges will be required to engage in certain activities to confirm an individual's eligibility for APTCs
- Exchanges are likely to reach out to employers in certain instances
  - Indirectly via the "Employer Coverage Form"
  - Directly via audit

Attachment A

EMPLOYER COVERAGE FORM

Applying for help with health insurance costs from the Health Insurance Marketplace?

The Health Insurance Marketplace application asks questions about any health coverage available through a current job (even if it's from another person's job, like a parent or spouse) to figure out if you might be able to get help paying for health insurance. Use this form to get the information you need from the employer who offers health coverage. We'll verify this information, so it's important to be accurate. If you have more than one job that offers health coverage, use a separate form for each employer.

EMPLOYEE Information

The **employee** needs to fill out this section. Write down the employee's information then you may request the information below from the employer. Use this completed form when you fill out a Health Insurance Marketplace application.

Employee Name (First, Middle, Last)	Social Security Number
	___ ___ ___ ___ ___ ___ ___ ___ ___

EMPLOYER Information

Ask the **employer** for this information.

Employer Name		Employer Identification Number (EIN)
		___ ___ ___ ___ ___ ___ ___ ___ ___
Employer Address		Employer Phone Number ( ) -
City	State	Zip Code

Who can we contact about employee health coverage at this job?

Phone Number ( ) -	Email Address

Tell us about the **health plan offered by this employer**

☐ This employee isn't eligible for coverage under this employer's plan.

The employee is eligible for coverage under this employer's plan on _____ (Start Date).

What's the name of the **lowest** cost self-only health plan this employee could enroll in at this job? (Only consider plans that meet the "minimum value standard" set by the Affordable Care Act.)*

Name: _____

☐ No plans meet the "minimum value standard"

How much would the employee have to pay in premiums for that plan?

$ _____ How Often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other: _____

*According to the standards set by the Affordable Care Act of 2010. If you're not sure, ask your employer or health insurance issuer.

Use the information in this form to complete your Health Insurance Marketplace application.

Apply online at **www.placeholder.gov**, or call us at 1-800-XXX-XXXX to get started.

NEED HELP WITH YOUR APPLICATION? Call us at 1-800-XXX-XXXX, or visit us at www.placeholder.gov

Para obtener una copia de este formulario en Español, llame 1-800-XXX-XXXX.

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Tell us about the **health plan offered** by this **employer**

☐ This employee isn't eligible for coverage under this employer's plan.

The employee is eligible for coverage under this employer's plan on _____ (Start Date).

What's the name of the **lowest** cost self-only health plan this employee could enroll in at this job? (Only consider plans that meet the "minimum value standard" set by the Affordable Care Act.)*

Name: _____

☐ No plans meet the "minimum value standard"

How much would the employee have to pay in premiums for that plan?

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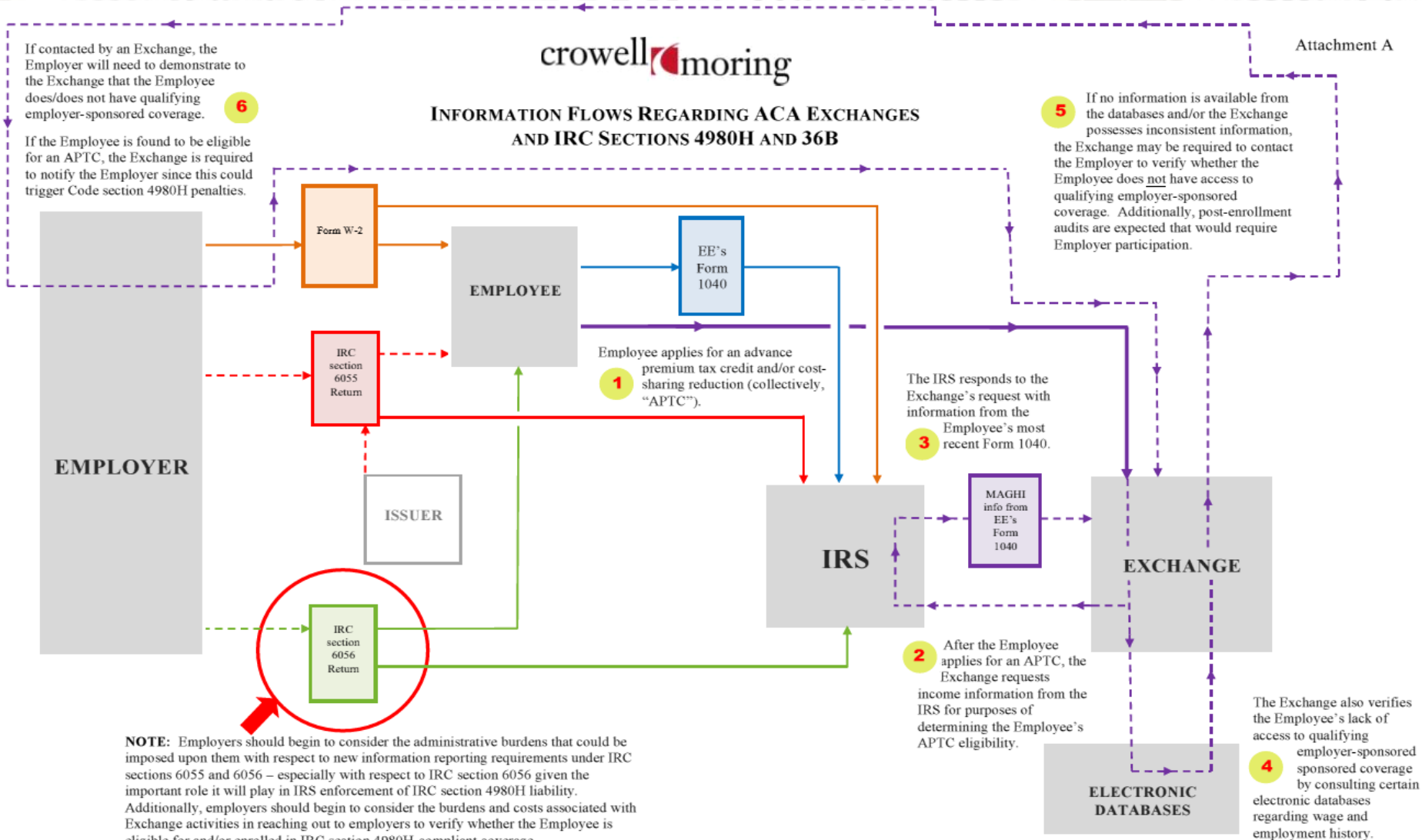
*According to the standards set by the Affordable Care Act of 2010. If you're not sure, ask your employer or health insurance issuer.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Attachment A
INFORMATION FLOWS REGARDING ACA EXCHANGES AND IRC SECTIONS 4980H AND 36B
If contacted by an Exchange, the Employer will need to demonstrate to the Exchange that the Employee does/does not have qualifying employer-sponsored coverage.
6
If the Employee is found to be eligible for an APTC, the Exchange is required to notify the Employer since this could trigger Code section 4980H penalties.
5
If no information is available from the databases and/or the Exchange possesses inconsistent information, the Exchange may be required to contact the Employer to verify whether the Employee does not have access to qualifying employer-sponsored coverage. Additionally, post-enrollment audits are expected that would require Employer participation.
EMPLOYER
Form W-2
EMPLOYEE
EE's Form 1040
IRC section 6055 Return
ISSUER
IRC section 6056 Return
Employee applies for an advance premium tax credit and/or cost-sharing reduction (collectively, "APTC").
1
The IRS responds to the Exchange's request with information from the Employee's most recent Form 1040.
3
IRS
MAGHI info from EE's Form 1040
EXCHANGE
2
After the Employee applies for an APTC, the Exchange requests income information from the IRS for purposes of determining the Employee's APTC eligibility.
ELECTRONIC DATABASES
4
The Exchange also verifies the Employee's lack of access to qualifying employer-sponsored sponsored coverage by consulting certain electronic databases regarding wage and employment history.
NOTE: Employers should begin to consider the administrative burdens that could be imposed upon them with respect to new information reporting requirements under IRC sections 6055 and 6056 – especially with respect to IRC section 6056 given the important role it will play in IRS enforcement of IRC section 4980H liability. Additionally, employers should begin to consider the burdens and costs associated with Exchange activities in reaching out to employers to verify whether the Employee is eligible for and/or enrolled in IRC section 4980H-compliant coverage.

Whistleblower Protection

- FLSA section 18C
- Modeled on Sarbanes-Oxley
- Administrative enforcement by OSHA
- Comments due April 30, 2013

Whistleblower Protection

- Unlawful acts of retaliation
  - Receipt of tax credit
  - Complaints about ACA Title I issues
- Coverage of “issuers” not acting as employers
- Actions that “limit or end” coverage

Whistleblower Protection

- Pro-plaintiff provisions
  - Expanded coverage to applicants and former employees
  - Temporary reinstatement remedy
  - “Clear and convincing” burden of proof for employer
  - Compensatory damages and attorneys fees

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AMERICAN BENEFITS COUNCIL

BENEFITS BRIEF

January 4, 2013 | BR 2013-2

TREASURY, IRS RELEASE PROPOSED REGULATIONS REGARDING EMPLOYER SHARED RESPONSIBILITY REQUIREMENT

PREPARED BY SETH PERRETTA AND ALLISON ULLMAN OF CROWELL & MORING LLP

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On December 28, 2012, the Department of the Treasury and the Internal Revenue Service (collectively, the "Service") issued a proposed rule ("Proposed Rule") regarding the employer shared responsibility provisions – the so-called "pay or play" provisions – set forth in Section 4980H of the Internal Revenue Code of 1986, as amended ("Code").

Code Section 4980H, which was added by Section 1513 of the Patient Protection and Affordable Care Act ("PPACA"),[1] imposes new shared responsibility requirements on employers regarding the offering of health coverage by employers to their full-time employees, effective for months beginning after December 31, 2013. The Proposed Rule was published in the Federal Register on January 2, 2013. Comments are due by March 18, 2013, and a public hearing is scheduled for April 23, 2013.

In connection with its issuance of the Proposed Rule, the Service also issued certain sub-regulatory guidance entitled "Questions and Answers on Employer Shared Responsibility Provisions Under the Affordable Care Act."[2]

Employers may rely on the Proposed Rule for guidance pending the issuance of a final rule or other applicable guidance. The preamble to the Proposed Rule does not address whether employers may rely on the Proposed Rule through 2014 even if final regulations are released before then. The preamble does state, however, that, if and to the extent future guidance is more restrictive than the guidance in the Proposed Rule, the future guidance will be applied without retroactive effect and employers will be

[1] Pub. L. No. 111-148 (as amended by Section 1003 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152).

[2] The Questions and Answers are available at http://www.irs.gov/uac/Newsroom/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act.

provided with sufficient time to come into compliance with the final regulations. Of note, previous guidance issued by the IRS provided for reliance *through* 2014 with respect to certain items described herein.

The Proposed Rule provides much needed clarification on numerous issues regarding the mechanics and application of Code Section 4980H. Additionally, the Proposed Rule and the preamble provide some important transition relief for employers. Highlights of the proposed rule include:

- Whether an employer is an "applicable large employer" (and thus subject to Code Section 4980H) is determined across an employer's controlled group.

- The determination of assessable payments and penalties under Code Section 4980H does not apply on a controlled group basis, but applies on a member company-by-member company basis.[3]

- The requirement to offer minimum essential coverage under Code Section 4980H(a) applies not only to an applicable large employer's full-time employee, but also the full-time employee's children (within the meaning of Code Section 152(f)(1)) up to age 26.

- For purposes of Code Section 4980H(b), whether a full-time employee's coverage is affordable is determined by reference to the employee's cost for self-only coverage. Thus, coverage other than self-only coverage need not be affordable to avoid Code Section 4980H penalties.

- Three special safe harbors are provided for use by employers in measuring the affordability of employee coverage: the W-2 Safe Harbor, the Rate of Pay Safe Harbor, and the Federal Poverty Line Safe Harbor.

- Proposed rules are provided regarding break in service and change in employment status/position for purposes of applying the measurement and stability period rules in determining full-time employee status.

- Special transition rules, including:

    - For qualifying employers with non-calendar year plans, such employers will not be subject to penalties under Code Section 4980H until the first day of the 2014 plan year.

    - Employers may use a 12-month stability period in 2014 so long as they use

[3] Notably, existing and future nondiscrimination rules are likely to continue and/or to apply and thus should be taken into account as part of 2014 planning.

a transition measurement period that is at least six months long, commences no later than July 1, 2013, and ends no earlier than 90 days before the start of the 2014 plan year.

- For 2014, an employer will not be subject to penalty under Code Section 4980H(a) in 2014 for failing to offer child coverage if it takes steps in 2014 toward complying with this requirement.

- Beginning in 2015, an employer will be required to assume that, although an employee's hours of service might be expected to vary, the employee will continue to be employed for the full duration of the initial measurement period. Thus, the employer cannot take into consideration the likelihood that the employee's employment will terminate in advance of the end of the initial measurement period in determining whether he or she is a full-time employee. Notwithstanding the transition relief, for purposes of 2014 and beyond, an employer may not consider aggregate employee turnover in determining whether any given employee is a full-time employee.

OVERVIEW OF CODE SECTION 4980H

Effective for months beginning after December 31, 2013, Code Section 4980H generally provides that an "applicable large employer" will be liable for an "assessable payment," i.e., a tax penalty, if certain health care coverage requirements are not satisfied. Specifically, liability for the assessable payment will be imposed on an applicable large employer if any "full-time employee" of the employer is certified as eligible to receive an applicable premium tax credit or cost-sharing reduction, *and* either:

- the employer fails to offer its "full-time employees (and their dependents)" the opportunity to enroll in minimum essential coverage[4] under an eligible employer-sponsored plan (very generally equal to $2,000 per each full-time employee, less the first 30 full-time employees), or

- the employer offers its "full-time employees (and their dependents)" the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan that, with respect to a full-time employee who has been certified for the advance payment of an applicable premium tax credit or

[4] The preamble of the Proposed Rule states that future regulations under Code Section 5000A are to provide that an employer-sponsored plan will not fail to be minimum essential coverage solely because it is a plan to reimburse employees for medical care for which reimbursement is not provided under a policy of accident and health insurance (a self-insured plan).

cost-sharing reduction, either is unaffordable or does not provide minimum value (very generally equal to $3,000 per full-time employee who receives a premium tax credit and obtains coverage through a health exchange).

Liability under Code Section 4980H is only imposed on applicable large employers if the health care coverage requirements described above are not satisfied. An employer is generally an applicable large employer for a calendar year if it employed an average of at least 50 full-time employees (counting full-time equivalents, as discussed below) on business days during the preceding calendar year. The amount of any assessable payment turns on how many full-time employees (not including full-time equivalents) are employed by an employer in a given year.[5]

The statutory language of Code Section 4980H provides that a full-time employee with respect to any month is one who is employed on average at least 30 hours of service per week (although as noted below, the Proposed Rule allows employers to use 130 hours per month in lieu of the weekly standard).

DETERMINATION OF APPLICABLE LARGE EMPLOYER STATUS

As noted above, only "applicable large employers" may be liable for an assessable payment under Code Section 4980H. An employer is an applicable large employer if it employed an average of at least 50 full-time employees (taking into account full-time equivalents) on business days during the preceding calendar year.

1. Definition of "Employee"

For purposes of determining whether an employer is an applicable large employer, "employee" means an individual who is a common-law employee. A "leased employee" as defined in Code Section 414(n) is not considered an employee for purposes of Code Section 4980H.

Comment: The identification of full-time employees for purposes of determining status as an applicable large employer is based on the actual hours of service of employees in the prior year. However, for purposes of determining whether an employer is an applicable large employer for 2014 (i.e., the first year of applicability of Code Section 4980H), an employer has the option to determine its status as an applicable large employer by reference to a period of at least six consecutive calendar months, as chosen by the employer, in the 2013 calendar year (rather than the entire 2013 calendar year).

[5] The assessable payment under Code Section 4980H(a) is based on all (excluding the first 30) full-time employees, while the annual assessable payment under Code Section 4980H(b) is based on the number of full-time employees who are certified to receive an advance payment of an applicable premium tax credit or cost-sharing reduction.

2. Definition of "Employer"

An "employer" for purposes of Code Section 4980H is a common-law employer, including a government entity or a tax-exempt entity. The entire controlled group under Code Section 414(b), (c), (m), and (o) is taken into account for purposes of deciding whether an employer is an applicable large employer.

Comment: With respect to new employers, an employer not in existence during an entire preceding calendar year is an applicable large employer for the current calendar year if it is reasonably expected to employ an average of at least 50 full-time employees (taking into account full-time equivalents, discussed below) on business days during the current calendar year.

3. Limited Exception Regarding Seasonal Employees

An employer that would otherwise constitute an applicable large employer may be excepted from application of Code Section 4980H to the extent that the employer's workforce exceeds 50 full-time employees for 120 days or fewer during a calendar year, and the employees in excess of 50 who were employed during that period of no more than 120 days were seasonal workers.

The Proposed Rule provides that a period of four calendar months (whether or not consecutive) or a period of 120 days (whether or not consecutive) may be used by an employer to determine whether the seasonal worker exception applies. The Proposed Rule also clarifies that the term "seasonal worker" is not limited to agricultural or retail workers.

Comment: This exception is solely for the purposes of determining whether an employer is an applicable large employer and should not be construed to except seasonal employees from the definition of employee for purposes of Code Section 4980H generally.

4. Determining Full-Time Equivalents

Solely for purposes of determining applicable large employer status, an employer must calculate the number of full-time equivalents ("FTE") it employed during the preceding calendar year and count each FTE as one full-time employee for that year.

The Proposed Rule provides that all employees (including seasonal workers) who were not full-time employees for any month in the preceding calendar year are included in calculating the employer's FTEs for that month by (i) calculating the aggregate number of hours of service (but not more than 120 hours of service for any

employee) for all employees who were not employed on average at least 30 hours of service per week for that month, and (ii) dividing the total hours of service by 120.

> ***Comment:*** For purposes of performing the above calculations, fractions are taken into account in determining the number of FTEs for each month, but employers should round down the final resulting calculation to determine whether they are an applicable large employer, i.e., after adding the 12 monthly full-time employee and FTE totals and dividing by 12, employers should round the resulting number down to the nearest whole number.

IDENTIFYING FULL-TIME EMPLOYEES FOR CODE SECTION 4980H PURPOSES

Once an employer has determined that it is an applicable large employer for purposes of Code Section 4980H, then an employer needs to determine which of its employees qualify as full-time employees for purpose of understanding its potential liability under Code Section 4980H.[6]

The statutory language to Code Section 4980H provides that a full-time employee is an employee who was employed on average at least 30 hours of service per week.

> ***Comment:*** Although individual employers may use a different definition of full-time employee in their business (for example, for purposes of benefit plan eligibility), because the full-time employee definition is set forth in the statute and uses a benchmark of only 30 hours per week, employers are required to use the 30-hour maximum for determining full-time status for purposes of Code Section 4980H.

In accordance with past sub-regulatory guidance, the Proposed Rule provides, in the interest of "administrative simplicity," that 130 hours of service in a calendar month is treated as the monthly equivalent of 30 hours of service per week, provided the employer applies this "equivalency rule" on a reasonable and consistent basis. This rule is based on the notion that there are generally more than four weeks in all calendar months.

The Proposed Rule further provides that an employee's hours of service include: (i) each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer; and (ii) each hour for which an employee is paid, or entitled to payment by the employer on account of a period of time during which no duties are

[6] As noted above, FTEs do not count for purposes of determining the assessable payment, if any, for which an applicable large employer is liable. They only count for purposes of determining an employer's status as an applicable large employer.

performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence.

Comment: The Proposed Rule provides that there is *no* limit on the amount of paid leave that must be taken into account in determining full-time status. This is a divergence from prior sub-regulatory guidance in which regulators indicated they were considering a rule that would have required employers to only take into consideration the first 160 hours of paid leave in a given calendar year.

For employees paid on an hourly basis, employers must calculate actual hours of service from records of hours worked and hours for which payment is made or due for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence.

For employees not paid on an hourly basis, employers are permitted to calculate the number of hours of service under any of the following three methods: (i) counting actual hours of service; (ii) using a days-worked equivalency method whereby the employee is credited with eight hours of service for each day for which the employee would be required to be credited with at least one hour of service under these service crediting rules; or (iii) using a weeks-worked equivalency of 40 hours of service per week for each week for which the employee would be required to be credited with at least one hour of service under these service crediting rules.

Comment: The Proposed Rule allows an employer to apply different methods for different classifications of non-hourly employees, so long as the classifications are reasonable and consistently applied. An employer may change methods for each calendar year. However, the Proposed Rule prohibits use of the days-worked or weeks-worked equivalency method if the result would be to substantially understate an employee's hours of service in a manner that would cause that employee not to be treated as a full-time employee when he otherwise should.

The Proposed Rule provides that hours of service do not include hours of service to the extent the compensation constitutes foreign source income. Thus, hours of service generally do not include hours of service worked outside the United States, without regard to the residency or citizenship status of the individual.

In addition, the Proposed Rule provides special rules that are applicable to teachers and other employees of educational organizations. The Proposed Rule also requests comments on whether and, if so, how a special safe harbor or presumption should or could be developed with respect to the variable hour employee classification of the common-law employees of temporary staffing agencies. The Service states in the preamble to the Proposed Rule that it expects that the final regulations will contain an

anti-abuse rule to address situations involving temporary staffing agency structures. Under the anticipated rule, if an individual performs services as an employee of an employer, and also performs the same or similar services of that employer in the individual's purported employment at a temporary staffing agency or other staffing agency of which the employer is a client, then all the hours of service are attributed to the employer for purposes of applying Code Section 4980H.

1. New Employees

a. Reasonably Expected to Work a Full-Time Schedule

With respect to an employee who is reasonably expected at his or her start date to work a full-time schedule of 30 hours per week or 130 hours per month (and who is not a seasonal employee), an employer must offer coverage to the employee at or before the conclusion of the employee's initial three calendar months of employment, or face penalty under Code Section 4980H.

For purposes of determining whether an employee is reasonably expected to work a full-time schedule, an employer must take into account all facts and circumstances known to it as of the date of the employee's hire.

Regarding employees who are not reasonably expected to work a full-time schedule upon their start dates and do not in fact work such a schedule, an employer is not subject to penalty under Code Section 4980H.

Comment: If employees that are not reasonably expected to work full-time hours end up working full-time hours and/or an employer cannot demonstrate that the employee did not in fact work such hours, the employer could be subject to penalty. Thus, it may make sound business practice for employers to treat all employees who are not characterized as full-time employees as of their hire date as variable hour employees (see below) on a going-forward basis. This may help ensure compliance with Code Section 4980H.

b. Variable Hour Employees Not Reasonably Expected to Work a Full-Time Schedule

For variable hour employees that are not reasonably expected to work a full-time schedule, the Proposed Rule allows an employer to utilize an administrative scheme to determine whether an employee works a full-time schedule over a given period of time. Per this administrative scheme, an employer may use what is termed an initial "measurement period" of between three and 12 months to determine whether a newly hired variable hour employee works a full-time schedule, i.e., at least 30 hours per week or 130 hours per month.

If a variable hour employee is determined to have worked a full-time schedule during the initial measurement period, then the employer must treat the employee as a full-time employee on a going-forward basis for a specified period of time, which is termed the "stability period" in the Proposed Rule, and which must be the same length as that used for variable hour ongoing employees (see discussion below).

If a new variable hour employee is *not* determined to work a full-time schedule during the initial measurement period, he or she may be treated as not a full-time employee for possibly the full duration of the initial stability period, and the employer, therefore, will not be subject to a penalty under Code Section 4980H for failing to offer any, or compliant, coverage to the employee.

Comment: It is quite possible that an employer may find itself having to treat a new variable hour employee as a full-time employee prior to the expiration of the initial stability period that applies to such employee, notwithstanding that the variable hour employee worked less than 30 hours per week or 130 hours per month on average during the initial measurement period. This is because the employer is also required to "test" the new variable hour employee's full-time status under the measurement period that applies to ongoing employees (see below). If, as a result of this test, the employee is determined to have worked a full-time schedule using the measurement period that is used by the employer for all ongoing employees, the employer must then treat the employee as a full-time employee as of the start of the next stability period that applies to ongoing employees, even if the initial stability period that applies to the new employee has not yet expired.

c. Seasonal Employees

Notice 2012-58 provides that for purposes of Code Section 4980H an employer is not required to make available coverage to "seasonal employees" regardless of whether they work 30 hours per week or 130 hours per month.

Neither Notice 2012-58 nor the Proposed Rule includes a definition of the term "seasonal employee." Significantly, the Notice permits employers to use a good faith interpretation in determining which employees are seasonal employees. The Proposed Rule specifically reserves the definition of seasonal employee for future rulemaking, but restates the relevant language from the Notice as well as the fact that employers may rely on the Notice and their good faith interpretations for 2014.

The preamble to the Proposed Rule indicates the Service is considering defining a seasonal employee, in part, to be an employee that works less than a specified period of time within a calendar year. In this regard, the Service references the existing rule in Treasury Regulation Section 1.105-11, regarding the nondiscrimination rules for self-

funded group health plans under Code Section 105(h), which defines a seasonal employee as employees "whose customary annual employment is less than 9 months, if other employees in similar work with the same employer (or, if no employees of the employer are in similar work, in similar work in the same industry and location) have substantially more months." Treasury Regulation Section 1.105-11 goes on to state that "any employee whose customary annual employment is less than 7 months may be considered as a part-time or seasonal employee."

Comment: It remains unclear the extent to which a seasonal employee may encompass only those positions that are recurring on an annual basis, perhaps also by reference to a specific time of the year (such as ski instructors in the winter in the Northeast Region), or may also encompass merely a short-term employee, i.e., an employee who is hired on a full-time basis for a limited number of days, weeks or months.

d. Permissible Administrative Period

In accordance with past guidance, the Proposed Rule also permits an employer to use for administrative convenience an "administrative period" of up to but no more than 90 days. This administrative period must occur between the measurement period and the stability period and must overlap with the close of the prior stability period. The purpose of the administrative period is to allow time for employers to make coverage options available to those employees determined to have worked a full-time schedule during the preceding measurement period and to allow such full-time employees time to make coverage elections for the following stability period.

As noted above, the initial measurement period, as with the measurement period for ongoing employees (see discussion below), may be a period between three and 12 months. Additionally, as noted above, the Proposed Rule permits the use of an administrative period that may be up to 90 days. Significantly, however, and in accordance with past sub-regulatory guidance, the Proposed Rule provides that the initial measurement period and the administrative period combined may <u>not</u> extend beyond the last day of the first calendar month beginning on or after the one-year anniversary of the employee's start date (totaling, at most, 13 months and a fraction of a month).

Comment: Given the above rule, for new variable hour employees, employers will likely be required in practice to use an *initial* measurement period for new employees of less than the maximum allowable 12 months because they will want to build in some time for an administrative period to allow for plan enrollment for resulting full-time employees.

If an employer complies with these requirements, then no assessable payment under Code Section 4980H will be due with respect to the variable hour or seasonal employee during the initial measurement period or the administrative period.

e. Changes in Employment

Following the issuance of earlier sub-regulatory guidance, many questions and comments arose regarding how the rules apply to new employees that change positions within the organization during the initial measurement and stability periods or otherwise are terminated and rehired during the same periods. Thankfully, the Proposed Rule provides some important clarifications on these issues.

In the event a new variable or seasonal employee has a material change in the position of employment or other employment status that, had the employee begun employment in the new position or status, would have resulted in the employee being reasonably expected to be employed on average at least 30 hours of service per week during the measurement period, the Proposed Rule provides that he or she must be treated as a full-time employee under Code Section 4980H as of the first day of the fourth month following the change in employment status, or, if earlier and the employee averages more than 30 hours of service per week during the initial measurement period, the first day of the first month following the end of the initial measurement period (including any optional administrative period applicable to the initial measurement period).

Comment: The Proposed Rule provides that the change in employment status rule applies only to *new* variable hour and seasonal employees. A change in employment status for an ongoing employee does not change the employee's status as a full-time employee or otherwise during the stability period.

f. Breaks in Service

The preamble to the Proposed Rule notes that an employee may incur an unpaid break in service, either through a termination and rehire, an unpaid leave of absence or a continuous period during which the employee is not credited with any hours of service and is not paid for some other reason. The Proposed Rule provides that if the period for which no hours of service is credited is at least 26 consecutive weeks, an employer may treat an employee who has an hour of service after that period, for purposes of determining the employee's status as a full-time employee (for employers using the look-back measurement method), as having terminated employment and having been rehired as a new employee of the employer.

For periods of less than 26 weeks, the employer may choose to apply a "rule of parity" under which an employee may be treated as having terminated employment

and having been rehired as a new employee if the period with no credited hours of service (of less than 26 weeks) is at least four weeks long and is longer than the employee's period of employment immediately preceding that period with no credited hours of service. The preamble uses as an example of the application of this "rule of parity" a situation in which a newly-hired employee works three weeks for an applicable large employer, terminates employment and is rehired by that employer ten weeks after terminating employment. In that situation, the preamble notes that the "rule of parity" applies because the ten-week period with no credited hours of service is longer than the immediately preceding three-week period of employment.

If the unpaid leave of absence is less than 26 weeks and the "rule of parity" does not apply, the Proposed Rule provides that the measurement and stability period that would have applied to the employee had the employee not experienced the unpaid leave of absence would continue to apply upon the employee's resumption of service, i.e., if the employee returns during a stability period in which the employee is treated as a full-time employee, the employee is treated as full-time employee upon return and through the end of that stability period.

The Proposed Rule also identifies unpaid leave on account of jury duty and unpaid leave subject to the Family and Medical Leave Act of 1993 and the Uniformed Services Employment and Reemployment Rights Act of 1994 as "special unpaid leave." For such special unpaid leave, the Proposed Rule provides a method for averaging hours when applying the look-back measurement method. Under this method, the employer either (a) determines the average hours of service per week for the employee during the measurement period excluding the special unpaid leave period and uses that average as the average for the entire measurement period; or (b) treats employees as credited with hours of service for special unpaid leave at a rate equal to the average weekly rate at which the employee was credited with hours of service during the weeks in the measurement period that are not special unpaid leave.

Comment: In the preamble to the Proposed Rule, the Service indicates that it is considering issuing special rules regarding new short-term employees or regarding new employees hired into high-turnover positions. (See above comments and discussion regarding seasonal employees.)

2. Variable Hour *Ongoing* Employees

With respect to variable hour employees who have been employed by an employer for a period of time (hereinafter referred to as "ongoing employees"), an applicable large employer may either treat these employees as full-time employees or, at its election, may use a measurement period to determine each ongoing employee's full-time status. This measurement period, as with new variable hour employees, may not be less than three and not more than 12 consecutive months, as chosen by the employer.

If the employer determines that a variable hour ongoing employee was employed on average at least 30 hours of service per week during the measurement period, then the employer must treat the employee as a full-time employee during the subsequent stability period, regardless of the employee's number of hours of service during the stability period, so long as he or she remains an employee. The stability period must be the greater of (i) six months, and (ii) the length of the preceding measurement period.

Comment: As with new variable hour employees, an applicable large employer may also elect to add an administrative period between the measurement period and the stability period as part of this method. Such administrative period may last up to 90 days, but may neither reduce nor lengthen the measurement period or the stability period. Also, it must overlap with the prior stability period so that for ongoing employees during any such administrative period applicable following a standard measurement period, those employees who are enrolled in coverage because of their status as full-time employees based on a prior measurement period will continue to be covered.

For an employee whom the employer determines to <u>be</u> a full-time employee during a measurement period, the stability period would be the period immediately following the measurement period (and any applicable administrative period), the duration of which would be at least the greater of six consecutive calendar months or the length of the standard measurement period.

For an employee whom the employer determines to *not be* a full-time employee during a measurement period, the employer would be permitted to treat the employee as not a full-time employee during the immediately following stability period (which may be no longer than the associated standard measurement period).

Generally the measurement and stability periods selected by an applicable large employer member must be uniform for all employees, but different periods may be applied to the following categories: (i) each group of collectively bargained employees covered by a separate collective bargaining agreement; (ii) collectively bargained and non-collectively bargained employees, (iii) salaried employees and hourly employees; and (iv) employees whose primary places of employment are in different states.

Comment: The Proposed Rule provides that, for administrative convenience, employers can adjust the starting and ending dates of their measurement periods in order to avoid splitting employees' regular payroll periods if each of the payroll periods is one week, two weeks, or semi-monthly in duration. For example, an employer using the calendar year as a measurement period could exclude the entire payroll period that included January 1 (the beginning of the year) if it included the entire payroll period that included December 31 (the end of that same calendar year).

COMPLIANCE WITH CODE SECTION 4980H

Per the discussion above, the determination of whether an employer is an applicable large employer, and thus subject to Code Section 4980H in the first instance, is made on a controlled group basis. Similarly, the provision in the Proposed Rule that allows an applicable large employer to disregard the first 30 employees in calculating penalty amounts under Code Section 4980H(a) applies across the controlled group. In this regard, the first 30 employees that may be disregarded for purposes of Code Section 4980H(a) are allocated ratably among the applicable large employer members on the basis of the number of full-time employees employed by each applicable large employer member during the calendar year.[7]

Very significantly, the Proposed Rule provides that in determining whether an applicable large employer is subject to an assessable payment under Code Sections 4980H(a) and (b), this determination is made on a member company-by-member company basis, rather than on a controlled group basis. Thus, for example, if a parent company has 20 controlled group subsidiaries, whether the assessable payments, i.e., penalties, of Code Section 4980H apply will be determined separately for each of the 21 members of the controlled group.

Comment: The provision in the Proposed Rule that states that the Code Section 4980H penalties apply on a member-by-member basis (rather than across the controlled group) is welcome news for employers that had asked for the ability to choose to "pay" or "play" on a member basis. It is important for employers to keep in mind, however, that existing nondiscrimination rules for self-funded group health plans under Code Section 105(h) continue to apply to employers and that to-be-issued nondiscrimination rules for insured group health plans under new Public Health Service Act ("PHSA") Section 2716 will likely also apply to limit employer discretion in this regard. The to-be-issued rules under new PHSA Section 2716 are to be modeled on certain aspects of the Code Section 105(h) rules for self-insured plans. Although the existing regulatory scheme under Code Section 105(h) is largely outdated (and we understand subject to future revision by the Service in connection with rulemaking on new PHSA Section 2716), the existing regulations generally limit an employer's ability to only offer coverage to a certain group of employees within the employer's controlled group, at the exclusion of certain other employees, unless the group that is offered coverage constitutes a reasonable nondiscriminatory classification within the meaning of Treasury Regulation Section 1.105-11, which incorporates by reference the rules of Code Section 410(b). For purposes of determining whether an eligible class is a reasonable nondiscriminatory

[7] Of note, to the extent the 30-employee reduction results in an applicable large employer member being allocated more than zero but less than one full-time employee, the Proposed Rule provides that the member's share will be rounded up to one full-time employee.

classification, questions remain regarding whether employers may utilize the old regulations under Code Section 410(b) or whether employers must utilize the current regulations, which impose a very strict test when applied to employer-sponsored health plans that makes it very difficult to pass. Even if it is clarified that employers are permitted to use the old Code Section 410(b) regulations, these regulations utilize a facts and circumstances test (rather than the strict numeric test), which could leave employers subject to challenge or second guessing by the regulators.

The preamble to the Proposed Rule makes clear that an applicable large employer cannot be liable under both Code Section 4980H(a) and Code Section 4980H(b) for the same calendar month.

1. Code Section 4980H(a)

An applicable large employer is liable for an assessable payment under Code Section 4980H(a) if, for any month, any full-time employee is certified to receive an applicable premium tax credit or cost-sharing reduction and the applicable large employer fails to offer its full-time employees (and their dependents) the opportunity to enroll in "minimum essential coverage" under an eligible employer-sponsored plan. Whether the minimum essential coverage is affordable or provides minimum value is not relevant.

***Comment*:** "Minimum essential coverage" for purposes of Code Section 4980H is defined by reference to new Code Section 5000A(f). In what appears to have been scrivener's error, Congress failed to include a self-funded, non-grandfathered, employer-sponsored plan as one of the types of coverages that constitute "minimum essential coverage." The Service states in the preamble to the Proposed Rule that "[f]uture regulations under Section 5000A are expected to provide further guidance on the definition of [minimum essential coverage] and eligible employer-sponsored plans," and that "[t]hese regulations under Section 5000A are expected to provide that an employer-sponsored plan will not fail to be [minimum essential coverage] solely because it is a plan to reimburse employees for medical care for which reimbursement is not provided under a policy of accident and health insurance (a self-insured plan)." Some have expressed concern that the Service could seek to utilize its administrative prerogative (absent a technical correction by Congress) to define "minimum essential coverage" for purposes of Code Section 5000A(f), and thus Code Section 4980H, to mean only employer-sponsored self-funded non-grandfathered coverage that is something more than merely a self-funded plan that complies with the PPACA market reforms, i.e., a plan that includes a certain level of essential benefits. If so, this could operate to increase employer costs in complying with Code Section 4980H(a) via the offering of coverage. Such a definition would also seem to be contrary to employer expectations.

Of note, the Proposed Rule finally addresses a long-standing question regarding exactly to whom an employer must offer minimum essential coverage. As noted above, the express statutory language of Code Section 4980H(a) provides that an applicable large employer must offer minimum essential coverage to all "full-time employees (and their dependents)."

As a result of the parenthetical and the absence of clear legislative history, questions remained regarding whether subject employers would be required to make available minimum essential coverage for full-time employees only (i.e., self-only coverage), or whether subject employers would also be required to make available coverage to a full-time employee's spouse and or children.

The Proposed Rule answers this question and provide that for purposes of Code Section 4980H(a), an applicable large employer must offer minimum essential coverage to not only each full-time employee, but also each full-time employee's child (as defined in Code Section 152(f)(1)) who is under 26 years of age. An offer of coverage to an employee's spouse is not required for purposes of Code Section 4980H(a).

Pursuant to a transition rule contained in the Proposed Rule (as also discussed toward the end of this document), any employer that takes steps during its plan year that begins in 2014 toward satisfying the Code Section 4980H provisions relating to the offering of coverage to full-time employees' dependents will not be liable for any assessable payment under Code Section 4980H solely on account of a failure to offer coverage to the dependents for that plan year.

Comment: The proposed rule has the effect of making mandatory in some respects the adult child coverage requirement contained in the PPACA market reform provisions. Under the market reforms, only those employers that offered coverage to a child under the age of 18 were required to offer coverage to adult children up to age 26. Thus, an employer could avoid having to make available adult child coverage by choosing not to offer coverage to children under age 18. Applicable large employers will now be required to offer coverage to adult children up to age 26 – at least with respect to the children of full-time employees. It seems at least possible that such an employer could continue to not make available any child coverage for employees that are other than full-time employees.

Comment: As noted above, the Proposed Rule would require applicable large employers to pay a penalty under Code Section 4980H(a) or otherwise make available "minimum essential coverage" to all Code Section 152(f)(1) children of each full-time employee. Code Section 152(f)(1) includes a somewhat broad definition of "child" that incorporates not only by blood or legal adoption, but also includes step- children and

foster children. Many employers may have in good faith adopted a definition of "child" for purposes of complying with the market reform requirement (see comment above) that did not include foster children or step-children. These employers will need to revisit their plan eligibility rules to consider what changes may need to be made to their plans.

The Proposed Rule provides that if an applicable large employer member fails to offer coverage to a full-time employee for any day of a calendar month during which the employee was employed by the employer, then the employee is treated as not being offered coverage during that entire month. However, in a calendar month when a full-time employee terminates employment, if the employee would have been offered coverage for the entire month if the employee had been employed for the entire month, the employee is treated as having been offered coverage during that month.

Comment: The Proposed Rule provides that, if an employee has not been offered an effective opportunity to accept coverage, he or she will not be treated as having been offered the coverage for purposes of Code Section 4980H. The employee must also have an effective opportunity to decline an offer of coverage that is not minimum value coverage or that is not affordable. Thus, an applicable large employer cannot render an employee ineligible for a premium tax credit (and thus be saved from Code Section 4980H penalties) by providing an employee with mandatory coverage (*e.g.*, coverage that is a condition of employment) that does not provide minimum value or which is not affordable.

The Proposed Rule provides that if an employee enrolls in coverage but fails to pay the employee's share of premium on a timely basis (i.e., in instances where the employee's share of the premium is not collected through withholding from the employee's salary but is instead billed to the employee), the employer is not required to provide coverage for the period for which the premium is not timely paid, and the employer is treated as having offered that employee coverage for the remainder of the coverage period (generally the remainder of the plan year). The Proposed Rule adopts the rule from the COBRA regulations with regard to payment of premiums, and hence incorporates both a 30-day grace period for payment and rules with regard to timely payments that are less (but not significantly less) than the amount of the employee's share of the premium.

The preamble to the Proposed Rule notes that the Service believes it should exercise its "administrative authority to allow recognition of a margin of error consistent with an intent to recognize the possibility of inadvertent errors together with the specificity and administrability of a specific percentage." Hence, the Proposed Rule provides a "de minimis" rule for purposes of complying with the requirements of Code Section 4980H(a) under which an applicable large employer member will be treated as offering

coverage to its full-time employees (and their dependents) for a calendar month if, for that month, it offers coverage to all but five percent or, if greater, five of its full-time employees (provided that an employee is treated as having been offered coverage only if the employer also offered coverage to that employee's dependents).

Comment: Although unclear, it appears that the de minimis rule applies on a member company-by-member company basis, rather than across the controlled group. Thus, for example, assume a holding company, Holdco, has two subsidiaries, Sub X and Sub Y. Assume further that Sub X has 100 full-time employees and Sub Y has 100 full-time employees and that Sub X decides to comply with Code Section 4980H by offering minimum essential coverage to its full-time employees "(and their dependents)" and Sub Y chooses to comply by paying the penalty. Sub X, notwithstanding its best efforts, misclassifies seven variable hour employees as not full-time even though they work on average more than 30 hours per week during the measurement period. As a result, Sub X fails to offer these 7 individuals minimum essential coverage as of the start of the next stability period and only makes an offer to 93 of its 100 full-time employees. Although 7 is less than 5% of the controlled group full-time employees of Holdco, it is greater than 5% of the 100 full-time employees of Sub X. Thus, it appears that the de minimis rule does not apply to Sub X and Sub X could be subject to penalty under Code Section 4980H(a).

2. Code Section 4980H(b)

Code Section 4980H(b) provides that if an applicable large employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential coverage under an eligible employer-sponsored plan but nonetheless one or more full-time employees have been certified for the payment of an applicable premium tax credit or cost-sharing reduction, the employer generally is liable for a Code Section 4980H(b) penalty if it fails to offer minimum essential coverage that is also (i) affordable, and (ii) provides minimum value. The amount of the penalty is based on the number of its full-time employees receiving an applicable premium tax credit or cost-sharing reduction.

Under Code Section 4980H(b), a penalty may be assessed against an employer if the employer's coverage is unaffordable within the meaning of Code Section 36B(c)(2)(C)(i) or does not provide minimum value within the meaning of Code Section 36B(c)(2)(C)(ii). (Code Section 36B governs the premium tax credit.) Code Section 36B(c)(2)(C)(i) generally provides that coverage is unaffordable if the employee's premium share for self-only coverage exceeds 9.5% of the employee's modified adjusted gross household income (with certain exceptions).

Comment: Regulators had indicated in prior sub-regulatory guidance that they were planning to issue proposed regulations that would provide that affordability for

purposes of Code Section 4980H is based solely on a full-time employee's cost of coverage. The Proposed Rule is welcome news for employers in that it confirms this interpretation. Accordingly, although a subject employer must make available minimum essential coverage to each full-time employee and such employee's child up to age 26 for purposes of Code Section 4980H, an employer need only provide affordable and minimum value coverage to the full-time employee. This should reduce the costs for employers that seek to comply with Code Section 4980H(b) by making available affordable, minimum value coverage to their full-time employees.

Comment: Questions remain regarding whether a full-time employee's spouse and child will be eligible for federal premium and cost-sharing tax credits under Code Section 36B for the purchase of exchange-based coverage if the employer provides affordable and minimum value coverage to such full-time employee. Many employers and stakeholders support allowing the spouse and child to receive such tax credits. It is our understanding, however, that this issue remains under consideration by the Service and the Administration given the revenue costs associated with such a rule.

The Proposed Rule sets forth three affordability safe harbors for purposes of determining whether an employer's coverage satisfies the 9.5% affordability test. Specifically, the Proposed Rule provides the following safe harbors:

(i) "W-2 Safe Harbor" – This safe harbor relies on the use of an employee's Form W-2 wages in determining affordability. Wages would be the amount required to be reported in Box 1 of W-2.

(ii) "Rate of Pay Safe Harbor" – Under this proposed safe harbor, an employer: (A) determines the hourly rate of pay for a given hourly employee who is eligible to participate in the health plan at the beginning of the plan year, (B) multiplies that rate by 130 hours per month, and (C) compares the resulting monthly wage amount with the cost of coverage to the employee. For salaried employees, monthly salary would be used instead of hourly salary multiplied by 130.

(iii) "Federal Poverty Line Safe Harbor" – The Proposed Rule provides that an employer may also rely on a design-based safe harbor using the federal poverty line ("FPL") for a single individual. Employer-provided coverage offered to an employee is affordable if the employee's cost for self-only coverage under the plan does not exceed 9.5% of the FPL for a single individual.

The following examples are in the Proposed Rule:

- ***W-2 Safe Harbor:*** Employee A is employed by applicable large employer member Z consistently from January 1, 2015 through December 31, 2015. In addition, Z offers Employee A and his dependents minimum essential coverage during that period that meets the minimum value requirements. The employee contribution for self-only coverage is $100 per calendar month, or $1,200 for the calendar year. For 2015, Employee A's Form W-2 wages with respect to employment with Z are $24,000. Because the employee contribution for 2015 is less than 9.5% of Employee A's Form W-2 wages for 2015, the coverage offered is treated as affordable with respect to Employee A for 2015 ($1,200 is 5% of $24,000).

- ***Rate of Pay Safe Harbor:*** Employee D is employed by applicable large employer member W from January 1, 2015 through December 31, 2015. In addition, W offers Employee D and his dependents minimum essential coverage during that period that meets the minimum value requirements. The employee contribution for self-only coverage is $85 per calendar month. Employee D is paid at a rate of $7.25 per hour (the minimum wage in Employer W's jurisdiction), for the entire year 2015. For purposes of applying the affordability safe harbor, W may assume that Employee D earned $942.50 per calendar month (130 hours of service multiplied by $7.25 per hour). Accordingly, affordability is determined by comparing the assumed income per month ($942.50) to the employee contribution per month ($85). Because $85 is less than 9.5% of Employee D's assumed income ($85 is 9.01% of $942.50), the coverage offered is treated as affordable with respect to Employee D for 2015.

- ***Federal Poverty Line Safe Harbor:*** Employee F is employed by applicable large employer member W from January 1, 2015 through December 31, 2015. In addition, W offers Employee F and his dependents minimum essential coverage during that period that meets the minimum value requirements. W uses the look-back measurement method. Under that method as applied by W, Employee F is treated as a full-time employee for the entire calendar year 2015. Employee F is regularly credited with 35 hours of service per week but is credited with only 20 hours of service during the month of March 2015 and only 15 hours of service during the month of August 2015. Assume for this purpose that the Federal poverty line for 2015 for an individual is $11,170. With respect to Employee F, W determines the monthly employee contribution for employee single-only coverage for each calendar month of 2015 as an amount equal to 9.5% multiplied by $11,170, which is $1,061.15, and that amount is then divided by 12, and the result is $88.43. Regardless of Employee F's actual wages for any calendar month, including the months of March 2015 and August 2015 when Employee F has lower wages because of significantly lower hours of service, the coverage under the plan is treated as affordable with respect to Employee F.

Additional examples in the Proposed Rule demonstrate how the safe harbors are calculated when an employee only works for the employer during a portion of the year.

With respect to payment mechanics, the Proposed Rule provides that the amount of the Code Section 4980H(b) assessable payment or "penalty" cannot exceed the amount of the assessable payment that would have been imposed under Code Section 4980H(a) had the employer failed to satisfy Code Section 4980H(a). In addition, any assessable payment under Code Section 4980H is treated as an excise tax and is payable upon notice and demand. Certain reporting requirements will be imposed on applicable large employer members under Code Section 6056 beginning in 2015 (see below for further discussion); separate regulations will be issued regarding this requirement.

TRANSITION RULES

The Proposed Rule provides a number of transition rules to assist employers in coming into compliance with the rapidly approaching effective date that applies for purposes of Code Section 4980H.

1. Fiscal Year Plans

The Proposed Rule provides a special transition rule for non-calendar year, i.e., fiscal year, plans. Under the Proposed Rule, if an applicable large employer member maintains a fiscal year plan as of December 27, 2012, such employer is not subject to penalties under Code Section 4980H with respect to a given full-time employee "(and their dependents)" if the employer makes available affordable, minimum value coverage to the employee by no later than the first day of the plan year that commences in 2014.

The Proposed Rules also include a special transition rule for applicable large employers (or members thereof) that as of December 27, 2012 have both calendar year plans and fiscal year plans. Under this special transition rule, if at least 25% of the employer's employees are covered under one or more fiscal year plans (as of December 27, 2012) that have the same plan year or if the employer offered coverage under those plans to 33% or more of its employees during the most recent open enrollment period before December 27, 2012, no payments under Code Section 4980H will be due for any month prior to the first day of the 2014 plan year with respect to employees who (i) are offered affordable, minimum value coverage no later than the first day of the 2014 plan year of the fiscal year plan, and (ii) would not have been eligible for coverage under any group health plan maintained by the applicable large employer member as of December 27, 2012 that has a calendar year plan year.

Comment: Although employers that utilize the above transition rules may not be subject to certain penalties under Code Section 4980H, the preamble to the Proposed Rule makes clear that the employers will still be required to comply with the tax reporting requirements under Code Section 6056 (by which an employer notices to the Internal Revenue Service those of its employees that were covered by qualifying coverage for each month of the preceding calendar year) during the period of transition relief.

2. Salary Reduction Elections for Accident and Health Plans Provided Through Cafeteria Plans for Cafeteria Plan Years Beginning in 2013

Following the issuance of prior sub-regulatory guidance, questions were asked about whether the existing cafeteria plan regulations were sufficient to enable employers to facilitate employees' mid-year changes in salary reduction elections in connection with IRC Section 4980H compliance. In response to these concerns, the Proposed Rule provides transition relief to allow employers to permit either or both of the following changes in salary reduction elections (with an appropriate amendment to the cafeteria plan):

(i) An employee who elected salary reduction through the cafeteria plan for accident and health plan coverage with a fiscal plan year beginning in 2013 is allowed to prospectively revoke or change his or her election with respect to the accident and health plan once, during that plan year, without regard to whether the employee experienced a change in status event described in Treasury Regulation Section 1.125-4; and

(ii) An employee who failed to make a salary reduction election through his or her employer's cafeteria plan for accident and health plan coverage with a fiscal plan year beginning in 2013 before the deadline for making elections for the cafeteria plan year beginning in 2013 is allowed to make a prospective salary reduction election for accident and health coverage on or after the first day of the 2013 plan year of the cafeteria plan, without regard to whether the employee experienced a change in status event described in Treasury Regulation Section 1.125-4.

The Proposed Rule provides that an applicable large employer may adopt the necessary plan amendments on a retroactive basis so long as the amendments are (i) adopted by no later than December 31, 2014, and (ii) are effective back to the first day of the cafeteria plan's 2013 plan year.

3. Measurement Periods for Stability Periods Starting in 2014

Solely for purpose of stability periods beginning in 2014, employers may adopt a transition measurement period that is shorter than 12 months but that is no less than six months long and that begins no later than July 1, 2013 and ends no earlier than 90 days before the first day of the plan year beginning on or after January 1, 2014.

Comment: This rule will be of most help to employers that sponsor calendar year plans and that seek to utilize a 12-month stability period that commences January 1, 2014. Significantly, for these employers, they will need to commence their transition measurement period well before July 1, 2013 if they plan to use any meaningful administrative period since the measurement period must be no less than six months. Thus, for example, if an employer with a calendar year plan seeks to commence a 12-month stability period on January 1, 2014 and to utilize an administrative period that coincides with the start of open enrollment on October 15, 2013 (which would then run from October 15, 2013 to December 31, 2013), the employer would need to commence its transition measurement period no later than mid-April 2013.

4. Applicable Large Employer Determination for 2014

The Proposed Rule includes a transition rule for small employers for purposes of determining whether they are an applicable large employer for 2014. Under the transition rule, an employer may determine its status as an applicable large employer by reference to a period of at least six consecutive calendar months, as chosen by the employer, in the 2013 calendar year (rather than the entire 2013 calendar year). Thus, an employer may determine whether it is an applicable large employer for 2014 by determining whether it employed an average of at least 50 full-time employees on business days during any consecutive six-month period in 2013.

5. Coverage for Dependents

To provide employers sufficient time to extend coverage to dependents, any employer that "takes steps during its plan year that begins in 2014 toward satisfying the Code Section 4980H provisions relating to the offering of coverage to full-time employees' dependents will not be liable for any assessable payment under Code Section 4980H solely on account of a failure to offer coverage to the dependents for that plan year."

6. Multiemployer Plans

Following the issuance of prior sub-regulatory guidance, many questions were raised regarding how Code Section 4980H will apply to multiemployer plans. For purposes of 2014 only, the Proposed Rule provides that an employer will not be subject

to penalty under Code Section 4980H if (i) the employer is required to make a contribution to a multiemployer plan with respect to the full-time employee pursuant to a collective bargaining agreement or an appropriate related participation agreement, (ii) coverage under the multiemployer plan is offered to the full-time employee (and the employee's dependents), and (iii) the coverage offered to the full-time employee is affordable and provides minimum value.

Notwithstanding the transition relief, any waiting period for coverage under the plan must separately comply with 90-day limitation on waiting periods in Section 2708 of the PHSA.

7. Variable Hour Employee Definition

Effective as of January 1, 2015, and except in the case of seasonal employees, the employer will be required to assume for purposes of Code Section 4980H that, although an employee's hours of service might be expected to vary, the employee will continue to be employed by the employer for the entire initial measurement period; accordingly the employer will not be permitted to take into account the likelihood that the employee's employment will terminate before the end of the initial measurement period in determining whether the employee is a full-time employee.

Comment: Although this rule does not apply until 2015, the Proposed Rule provides that for purposes of 2014, the status of any individual employee as a variable hour employee cannot be based on employer expectations regarding aggregate turnover. Rather there must be objective facts and circumstances specific to the newly hired employee at the start date demonstrating that the individual employee's employment is reasonably expected to be of limited duration within the initial measurement period.

SERVICE QUESTIONS AND ANSWERS REGARDING CODE SECTION 4980H

The sub-regulatory guidance issued by the Service in conjunction with the Proposed Rule addresses many issues, including how an employer will know that it owes an employer shared responsibility payment, and how it will make an employer shared responsibility payment. Based on informal conversations with Service representatives, it is our understanding that employers will be able to contest an assertion by an employee that he or she was not offered qualifying coverage after the payment is assessed.

Comment: Employers were previously subject to a similar regime in connection with the subsidies paid for federal continuation coverage under the American Recovery and Reinvestment Act ("ARRA Subsidies") and disputes regarding whether an employee had experienced a voluntary or involuntary termination. However, in connection with

the ARRA Subsidies, the government paid the subsidy, so employers were not particularly interested in whether the determination regarding the employee was correct. In this case, the employer will be on the hook for payment, so it will be interesting to see what mechanism the Service develops and whether it will be workable for employers.

For more information, please contact Seth Perretta or Allison Ullman at (202) 624-2500.

AMERICAN BENEFITS COUNCIL

BENEFITS BRIEF

February 14, 2013 | BR 2013-6

EMPLOYER OBLIGATIONS TO SHARE AND REPORT COVERAGE AND AFFORDABILITY INFORMATION UNDER PPACA (PART 1 OF 2)

PREPARED BY SETH PERRETTA AND MALCOLM SLEE OF CROWELL & MORING LLP

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With 2014 fast approaching, many employers have been focusing on how the employer shared responsibility ("pay or play") provisions of new Internal Revenue Code ("Code") Section 4980H will apply to their businesses. Considering the potential expense in complying with "pay or play," employers are wise to give full consideration to this issue.

This memorandum, which is Part I of a two-part series, focuses on certain related aspects of the Patient Protection and Affordable Care Act ("PPACA") that have been given less attention by commentators (and likely many employers). These are the new federal tax reporting requirements that will apply to employers beginning in 2014 under new Code Sections 6055 and 6056, and the process that is being established by the U.S. Department of Health and Human Services ("HHS") for purposes of determining an individual's eligibility for certain federal premium and cost-sharing subsidies in connection with the purchase of Exchange-based coverage. Regarding the latter, this process will require a considerable amount of involvement by employers.

Part II of this series will focus on the proposed U.S. Department of the Treasury ("Treasury") regulations regarding Code sections 6055 and 6056, which we expect to be issued in the very near-term. Given the importance of these new tax reporting and Exchange-related requirements, employers should understand how these aspects of the PPACA are likely to affect their businesses and operations.

NEW TAX REPORTING REQUIREMENTS FOR EMPLOYERS

As Figure 1 is intended to illustrate, beginning in 2014, a great deal of information is expected to flow among and between the various stakeholders (which include employers, employees, health issuers, Exchanges, and the IRS). Related to this information flow are two new reporting requirements that apply to employers by reason of the PPACA.

These two new reporting requirements are found in new Code sections 6055 and 6056. As noted above, we are expecting Treasury to issue proposed rulemaking regarding sections 6055 and 6056. The to-be-issued regulations follow a set of notices[1] issued by the IRS in 2012 soliciting comments on issues related to the new reporting requirements. The Council submitted a comment letter to the IRS recommending that future implementation guidance allow sufficient time for compliance, minimize administrative burden and duplicative reporting and allow for electronic reporting and disclosure.[2]

The purpose of Code Section 6055 appears to be to help facilitate the IRS's enforcement efforts regarding the individual mandate, i.e., the requirement in Code Section 5000A that an individual taxpayer be enrolled in "minimum essential coverage" or otherwise pay an excise tax.[3] Per the statutory language of Code Section 6055, all "providers" of "minimum essential coverage" [4] will be required to provide certain information to the IRS regarding the extent to which an individual enrollee was covered by minimum essential coverage during the preceding taxable year. The term "providers" for this purpose is defined to include both issuers and employer plan sponsors. These reporting requirements will apply to minimal essential coverage provided on or after January 1, 2014, with the first returns to be filed in 2015.

For purposes of Code Section 6055, a provider must *also* provide a written statement to each individual named in the information return, by January 31 of the following year. The first information returns will be due in 2015. The written statement must include

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[1] IRS Notices 2012-32 and 2012-33.

[2] Council comment letter to IRS, June 11, 2012. Available at: http://www.americanbenefitscouncil.org/documents2012/hcr_irs-n2012-32-33_council-comments061112.pdf

[3] It is conceivable that this return will also be used to facilitate the IRS's enforcement of an employer's compliance with Code Section 4980H(a) (i.e., the requirement to make available minimum essential coverage to full-time employees and their children up to age 26), but that remains unclear.

[4] By statute, minimum essential coverage includes an insured employer-sponsored group health plan. Proposed regulations issued this week indicate that the IRS also considers non-grandfathered, self-funded employer-sponsored health coverage to be minimum essential coverage.

the name, address, and contact information of the provider filing the return and the information required to be shown on the return with respect to the individual.[5]

An additional filing requirement applies to employers that are subject to Code Section 4980H (employers with 50+ full-time employees or equivalents, i.e., "applicable large employers"), under new Code Section 6056. For periods beginning after December 31, 2013, each "applicable large employer" is required to file an information return reporting the terms and conditions of the health care coverage, if any, provided to its full-time employees for the year at issue.[6] The stated purpose of this information return is to assist the IRS in determining whether an employer may be subject to Code Section 4980H penalties for failing to provide affordable, minimum value, minimum essential coverage.[7] The first Code Section 6056 information returns will be due in 2015.

The type and extent of information that must be communicated to the IRS as part of a Code Section 6056 return are quite significant. More specifically, a subject employer will be required to remit information regarding:

- Its name and Employer Identification Number ("EIN");
- The date the return is filed;
- A certification of whether the employer offers its full-time employees (and their dependents) the opportunity to enroll in minimum essential

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[5] The IRS stated in Notice 2012-32 that, "[i]f health insurance coverage is provided by a health insurance issuer and consists of coverage provided through a group health plan of an employer, it is anticipated that the regulations would make the health insurance issuer responsible for the reporting." Based on this statement, it appears the IRS is contemplating making the issuer the sole reporting entity where the coverage at issue is insured (thus wholly excepting employer sponsors of insured plans from any reporting requirements under Code Section 6055). However, given that employers are likely to be in a better position to know certain of the information subject to reporting (such as the social security numbers and addresses of an employee's dependents, as well as the extent of any employer premium subsidy), it seems likely that some reporting obligations may remain with employer plan sponsors.

[6] Although by their express terms, the reporting requirements of Code Section 6056 run to the employer plan sponsor and not the issuer (to the extent any), Section 6056(d) permits the Treasury Secretary to provide that any statement required under Section 6056 may be provided as part of a return or statement under Section 6055 or on a Form W-2 provided by the employer. Additionally, Code Section 6056(d)(2) provides that "in the case of an applicable large employer offering health insurance coverage of a health insurance issuer, the employer may enter into an agreement with the issuer to include information required under [Section 6056] with the return required to be provided by the issuer under Section 6055."

[7] However, HHS earlier this month released a proposed regulation which stated in the preamble that an employer's liability under Code Section 4980H is limited to those employees who are "certified to the employer" under the PPACA as having enrolled in a plan through an Exchange, and for whom a applicable premium tax credit or cost-sharing reduction is allowed or paid. The proposed regulation requires the IRS to adopt methods to make such certifications to employers. One unanswered question is whether Section 6056 reporting will somehow be integrated into the certification process.

coverage under an eligible employer-sponsored plan (as defined in Code Section 5000A(f)(2)) and, if so: (i) the duration of any waiting period (as defined in Code Section 6056(b)(2)(C)) with respect to such coverage; (ii) the months during the calendar year when coverage under the plan was available; (iii) the monthly premium for the lowest cost option in each enrollment category under the plan; and (iv) the employer's share of the total allowed costs of benefits provided under the plan.

- The number of full-time employees for each month of the calendar year;

- For each full-time employee, the name, address, and taxpayer identification number of the employee and the months (if any) during which the full-time employee (or any dependents) were covered under the eligible employer-sponsored plan; and

- Such other information as may be required by the Treasury Secretary.

Code Section 6056 also provides that, no later than January 31 following the close of the calendar year, each applicable large employer must furnish to each full-time employee a written statement that includes the applicable large employer's name, address, and contact information (including a contact phone number), as well as the information that is required to be reported on the Code Section 6056 return (as set forth above).

EXCHANGE VERIFICATION OF EMPLOYEE ELIGIBILITY FOR APTCS

Employers will also be required to play an active role in an Exchange determining whether a given individual is eligible for an advance premium tax credit[8] ("APTC") to assist the individual in his or her purchase of affordable Exchange-based individual insurance coverage. An APTC is only available to an individual if he or she meets certain income requirements and is either not enrolled in employer-sponsored coverage, or not eligible for Code Section 4980H(b)-compliant employer-sponsored coverage, i.e., affordable, minimum value, minimum essential coverage. Although the specifics remain subject to further rulemaking, it is certain that employers will be expected to provide Exchanges with information that will allow for verification of whether an individual is eligible to receive coverage through his or her job, and the level of coverage being offered.

Individuals will apply for APTCs through a process being developed by the Centers

[8] Most of the principles in here apply to certain cost-sharing reductions available under the PPACA to individuals, as well. For ease of reference this article only refers to APTCs, but it should generally be understood that these issues will similarly arise in regard to applications for cost-sharing reductions.

for Medicare and Medicaid Services ("CMS"). CMS is in the process of creating application materials, but drafts released last week suggest that an individual will be given a form to take to an employer asking for information about any health coverage available through his or her job. One of the draft forms issued by CMS (see Attachment A) asks for the employer to provide the name of the lowest cost self-only health plan available through the job and how much the employee would have to pay in premiums for that plan. The employer is also asked to provide the name of a point of contact who can answer questions about employee health coverage. Also, in proposed regulations issued earlier this month, HHS discussed the possibility of creating a template which an employer could download and populate with information regarding its coverage offerings and then distribute to employees at hiring, upon request, or on an employer intranet or benefit site. Completing such a template would be entirely voluntary from the perspective of the employer. No such template exists currently, but this could be a useful tool for employers whether they decide to "pay" (in which case the document will help employees apply for and receive APTCs) or "play" (in which case the document could explain to employees why they are *not* eligible for APTCs).

In addition, proposed Federal regulations provide that *after* an individual applies for an APTC, employers may be brought into the process used by an Exchange to verify if an applicant is enrolled in or eligible for qualifying coverage from an eligible employer-sponsored plan. (If they are eligible for coverage, that individual would be disqualified from receiving an APTC even if not enrolled in the plan, provided that the plan is "affordable" and provides "minimum value" under the standards of the PPACA.)

HHS has been struggling with how Exchanges would determine if an APTC applicant is enrolled in or eligible for employer-sponsored coverage for some time. The primary dilemma is that there is no current database or repository of employer-sponsored plans that would allow Exchanges to confirm the existence of employer-sponsored coverage. In the recently released proposed regulations, HHS proposed a number of data sources that Exchanges[9] must use in order to verify access to employer-sponsored coverage (while acknowledging that these data sources cannot, in fact, definitely establish whether an individual is eligible for such coverage). These data sources are:

- Any electronic data sources that are available to the Exchange and which have been approved by HHS. There are two categories of electronic data sources that may provide information. The first category includes sources that can provide data about enrollment and eligibility for coverage in employer-sponsored plans. This is designed to encompass state-based data sources that exist or may be developed by states (for example, a state database used to administer the CHIP premium assistance program). The second category includes sources that can

[9] Under the proposed regulations, an Exchange can also elect to have HHS conduct the verification process (including obtaining data from the various data sources) instead.

provide data regarding the employment of an applicant and the members of the household, such as state quarterly wage databases or commercial sources of current wage data.

- HHS itself, which can provide data maintained by the Office of Personnel Management regarding the Federal Employees Health Benefits Program.

- The small business (or "SHOP") Exchange being operated by the Exchange in the state.

While an Exchange is required to *verify* enrollment or eligibility for coverage using these data sources, the proposed regulations also require the Exchange to accept on its face an applicant's attestation regarding his or her eligibility for coverage — except under two circumstances. If an applicant's attestation is not reasonably compatible with the information obtained through the above data sources, the Exchange must go through a process described in the proposed regulation to investigate the inconsistency. And if the Exchange cannot get any information regarding an applicant from the data sources listed above, and either cannot get employment data on the applicant or the employment data is not compatible with the applicant's attestation, the Exchange must select a statistically significant random sample of such applicants and contact the applicants' employers to verify whether the applicant is eligible for coverage. As a result, it is entirely possible that an employer will have to respond to inquiries from the Exchanges or HHS regarding the health coverage made available by such employer to certain individuals.

Even if an applicant "slips through the cracks" and is approved for an APTC in spite of the fact that he is eligible for employer-sponsored coverage, Exchanges will be required to provide employers with the ability to appeal a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan, or that such coverage is not affordable. Also, the IRS has indicated in guidance that it will contact employers to inform them of their potential liability under 4980H and provide them an opportunity to respond before any liability is assessed or notice and demand for payment is made. This should provide some comfort to employers that choose to "play" but have concerns regarding how the verification process described above will work.

In light of all this, employers should expect to play an active role in connection with an Exchange's determinations of an individual's APTC-eligibility – whether it be through the use of voluntary attestations *prior* to the application process, or in connection with an Exchange's audit activity in verifying these attestations *after* an individual's submission of an APTC application.

CONCLUSION

Given the financial costs and administrative burdens that are likely to result to employers, as well as the need by many employers to coordinate certain activities across payroll, tax and HR, employers should begin consulting with their advisors and developing a compliance strategy. However, they should also be aware that additional guidance from the federal agencies is imminent. Part 2 of this memorandum will review anticipated guidance under Code Sections 6055 and 6056 once it is released.

Attachment A

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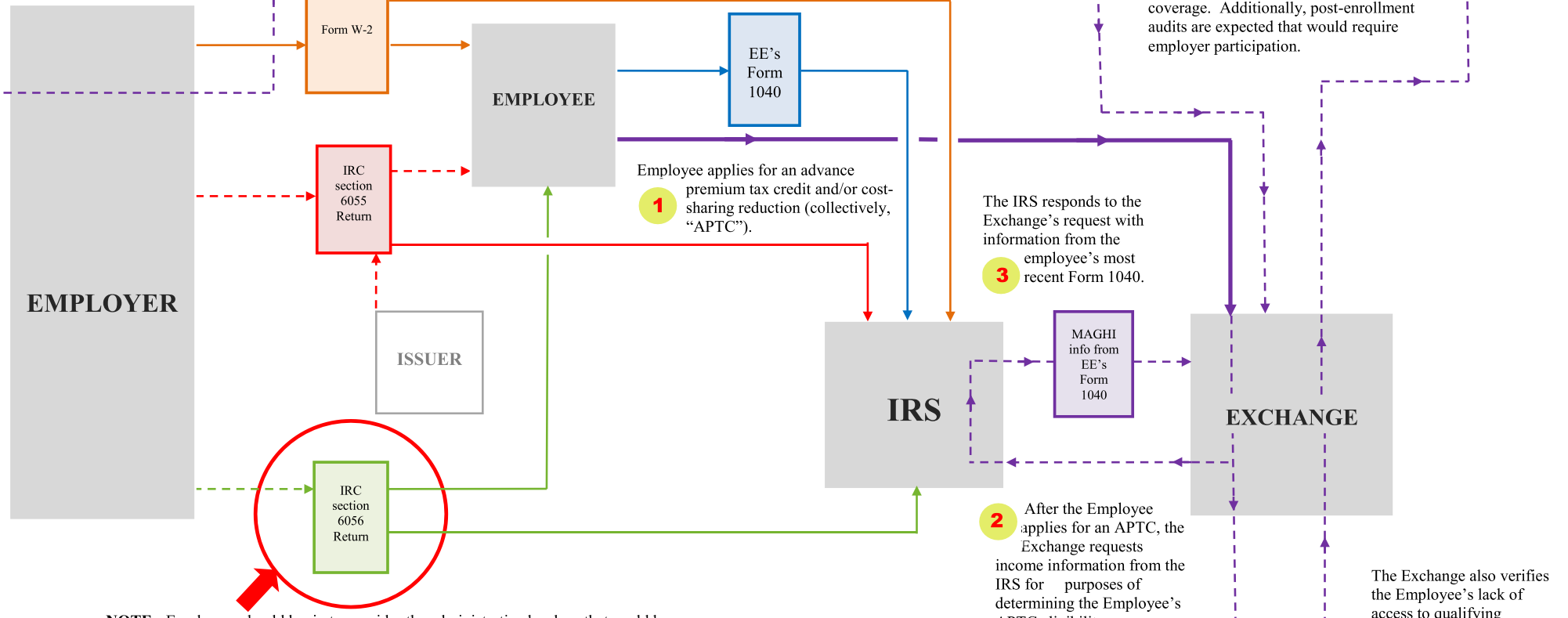
INFORMATION FLOWS REGARDING ACA EXCHANGES AND IRC SECTIONS 4980H AND 36B

If contacted by an Exchange, the Employer will need to demonstrate to the Exchange that the Employee does/does not have qualifying employer-sponsored coverage. **6**

If the Employee is found to be eligible for an APTC, the Exchange is required to notify the employer since this could trigger Code section 4980H penalties.

5 If no information is available from the databases and/or the exchange possesses inconsistent information, the Exchange may be required to contact the Employer to verify whether the Employee does not have access to qualifying employer-sponsored coverage. Additionally, post-enrollment audits are expected that would require employer participation.



NOTE: Employers should begin to consider the administrative burdens that could be imposed upon them with respect to new information reporting requirements under IRC sections 6055 and 6056 – especially with respect to IRC section 6056 given the important role it will play in IRS enforcement of IRC section 4980H liability. Additionally, employers should begin to consider the burdens and costs associated with Exchange activities in reaching out to employers to verify whether the Employee is eligible for and/or enrolled in IRC section 4980H-compliant coverage.

Attachment A

EMPLOYER COVERAGE FORM

Applying for help with health insurance costs from the Health Insurance Marketplace?

The Health Insurance Marketplace application asks questions about any health coverage available through a current job (even if it's from another person's job, like a parent or spouse) to figure out if you might be able to get help paying for health insurance. Use this form to get the information you need from the employer who offers health coverage. We'll verify this information, so it's important to be accurate. If you have more than one job that offers health coverage, use a separate form for each employer.

EMPLOYEE Information

The **employee** needs to fill out this section. Write down the employee's information then you may request the information below from the employer. Use this completed form when you fill out a Health Insurance Marketplace application.

Employee Name (First, Middle, Last)	Social Security Number
	__ __ __ - __ __ - __ __ __ __

EMPLOYER Information

Ask the **employer** for this information.

Employer Name	Employer Identification Number (EIN)
	__ __ - __ __ __ __ __ __ __
Employer Address	Employer Phone Number ( ) –
City / State / Zip Code	
Who can we contact about employee health coverage at this job?	
Phone Number ( ) –	Email Address

Tell us about the **health plan** offered by this **employer**.

☐ This employee isn't eligible for coverage under this employer's plan.

The employee is eligible for coverage under this employer's plan on _____ (Start Date).

What's the name of the **lowest** cost self-only health plan this employee could enroll in at this job? (Only consider plans that meet the "minimum value standard" set by the Affordable Care Act.)*

Name: _____

☐ No plans meet the "minimum value standard"

How much would the employee have to pay in premiums for that plan?

$ _____ How Often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly ☐ Other: _____

*According to the standards set by the Affordable Care Act of 2010. If you're not sure, ask your employer or health insurance issuer.

Use the information in this form to complete your Health Insurance Marketplace application.

Apply online at **www.placeholder.gov**, or call us at 1-800-XXX-XXXX to get started.

December 12, 2012

Summary: Treasury, IRS Release Final Patient-Centered Outcomes Research Institute (PCORI) Fee Regulations

Prepared by Seth Perretta and Allison Ullman of Crowell & Moring LLP

On December 5, 2012, the Department of the Treasury and the Internal Revenue Service (collectively, the "Service") released for public inspection final regulations ("Final Regulations") that implement and provide guidance on the fees imposed by the Patient Protection and Affordable Care Act ("PPACA") on issuers of certain health insurance policies and plan sponsors of certain self-insured health plans to fund the Patient-Centered Outcomes Research Trust Fund ("PCORI fee"). The Final Regulations were published in the December 6, 2012 Federal Register and became effective on that date. The Final Regulations apply to policy and plan years ending on or after October 1, 2012 and before October 1, 2019. The Service previously requested comments regarding the PCORI fee via Notice 2011-35, and it published proposed regulations on April 17, 2012 ("Proposed Regulations").

The PPACA established the Patient-Centered Outcomes Research Institute ("PCORI"), which is intended to, through research, "assist patients, clinicians, purchasers, and policymakers in making informed health decisions by advancing the quality and relevance of evidence-based medicine through the synthesis and dissemination of comparative clinical effectiveness research findings." PCORI is to be funded through the Patient-Centered Outcomes Research Trust Fund ("Fund") (as established by Section 9511 of the Internal Revenue Code of 1986 ("Code"), as added by the PPACA), and Code sections 4375, 4376, and 4377 (as added by the PPACA) are intended to provide a funding source for the Fund. The Final Regulations implement the requirements under Code sections 4375 through 4377.

OVERVIEW AND AMOUNT OF THE PCORI FEE

Code Section 4375 imposes the PCORI fee on an issuer of a "specified health insurance policy" for each policy year ending on or after October 1, 2012 and before October 1, 2019. Code Section 4376 imposes the PCORI fee on a plan sponsor of an "applicable self-insured health plan" for each plan year ending on or after October 1, 2012 and before October 1, 2019.

The PCORI fee is two dollars (one dollar in the case of policy or plan years ending before October 1, 2013) multiplied by the average number of lives covered under the policy or plan. For policy or plan years ending on or after October 1, 2014, the amount of the PCORI fee will be adjusted based on increases in the projected per capita amount of National Health Expenditures.

With respect to insured plans, a "specified health insurance policy" is any accident or health insurance policy (including a policy under a group health plan) issued with respect to individuals residing in the United States. The term does not include a policy if substantially all of its coverage consists of excepted benefits described in Code Section 9832(c). Therefore, the following types of coverage are excluded:

- The following benefits in general:
    - Coverage only for accident, or disability income insurance, or any combination thereof
    - Coverage issued as a supplement to liability insurance
    - Liability insurance, including general liability insurance and automobile liability insurance
    - Workers' compensation or similar insurance
    - Automobile medical payment insurance
    - Credit-only insurance
    - Coverage for on-site medical clinics
    - Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits

- The following benefits, if offered separately:
    - Limited scope dental or vision benefits
    - Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof
    - Such other similar, limited benefits as are specified in regulations

- The following benefits, if offered as independent, noncoordinated benefits:
    - Coverage only for a specified disease or illness
    - Hospital indemnity or other fixed indemnity insurance

- The following benefits, if offered as a separate insurance policy:
    - Medicare supplemental health insurance (as defined under Section 1395ss(g)(1) of title 42),
    - Coverage supplemental to the coverage provided under chapter 55 of title 10
    - Similar supplemental coverage provided to coverage under a group health plan

Prepaid health coverage arrangements (i.e., arrangements whereby fixed payments or premiums are received as consideration for a person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how the coverage is provided or arranged to be provided) are included in the definition of specified health insurance policy.

With respect to self-insured plans, an "applicable self-insured health plan" is any plan providing "accident or health coverage" (i.e., any coverage that, if provided by an insurance policy, would cause the policy to be a specified health insurance policy) if any portion of the coverage is provided other than through an insurance policy, and the plan is established or maintained (i) by one or more employers for the benefit of their employees or former employees, (ii) by one or more employee organizations for the benefit of their members or former members, (iii) jointly by one or more of the foregoing for the benefit of employees or former employees, (iv) by a voluntary employees' beneficiary association described in Code Section 501(c)(9), (v) by any organization described in Code Section 501(c)(6), or, (vi) if not previously described, by a multiple employer welfare arrangement, a rural electric cooperative, or a rural telephone cooperative association.

As is the case with a specified health insurance policy, the term "applicable self-insured health plan" excludes excepted benefits described in Code Section 9832(c), as set forth above.

Comment: The Proposed Regulations excluded from the definition of applicable self-insured health plan an employee assistance program ("EAP"), disease management program, or wellness program <u>if the program does not provide significant benefits in the nature of medical care or treatment</u>. The Final Regulations extend the exclusion to the definition of specified health insurance policy, providing that the term does not include any insurance policy to the extent that the policy provides for an EAP, disease management program, or wellness program if the program does not provide significant benefits in the nature of medical care or treatment. The Final Regulations provide no additional guidance regarding what constitutes "significant benefits."

With respect to insured plans, the issuer is responsible for paying the PCORI fee. With respect to self-insured plans, the plan sponsor is responsible for paying the PCORI fee.

The plan sponsor is defined as the employer in the case of a plan established or maintained by a single employer, or the employee organization in the case of a plan established or maintained by an employee organization. In the case of (i) a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, (ii) a multiple employer welfare arrangement, or (iii) a voluntary employees' beneficiary association described in Code Section 501(c)(9), the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. Code Section 4376 further provides that, in the case of a plan established or maintained by a rural electric cooperative or rural telephone cooperative association, the plan sponsor is the cooperative or association that establishes or maintains the plan.

Comment: The Final Regulations note in a footnote that the Department of Labor ("DOL") has advised that, because the PCORI fee is imposed on the plan sponsor with respect to a self-insured plan (instead of the plan itself), payment of the PCORI fee generally does not constitute a permissible expense of a benefit plan for purposes of Title I of the Employee Retirement Income Security Act ("ERISA"). The preamble to the Final Regulations states that the DOL will provide guidance on this topic in the near future on its website. Significantly, this is in contrast to the per capita fee payable by self-insured plans with respect to the transitional reinsurance program, as set forth in PPACA Section 1341. In a footnote to recently proposed guidance, the Department of Health and Human Services indicates that the DOL has stated that the transitional reinsurance fee may properly be paid from plan assets.

DETERMINING THE AVERAGE NUMBER OF COVERED LIVES

The amount of the PCORI fee is based on the average number of lives covered under the policy or plan during the policy or plan year.

The Final Regulations do not provide for a flat rule that the PCORI fee may apply only once with respect to each covered life, stating that it would be contrary to the explicit statutory language applying the fee to each specified health insurance policy or applicable self-insured health plan. The preamble to the Final Regulations states that there are no allocation rules or other methods of applying the PCORI fee on an aggregated basis in the statute or legislative history, and thus there is no evidence of an intent to apply the statutory provisions in a manner that aggregates these separate arrangements for a single covered individual.

The Final Regulations do, however, permit an applicable self-insured health plan that provides accident and health coverage through both fully-insured options and self-insured options to determine the fee imposed by Code Section 4376 by disregarding the lives that are covered solely under the fully-insured options. Significantly, however, the issuer of such fully-insured options would appear to remain liable itself for the PCORI fee with respect to enrollees in such options (and plan sponsors should expect that this fee will be passed on to enrollees and/or plan sponsors depending on the manner in which the premiums are funded).

As with the Proposed Regulations, the Final Regulations also adopt a rule designed to prevent the double-counting of individuals covered by multiple self-insured arrangements. Specifically, the Final Regulations provide that, for purposes of Code Section 4376, two or more arrangements established or maintained by the same plan sponsor that provide for accident and health coverage other than through an insurance policy and that have the same plan year may be treated as a single applicable self-insured health plan for purposes of calculating the fee. The Service did not extend this exception to insured arrangements.

Comment: In declining to extend the double-counting rules to insured arrangements, the Service pointed out that the Code specifically applies the PCORI fee to an issuer of a specified health insurance policy and to the sponsor of an applicable self-insured health plan (subject to certain exceptions), respectively. The Service noted that the statute specifically contemplates that different arrangements involving different plan sponsors or issuers would be subject to separate fees. The Service noted that the double-counting rule implemented for self-insured arrangements is workable under the statute because there is no significant difference between maintaining multiple self-insured plans and having a single "umbrella" plan. In contrast, if the two arrangements are sponsored by two different plan sponsors or issuers, the Service indicated there is no single plan equivalent.

Issuers and plan sponsors are permitted to use alternative methods for determining the average number of lives for the year. Issuers may choose from the following four methods:

(i) the *actual count method*, whereby an issuer may determine the average number of lives covered for a policy year by adding the total number of lives covered for each day of the policy year and dividing by the number of days in the policy year;

(ii) the *snapshot method*, whereby an issuer may determine the average number of lives covered under a policy for a policy year by adding the total number of

lives covered on a date or dates during the first, second, or third month of each quarter and dividing by the number of dates on which a count is made;

(iii) the *member months method*, whereby an issuer may determine the average number of lives covered under all policies in effect for a calendar year based on the member months reported on the National Association of Insurance Commissioners ("NAIC") Supplemental Health Care Exhibit filed for that calendar year; or

(iv) the *state form method*, whereby an issuer that is not required to file NAIC annual financial statements may use a form that is filed with the issuer's state of domicile.

Plan sponsors can choose from one of three alternative methods with respect to an applicable self-insured health plan:

(i) the *actual count* method (similar to the above);

(ii) the *snapshot method* (similar to the above); or

(iii) the *Form 5500 method*, whereby the plan sponsor may determine the average number of lives covered based on the number of participants reported on the Form 5500 for that plan year, so long as it is filed no later than the due date for the PCORI fee.

Comment: With respect to the snapshot method, which requires issuers and plan sponsors to count the number of individuals on a date (or an equal number of dates) in each quarter and to determine the number of covered individuals on average covered over those dates, the Final Regulations require that the date or dates used in each quarter must be within three days of the date in that quarter that corresponds to the date in the first quarter.

Comment: The Final Regulations, consistent with the Proposed Regulations, provide special rules for the first year the PCORI fee is in effect. Specifically, an issuer using the actual count method for determining the average number of lives covered under a policy with a policy year that ends on or after October 1, 2012 could begin counting lives covered under a policy as of May 14, 2012 (30 days after the date the Proposed Regulations were published in the Federal Register) rather than the first day of the policy year, and divide by the appropriate number of days remaining in the policy year. Similarly, for policy years ending on or after October 1, 2012 but beginning before May 14, 2012, issuers using the snapshot method could use counts from quarters beginning on or after May 14, 2012, to determine the average number of lives covered under the

policy. The Final Regulations also permit a plan sponsor to use any reasonable method to determine the average number of lives covered under an applicable self-insured health plan for a plan year beginning before July 11, 2012 (90 days after the date that the Proposed Regulations were published in the Federal Register) and ending on or after October 1, 2012.

TREATMENT OF CERTAIN TYPES OF PLANS AND POLICIES

Retiree-Only Plans

The preamble to the Final Regulations confirms that the PCORI fee does apply to a retiree-only plan. Even though group health plans with fewer than two participants who are current employees are excluded from the requirements of chapter 100 of the Code (which sets forth requirements applicable to group health plans including portability, nondiscrimination, and market reform), the Code sections that implement the PCORI fee are not in chapter 100, and thus the chapter 100 exclusion for retiree-only plans does not apply with respect to the PCORI fee. In addition, Code Section 4376 states explicitly that an applicable self-insured health plan includes a plan established or maintained by one or more employers for the benefit of their employees or former employees.

Comment: The preamble to the Final Regulations notes that some commentators urged exclusion of retiree-only plans from the PCORI fee on public policy grounds, but states that there is no statutory basis for such an exclusion. Significantly, the treatment of retiree-only plans differs for purposes of the PCORI fee and for purposes of Section 1341 of the PPACA, which provides for a per capita fee to help fund a transitional reinsurance program for the individual insurance market. The per capita fee under the transitional reinsurance program is applied based on the Medicare Secondary Payer ("MSP") rules – where an individual has both Medicare coverage and employer-provided group health coverage, the fee under Section 1341 of the PPACA only applies to the group health coverage if it is the primary payer of medical expenses.

Continuation Coverage

The Final Regulations do not provide an exception from the PCORI fee for continuation coverage required under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or similar continuation coverage under other federal or state law. The preamble to the Final Regulations states that if the coverage provided under the continuation coverage is accident and health coverage, there is no basis to exclude the arrangement from the PCORI fee and continuation coverage must be taken into account in determining the PCORI fee, unless the arrangement is otherwise excluded.

Comment: In light of the statements contained in the preamble to the Final Regulations, it appears that all individuals enrolled in coverage by reason of federal COBRA, state mini-COBRA or the like, or voluntary continuation coverage, must be counted for purposes of the fee.

Exempt Governmental Programs

Code Section 4377 provides that, notwithstanding any other law or rule of law, governmental entities will be exempt from the PCORI fee only if the policy or plan is an exempt governmental program. An "exempt governmental program" is defined by statute to be:

(i) any insurance program established under Medicare;

(ii) the medical assistance program established by Medicaid or the Children's Health Insurance Program;

(iii) any program established by federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being members of the Armed Forces of the United States or veterans; and

(iv) any program established by federal law for providing medical care (other than through insurance policies) to members of Indian tribes.

Comment: A governmental entity that is the plan sponsor of an applicable self-insured health plan that does not meet the definition of an exempt governmental program is subject to the PCORI fee with respect to such plan.

HRAs and FSAs

The Final Regulations continue to include in the definition of applicable self-insured health plan health reimbursement arrangements ("HRAs") and health flexible spending arrangements ("FSAs") that do not satisfy the requirement to be treated as an excepted benefit within the meaning of Code Section 9832(c). The preamble to the Final Regulations points out that an HRA or FSA that is sponsored by an employer that also sponsors another self-insured plan with the same plan year will not be subject to a separate fee. However, an HRA or FSA that is offered by an employer that only sponsors an insured plan will be subject to the PCORI fee.

Comment: The viability of stand-alone HRAs under the PPACA remains unclear; at present, the agencies appear to be of the view that such arrangements are impermissible to the extent they provide for the reimbursement of essential health benefits (and perhaps to the extent they allow for the reimbursement of premiums for insurance that would cover essential health benefits). Although stand-alone HRAs would give rise to additional PCORI fee liability, HRAs that are integrated with a major medical plan generally would not give rise to additional fee liability (unless, perhaps, the HRA is insured and the major medical coverage is self-funded, or vice-versa).

"Residing in the United States"

The term specified health insurance policy includes only an accident and health insurance policy that is issued with respect to an individual residing in the United States. The Final Regulations adopt the rule in the Proposed Regulations that provides that if the address on file with the issuer or plan sponsor for the primary insured is outside of the United States, the issuer or plan sponsor may treat the primary insured and the primary insured's spouse, dependents, or other beneficiaries covered under the policy as having the same place of abode and not residing in the United States. The determination of place of abode is based on the most recent address on file with the issuer or plan sponsor.

Comment: The term "primary insured" refers to the individual covered by the policy whose eligibility for coverage was not due to his or her status as a spouse, dependent or other beneficiary of another insured individual. Also, for purposes of the PCORI fee, "an individual residing in the United States" means an individual who has a place of abode in the United States. Since, as noted above, the issuer or plan sponsor may treat the primary insured's spouse, dependents, or other beneficiaries covered under the policy as having the same place of abode as the primary insured (and thus, as not residing in the United States), it appears that even where the primary insured's spouse, dependents or other beneficiaries actually do live in the United States, they will not be covered enrollees for purposes of the PCORI fee.

Comment: The Final Regulations conclude that an individual on a temporary U.S. visa who has a place of abode in the United States is residing in the United States.

Expatriate Plans

The Proposed Regulations provided for an exception from the fee for insured expatriate coverage. In response to stakeholder comments, the Final Regulations

confirm that the term applicable self-insured health plan does not include a self-insured plan if the facts and circumstances show that the self-insured plan was designed specifically to cover primarily employees who are working and residing outside of the United States.

Stop-Loss and Indemnity Reinsurance

Stop-loss and indemnity reinsurance policies are not subject to the PCORI fee.

Comment: Questions remain regarding what constitutes stop-loss versus health insurance where the stop-loss coverage uses a low attachment or triggering point. In connection with other rulemaking projects, the agencies have requested comments on low attachment point stop-loss generally, with suggestions that there may be a point at which low attachment point stop-loss should be treated not as stop-loss but as health insurance, at least for purposes of the PPACA.

REPORTING AND PAYMENT DEADLINE

As with the Proposed Regulations, the Final Regulations require an issuer of a specified health insurance policy and plan sponsor of an applicable self-insured health plan to report and pay the PCORI fee for a policy year or plan year no later than July 31 of the year *following* the last day of the policy year or plan year. The PCORI fee must be reported and paid on the Form 720, "Quarterly Federal Excise Tax Return."

Applicable penalties related to late filing of the applicable form or late payment of the applicable fee may be waived or abated if the issuer or plan sponsor has reasonable cause and the failure was not due to willful neglect.

The Final Regulations do not permit or include rules for third-party reporting or payment of the PCORI fee. The Service states that the burden and complexity that would have to be addressed by issuers, plan sponsors and the Service to develop and operate a third-party reporting and payment regime significantly outweigh the benefits of such a regime.

Comment: Stakeholders had requested that plan sponsors be permitted to delay the filing and payment of the fee until the filing of the related Form 5500 for the plan/arrangement at issue. The preamble to the Final Regulations states that the Service considered such a request but that the Service believed allowing for such a rule – given the delayed filing date of Form 5500s with extensions, i.e., typically October 15th of the following year – would hinder the funding and efficacy of the PCORI.

TAX TREATMENT OF PCORI FEE

The PCORI fee is treated as an excise tax for purposes of subtitle F of the Code. Unlike certain other ACA fees and taxes that are expressly *not* deductible by statute, the applicable Code language regarding the PCORI Fee does not include similar limiting language. Generally excise taxes are deductible under Code section 162 to the extent they are an ordinary and necessary business expense in carrying on a trade or business. Like the statutory provisions, the Final Regulations also do not clarify the deductibility of the PCORI Fee by issuers or employer plan sponsors. It is our understanding that the issue remains under consideration by the IRS. Some have suggested that the time-limited nature of the PCORI Fee and its unusual purpose (i.e., to fund research by an institute on comparative effectiveness), as well the relatively small amount of the PCORI Fee itself (i.e., just $1 in its first year of application) could lead the IRS to conclude that the fee is not deductible. It is also conceivable that the IRS could reach different conclusions on the deductibility of the Fee by employers versus issuers.

Comment: In the event that the PCORI Fee is determined by the IRS to not be tax deductible, the PCORI Fee would be effectively more costly than the stated per capita fee amount because of the employer's lost deduction. Very generally, the increased cost would be equal to the issuer or plan sponsor's marginal federal income tax rate.

ABILITY TO REIMBURSE THE PCORI FEE FROM ERISA PLAN ASSETS

The Final Regulations make clear that the PCORI Fee is a liability of the plan sponsor by statute – and not the underlying ERISA plan – and, thus, may not be reimbursed from ERISA plan assets. This is in contrast to the transitional reinsurance contribution, which DOL has indicated may be properly charged to the respective ERISA plan.

For more information, please contact Seth Perretta or Allison Ullman at Crowell & Moring LLP at (202) 624-2500.

AMERICAN BENEFITS COUNCIL

BENEFITS BRIEF

March 8, 2013 | BR 2013-7

SUMMARY OF HHS FINAL REGULATIONS ADDRESSING PPACA TRANSITIONAL REINSURANCE FEE

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On March 1, 2013, the U.S. Department of Health and Human Services ("HHS") released for public inspection **a final rule** ("Final Rule") setting forth guidance with respect to, among other things, the standards related to reinsurance, risk corridors, and risk adjustment consistent with sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act, as amended ("PPACA"). The Final Rule is the latest in a series of guidance issued by HHS with respect to sections 1341, 1342, and 1343, and it constitutes the final annual HHS Notice of Benefit and Payment Parameters for 2014. The Final Rule is scheduled to be published in the March 11, 2013 Federal Register.

Of particular interest to plan sponsors is the transitional reinsurance program established under Section 1341, which will require health insurance issuers, as well as self-insured group health plans, to make contributions to a transitional reinsurance program for the three-year period beginning January 1, 2014. The transitional reinsurance program is required to be established in each state to help stabilize premiums for coverage in the individual market from 2014 through 2016.

The first part of this Benefits Brief sets forth the most salient points of the Final Rule with respect to the transitional reinsurance program. The second part of this Benefits Brief provides a more comprehensive overview of the transitional reinsurance program, taking into account all guidance issued to date. This Benefits Brief is intended to allow those familiar with the transitional reinsurance program and its regulatory history to be able to quickly identify the important modifications made by the Final Rule, while enabling those who have not been deeply immersed in the transitional reinsurance program and the myriad guidance issued with respect thereto to gain a broader perspective on how the transitional reinsurance program will operate in general in light of all guidance issued to date.

EXECUTIVE SUMMARY: HIGHLIGHTS OF THE FINAL RULE

As noted above, the Final Rule is the latest in a series of final and proposed regulations on this topic. Previously, final regulations on the transitional reinsurance program, including fee collection, were issued on March 23, 2012 ("March 2012 Final Rule"). On December 7, 2012, HHS issued proposed regulations providing additional guidance on the mechanics and operation of fee collection under the transitional reinsurance program ("December 2012 Proposed Rule"). The Final Rule incorporates many of the propositions from the December 2012 Proposed Rule, responds to stakeholders' comments, and provides further clarification regarding how fees will be collected with respect to the transitional reinsurance program.

Below are some key highlights from the Final Rule pertaining to the transitional reinsurance program.

- ***Amount of Fee for 2014.*** The Final Rule states that the annual amount of the fee per covered life for 2014 will be $63 (or $5.25 per month), as provided in the December 2012 Proposed Rule.

- ***Fee Only Applies to a "Commercial Book of Business."*** With respect to insured coverage, the Final Rule clarifies that the reinsurance fee requirement is limited to an issuer's *commercial* book of business, meaning that Medicare Part C and Part D products (which are part of a *governmental* book of business) offered by an issuer are not subject to the reinsurance fee.

- ***Prescription Drug Plans, Integrated HRAs, HSAs, and FSAs Not Subject to the Fee.*** The Final Rule reiterates that the reinsurance fee requirement does not apply to coverage that is not "major medical coverage," and it adds a specific exception clarifying that coverage that is limited to prescription drug benefits is excluded from the reinsurance fee. Further, the Final Rule retains the specific exclusions set forth in the December 2012 Proposed Rule of certain types of plans that are not major medical coverage and therefore not subject to the reinsurance fee requirement. These excluded plans include health savings accounts ("HSAs") and flexible spending arrangements ("FSAs"), as well as health reimbursement arrangements ("HRAs") that are integrated with a group health plan. In addition, employee assistance plans ("EAPs"), disease management programs, and wellness programs will be excluded to the extent they do not provide major medical coverage within the meaning of the Final Rule. A high-deductible health plan is subject to the fee.

- ***COBRA Coverage May Be Subject to the Reinsurance Fee.*** Per stakeholders' requests for clarification, the Final Rule provides that continuation coverage such

as that required to be provided pursuant to the Consolidated Omnibus Budget Reconciliation Act ("COBRA") constitutes employment-based group health coverage and is subject to the reinsurance fee to the extent that such coverage qualifies as major medical coverage and no other exception applies. In addition, state mini-COBRA continuation coverage and voluntary continuation coverage would be subject to the fee.

- ***No Separate Exception Provided for Employer-Provided Retiree Coverage.*** In response to comments requesting that employer-provided retiree coverage be excluded from the reinsurance contribution requirement, the preamble to the Final Rule states that HHS does not have statutory authority to categorically exclude employer-provided retiree coverage, and that employer-provided retiree coverage is subject to the reinsurance contribution requirement unless one of the general exceptions applies. For example, retiree coverage would not be subject to the reinsurance contribution requirement if it: 1) only offers prescription drug benefits; 2) offers coverage that is secondary to Medicare; or 3) is not part of an insurer's commercial book of business.

- ***Expatriate Coverage Excluded.*** In accordance with stakeholders' comments, the Final Rule excludes expatriate coverage from the reinsurance fee requirement. HHS will issue further guidance on the definition of expatriate health coverage in the near future.

- ***Self-Insured Group Health Plans Ultimately Liable for Payment of Fee.*** With respect to a self-insured group health plan, the March 2012 Final Rule defined "contributing entity" to mean "a health insurance issuer or a third party administrator on behalf of a self-insured group health plan." Although the preamble to the December 2012 Proposed Rule provided that self-insured group health plans, and not their third party administrators, were liable for the fee, there remained some uncertainty (and no mention in the text of the regulations) regarding which party was in fact liable for payment of the fee. The Final Rule amends the definition of "contributing entity" to mean "a health insurance issuer or self-insured group health plan," and it further goes on to state that a self-insured group health plan is responsible for the reinsurance contributions, although it could, in its discretion, contract with a third party administrator or an administrative services only contractor to transfer the fee. Similarly, a self-insured group health plan is liable for reporting enrollment counts, though it may utilize a third party administrator or administrative services only contractor to perform such reporting.

- ***Self-Insured Group Health Plans Covered by ERISA Not Subject to Additional State Fees by Reason of PPACA.*** The December 2012 Proposed Rule and the Final Rule each allow a state that operates its own reinsurance program to collect additional fees if such additional fees are disclosed in the state's notice of benefit

and payment parameters. The Final Rule reiterates that nothing in Section 1341 nor the Final Rule gives a state the authority to collect any funds (whether under the national contribution rate or under an additional state contribution rate) from a self-insured group health plan covered by the Employee Retirement Income Security Act of 1974 ("ERISA").

- ***Changes to Counting Rules.*** The Final Rule includes modifications to the rules that apply for counting lives for purposes of determining fee liability, including with respect to what the Final Rule refers to as "multiple plans."

- ***Reinsurance Fee Is Permissible ERISA Plan Expense.*** As described above, liability for the reinsurance fee falls on a health insurance issuer or a self-insured group health plan. The preamble to the Final Rule states that the Department of Labor has advised HHS that paying the reinsurance fee is a permissible expense of the plan under Title I of ERISA.

- ***Reinsurance Fee Is Federal Tax-Deductible.*** In response to stakeholder concerns, the Final Rule references recently issued Internal Revenue Service Frequently Asked Questions regarding the deductibility of the reinsurance contribution fee, providing that taxpayers will be able to treat reinsurance contributions as ordinary and necessary business expenses.[1]

- ***Liability for Payment of Additional Contributions to United States Treasury Appears to Belong to Both Issuers and Self-Funded Plans.*** One component of the annual $63 fee is an additional payment to the general fund of the United States Treasury equal to $2 billion in 2014, $2 billion in 2015, and $1 billion in 2016. The statutory language is not entirely clear as to whether both insurers and self-insured group health plans are liable for payment of the portion of the fee to the general fund of the United States Treasury, or whether just insurers are liable for such portion of the fee. The preamble to the Final Rule provides that "[t]hese contributions are funded by health insurance issuers and self-funded group health plans." Thus, it appears to be the view of HHS that both insurers and self-insured group health plans are liable for the portion of the fee that will be paid to the general fund of the United States Treasury.

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[1] *See* PPACA Section 1341 Transitional Reinsurance Program FAQs, *available at* http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs.

OVERVIEW OF THE TRANSITIONAL REINSURANCE PROGRAM

Section 1341 requires the HHS Secretary, in consultation with the National Association of Insurance Commissioners ("NAIC"), to implement standards enabling states to establish and maintain a transitional reinsurance program pursuant to which health insurance issuers (with limited exception for certain types of insurance, discussed in detail below) and self-insured group health plans are required to make payments to an "applicable reinsurance entity" – a not-for-profit organization that carries out reinsurance functions under Section 1341 – for the three-year period beginning January 1, 2014. States are not required to establish a reinsurance program; if a state chooses not to establish a reinsurance program, then HHS will establish a reinsurance program for such state. Also, a state can establish a reinsurance program even if it does not establish a health insurance exchange.

Reinsurance contributions will be used to make reinsurance payments to health insurance issuers that cover high risk individuals in the individual market (excluding grandfathered health plans) for the three-year period beginning January 1, 2014. The transitional reinsurance program is intended to reduce the uncertainty of insurance risk and to stabilize premiums in the individual market during the first three years of operation of the state health insurance exchanges, *i.e.*, 2014 through 2016, by making payments to partially offset the high cost resulting from adverse selection.

Section 1341 itself does not provide much detail as to the method for determining the required contribution of each affected health insurance issuer or self-insured group health plan; rather, Congress delegated broad regulatory authority to HHS to shape the contours of the transitional reinsurance program. Initial proposed regulations published in the July 15, 2011 Federal Register left many questions unanswered. Final regulations, published in the March 23, 2012 Federal Register ("March 2012 Final Rule"), provided additional guidance regarding the implementation and operation of the transitional reinsurance program, but numerous outstanding issues remained. To address these concerns and provide a modified set of rules regarding the mechanics and operation of the fee collection, HHS released for public inspection proposed regulations on November 30, 2012 ("December 2012 Proposed Rule"). The Final Rule incorporates many of the propositions from the December 2012 Proposed Rule, responds to stakeholders' comments, and provides further clarification regarding the transitional reinsurance program.

LIABILITY FOR TRANSITIONAL REINSURANCE CONTRIBUTIONS

The express language of Section 1341 requires that health insurance issuers and third party administrators "on behalf of group health plans" make contributions to the transitional reinsurance program for the three-year period beginning January 1, 2014. With respect to a self-insured group health plan, the March 2012 Final Rule provided

that "contributing entities" would be required to make transitional reinsurance contributions, and it defined "contributing entity" to mean "a health insurance issuer or a third party administrator on behalf of a self-insured group health plan." Although the preamble to the December 2012 Proposed Rule provided that self-insured group health plans, and not their third party administrators, were liable for the fee, there remained some uncertainty (and no mention in the text of the regulations) regarding which party was in fact liable for payment of the fee.

The Final Rule and the preamble thereto provide much needed clarification on this point. The Final Rule amends the definition of "contributing entity" to mean "a health insurance issuer or self-insured group health plan" (i.e., it omits any reference to third party administrators). This clarification appears to be based on the express language of Section 1341, which states that "[t]he Secretary shall include . . . the method for determining the amount each health insurance issuer and group health plan . . . is required to contribute under such paragraph for each plan year beginning in the 36-month period beginning January 1, 2014" (emphasis added).

Like the December 2012 Proposed Rule, the Final Rule allows a self-insured plan to utilize a third party administrator to collect and remit the reinsurance contribution and to report enrollment counts to HHS. Specifically, the Final Rule states that "[a] self-insured group health plan . . . may elect to use a third party administrator or administrative services only contractor for transfer of the reinsurance contributions." Presumably, to the extent the plan administrator or the plan sponsor wishes for a third party administrator to remit the fee on the plan's behalf, this should be set forth in the documents governing the contractual relationship (such as the administrative services agreement).

Comment: Following the issuance of prior guidance, questions remained regarding if and how the fee applies to self-funded plans that are self-administered by the plan sponsor. As noted above, the Final Rule's preamble and amended definition of "contributing entity" make clear that the fee liability runs to the self-funded plan and not to the third party administrator, regardless of whether a plan relies on a third party administrator to remit the fee to HHS on its behalf.

GROUP HEALTH PLANS SUBJECT TO THE REINSURANCE CONTRIBUTION

Generally, contributing entities, as defined above, must make reinsurance contributions with respect to health insurance coverage and self-insured group health plans that provide major medical coverage, with the exception of certain types of coverage. Whether a type of coverage constitutes a group health plan generally will require a determination of whether such coverage provides benefits consisting of "medical care" within the meaning of Internal Revenue Code Section 213.

Excepted Coverage – Generally

Following the issuance of the March 2012 Final Rule, many questions remained regarding whether certain types of coverage could give rise to reinsurance fee liability. The December 2012 Proposed Rule provided some helpful clarifications in this regard. The Final Rule incorporates these clarifications and provides further guidance. The Final Rule provides that transitional reinsurance contributions are required with respect to health insurance coverage and self-insured group health plans except to the extent that 1) the self-funded plan or insurance is not major medical coverage, or, 2) in the case of health insurance coverage, the coverage is not considered to be part of an issuer's "commercial book of business."

With respect to what constitutes "major medical coverage," the preamble to the Final Rule reiterates the language in the preamble to the December 2012 Proposed Rule, stating that major medical coverage is "health coverage, which may be subject to reasonable enrollee cost sharing, for a broad range of services and treatments including diagnostic and preventive services, as well as medical and surgical conditions provided in various settings, including inpatient, outpatient, and emergency room settings. Coverage that is limited in scope (for example, dread disease coverage, hospital indemnity coverage, or stand-alone vision coverage or stand-alone dental coverage), or extent (for example, coverage that is not subject to [the PPACA prohibitions on annual and lifetime limits]) would not be major medical coverage."

With respect to what constitutes a "commercial book of business," the preamble to the Final Rule provides that such term is interpreted as referring to large and small group health insurance policies and individual market health insurance policies. Such term does not include products offered by an issuer under Medicare Part C or D (which are part of a governmental book of business) or a plan or coverage offered by a Tribe to Tribal members and their spouses and dependents. Coverage offered to federal, state or Tribal employees, however, would be part of an issuer's commercial book of business.

The Final Rule provides that the following types of coverage are not subject to the transitional reinsurance fee:

- Coverage consisting solely of excepted benefits as defined by Section 2791(c) of the Public Health Service Act ("PHSA"), including:
    - The following benefits in general:
        - Coverage only for accident, or disability income insurance, or any combination thereof
        - Coverage issued as a supplement to liability insurance
        - Liability insurance, including general liability insurance and automobile liability insurance
        - Workers' compensation or similar insurance

        - Automobile medical payment insurance
        - Credit-only insurance
        - Coverage for on-site medical clinics
        - Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits

    - The following benefits, if offered separately:
        - Limited scope dental or vision benefits
        - Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof
        - Such other similar, limited benefits as are specified in regulations

    - The following benefits, if offered as independent, noncoordinated benefits:
        - Coverage only for a specified disease or illness
        - Hospital indemnity or other fixed indemnity insurance

    - The following benefits, if offered as a separate insurance policy:
        - Medicare supplemental health insurance (as defined under Section 1395ss(g)(1) of title 42)
        - Coverage supplemental to the coverage provided under chapter 55 of title 10
        - Similar supplemental coverage provided to coverage under a group health plan

- Private Medicare, Medicaid, CHIP, federal or state high-risk pools, and basic health plans (because these are not part of a commercial book of business);

- Basic health plan coverage offered by issuers under contract with a state as described in PPACA Section 1331;

- Health reimbursement arrangements ("HRAs") integrated with a self-insured group health plan or health insurance coverage;

- Health savings accounts ("HSAs");

- Health flexible spending arrangements ("FSAs");

- Employee assistance plans ("EAPs"), disease management programs, and wellness programs (to the extent they do not provide major medical coverage);

- Stop-loss and indemnity reinsurance policies;

- Military health benefits (*e.g.*, TRICARE);

- Tribal coverage that is not employment-based and Indian Health Service health programs;

- Coverage that consists solely of benefits for prescription drugs (including employer group waiver plans and other employer-sponsored Part D plans).

- Expatriate coverage; and

- Employer-provided health coverage where such coverage applies to individuals with respect to which Medicare is the primary payor under the Medicare Secondary Payor rules.

Comment: There is some overlap between the types of coverage excluded from the transitional reinsurance fee and the types of coverage excluded for purposes of the Patient-Centered Outcomes Research Institute ("PCORI") fee, as set forth in new Internal Revenue Code Sections 4375 and 4376, and the new Form W-2 reporting requirements for applicable employer-sponsored plans, as set forth in Internal Revenue Code Section 6051(a)(14). However, the exclusions are not identical, so careful attention is required as to the PPACA provisions that may apply to a particular type of coverage.

Comment: The preamble to the Final Rule reiterates that contributing entities must make reinsurance contributions with respect to federal, state and local government plans covering employees, retirees or dependents because of a current or former employment relationship. Further, pursuant to the preamble to the March 2012 Final Rule, contributing entities must make reinsurance contributions on behalf of grandfathered health plans.

EAPs, Disease Management, On-Site Medical

The Final Rule, like the December 2012 Proposed Rule, excludes an EAP, disease management program, or wellness program (whether self-insured or insured) from the transitional reinsurance fee to the extent that the program does not provide major medical coverage. The Final Rule also notes that employers that provide one or more of the ancillary benefits described in this paragraph often sponsor major medical plans, which are generally subject to the transitional reinsurance fee.

Retiree-Only Coverage

In response to stakeholders' comments, the preamble to the Final Rule clarifies that employer-provided retiree coverage is subject to the reinsurance fee requirement unless one of the general exceptions applies.

Coverage Secondary to Medicare

The Final Rule reiterates the December 2012 Proposed Rule's provision that, in the case of employer-provided health coverage, when an individual has both Medicare coverage and employer-provided group health coverage, Medicare Secondary Payer ("MSP") rules under Section 1862(b) of the Social Security Act would be applicable, and the group health coverage would be subject to the reinsurance fee only if the group health coverage is the primary payer of medical expenses (and Medicare is the individual's secondary payer) under the MSP rules. It is intended that the above rules also apply with respect to individuals entitled to Medicare because of disability or end-stage renal disease.

Continuation Coverage

The December 2012 Proposed Rule did not expressly address the treatment of continuation coverage required to be offered under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") or similar continuation coverage under other federal or state law. In response to stakeholders' requests for clarification, the preamble to the Final Rule provides that COBRA and other continuation coverage constitutes employment-based group health coverage paid for by the former employee, and it is subject to the reinsurance fee to the extent such coverage qualifies as major medical coverage and no other exception applies.

Comment: Based on the Final Rule's consideration of continuation coverage as a group health plan subject to the transitional reinsurance fee, all individuals enrolled in coverage by reason of federal COBRA, state mini-COBRA or the like, or voluntary continuation coverage, must be counted for purposes of the fee. For those employers that seek to build the cost of the transitional reinsurance program fee into the cost of COBRA, they should keep in mind that the premium (or premium equivalent in the case of self-funded plans) charged to COBRA qualified beneficiaries generally may not exceed 102% of the total premium cost of the same coverage option for similarly situated active employees. Thus, employers seeking to pass on the cost of the per capita fee to COBRA qualified beneficiaries will likely need to build the cost into the premium that is charged for active employee coverage.

Expatriate Coverage

The December 2012 Proposed Rule was unclear as to the extent to which expatriate coverage could be subject to the reinsurance fee. Based on stakeholder input, the Final Rule provides a specific exclusion for expatriate coverage from the reinsurance fee requirement. The HHS Secretary will issue further guidance on the definition of expatriate coverage.

AMOUNT OF PER CAPITA TRANSITIONAL REINSURANCE CONTRIBUTION

As noted above, all health insurance issuers and self-insured group health plans are required to make contributions to support the transitional reinsurance program. The statute provides that, from 2014 through 2016, the aggregate contributions to be collected for and/or by all states will equal $10 billion for 2014, $6 billion for 2015, and $4 billion for 2016, with such amounts solely to be used in paying claims under the transitional reinsurance program. An additional amount equal, on a national basis, to $2 billion in 2014, $2 billion in 2015 and $1 billion in 2016 will be collected for deposit into the general fund of the U.S. Treasury. Additional amounts may be collected to cover administrative expenses.

A covered entity's contribution amount will be set based on a national contribution rate. Each "benefit year," which is defined to be a calendar year, HHS will set the national contribution rate in an annual HHS notice of benefit and payment parameters along with the proportion of the national contribution rate that will be allocated to reinsurance payments, payments to the U.S. Treasury, and administrative expenses of the applicable reinsurance entity for the state or HHS when carrying out the transitional reinsurance program. The March 2012 Final Rule permits a state to collect from issuers more than the amounts specified by the statute, if the state believes that such amounts are not sufficient to cover its transitional reinsurance payments or to cover its administrative costs.

Rather than using a "percent of premium" approach to determine the amount that a covered entity must contribute in a year, the March 2012 Final Rule provides that a flat per capita amount will be used to determine fee liability.

The Final Rule, in accordance with the December 2012 Proposed Rule, states that the flat per capita per month amount for 2014 will be $5.25 per covered life, per month, equivalent to $63 per covered life for the year. This per capita amount includes the additional $2 billion payable to the general fund of the U.S. Treasury, which, according to the preamble to the Final Rule, HHS has decided that it does not have statutory

authority to defer to 2016.[2] It also includes an additional amount for administrative expenses.

Comment: The statutory language is not entirely clear as to whether both insurers and self-insured group health plans are liable for payment of the portion of the fee to the general fund of the United States Treasury, or whether just insurers are liable for such portion of the fee. The preamble to the Final Rule provides that "[t]hese contributions are funded by health insurance issuers and self-funded group health plans." Thus, it appears to be the view of HHS that both insurers and self-insured group health plans are liable for the portion of the fee that will be paid to the general fund of the U.S. Treasury.

PERSONS COUNTED FOR PURPOSES OF THE CONTRIBUTION

The flat per capita amount referenced in the preceding section will be applied to all "reinsurance contribution enrollees" of such contributing entities.

A "reinsurance contribution enrollee" is defined as an individual covered by a plan for which reinsurance contributions must be made. For purposes of employer-sponsored plans, this appears to mean that a plan's total reinsurance contribution is based on the number of enrollees covered under the plan for the relevant period, including non-employee beneficiaries such as spouses and dependents. In other words, the per capita fee does not apply solely to the employee participant; it also applies to all other individuals covered under the plan.

Amount of Reinsurance Contributions Owed by the Plan or Issuer	**=**	Number of Enrollees Covered Under the Plans or Policies at Issue	**x**	Per Capita Fee

Comment: Please note that the transitional reinsurance fee will likely result in significantly greater fee liability on a plan-by-plan basis than the PCORI fee, which is limited to $1 times the average number of covered lives in the first year of the PCORI fee, and $2 times the average number of covered lives in later years of the PCORI fee.

[2] The preamble to the Final Rule makes clear that, to the extent that reinsurance payment requests for 2014 are less than the contributions collected for 2014, any unused funds will be used for reinsurance payments under the uniform reinsurance payment parameters for subsequent years.

PERMISSIBLE COUNTING METHODS

The Final Rule provides details as to how a health insurance issuer may determine the average number of covered lives of reinsurance contribution enrollees under a health insurance plan for a benefit year for purposes of the annual enrollment count. These methods are similar to the methods permitted for purposes of the fee to fund PCORI.

Specifically, health insurance issuers may use any of the following methods:

(i) The *actual count method*, pursuant to which a health insurance issuer would add the total number of lives covered for each day of the first nine months of the benefit year and divide that total by the number of days in those nine months;

(ii) The *snapshot count method*, pursuant to which a health insurance issuer would add the totals of lives covered on a date or dates during the same corresponding month in each of the first three quarters of the benefit year, and divide that total by the number of dates on which a count was made;

(iii) The *member months method* or *state form method*, pursuant to which a health insurance issuer would multiply the average number of policies for the first nine months of the applicable benefit year by the ratio of covered lives per policy calculated from the NAIC Supplemental Health Care Exhibit (or from a form filed with the issuer's state of domicile for the most recent time period).[3]

Self-insured plans may use the actual count method, the snapshot count method described above, a modified version of the snapshot count method (known as the snapshot factor method), or the Form 5500 method, pursuant to which the plan would use data from the Form 5500 for the last applicable plan year.[4]

The Final Rule provides that a contributing entity may use any reasonable method of estimating the number or percentage of its enrollees for whom the employer group health coverage is considered secondary to Medicare under the MSP rules.

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[3] Issuers would count the number of policies in the first nine months of the applicable benefit year by adding the total number of policies on one date in each quarter, or an equal number of dates for each quarter (or all dates for each quarter), and dividing the total by the number of dates on which a count was made.

[4] Pursuant to the Form 5500 method, a plan that offers only self-only coverage may add the total participants covered at the beginning and end of the benefit year, as reported on the Form 5500, and divide by two. A plan that offers self-only coverage and other coverage may calculate the number of lives covered by adding the total participants covered at the beginning and the end of the benefit year, as reported on the Form 5500.

Plans with Both Insured and Self-Insured Options

The Final Rule allows plans with both insured and self-insured options to use the actual count method or the snapshot count method to determine the number of covered lives to determine the reinsurance fee liability. A new provision in the Final Rule allows a plan with multiple coverage options to use any of the counting methods specified for insured or self-insured coverage, as applicable to each option, if it determines the number of covered lives under each option separately as if each coverage option provided major medical coverage (not including any coverage option that consists solely of excepted benefits, prescription drug coverage only, or that is a HRA, HSA or FSA).

Aggregation Rules Applicable to Plan Sponsors Maintaining Two or More Group Health Plans

The Final Rule includes aggregation rules for plan sponsors that maintain two or more group health plans that collectively provide major medical coverage for the same covered lives. The aggregation rules require such plans to be treated as a single group health plan for purposes of determining the amount of any transitional reinsurance fee due. However, the Final Rule provides that a plan sponsor may treat the multiple plans as separate group health plans for purposes of calculating the fee if it determines the number of covered lives under each separate group health plan as if the separate group health plan provided major medical coverage. Exceptions are provided for excepted benefits and for prescription drug coverage. In addition, the Final Rule provides exceptions for HRAs, HSAs, and FSAs.

Comment: The preamble to the Final Rule notes that this aggregation rule would prevent the double counting of a covered life for major medical coverage offered across multiple plans and prohibit a plan sponsor from splitting such coverage into separate arrangements to avoid reinsurance contributions on the grounds that it does not offer major medical coverage.

With respect to aggregated plans, where at least one of the plans is an insured plan, the plan sponsor must use either the actual count method or the snapshot count method for health insurance issuers, applied across the multiple plans as a whole. In addition, certain HHS reporting requirements would have to be fulfilled.

With respect to aggregated plans, where none of the plans is an insured plan, the plan sponsor must use either the actual count, snapshot count method, or snapshot factor method. In addition, certain HHS reporting requirements would have to be fulfilled.

Comment: The preamble to the Final Rule emphasizes that the applicable counting methods operate on a "benefit year" basis, which is defined to be the calendar year, and that the applicable counting methods all apply on that basis, despite the plan years of the plans at issue.

ANNUAL COLLECTION OF TRANSITIONAL REINSURANCE CONTRIBUTIONS

The Final Rule, like the December 2012 Proposed Rule, provides that the reinsurance contributions are to be collected on an annual basis. The Final Rule also adopts the language in the December 2012 Proposed Rule requiring issuers and plans to report to HHS their annual enrollment counts by November 15th of each year for the same calendar year. HHS will then provide a notice of fee liability to the issuer or plan sponsor by December 15th or thirty days (not fifteen days, as provided in the December 2012 Proposed Rule) after receipt of the annual enrollment count, whichever is later. Upon receipt of the notice of fee liability, plans and issuers will have 30 days to remit their fees to HHS.

The preamble to the Final Rule provides that HHS will provide details on the process for submission of reinsurance contributions in future guidance.

CENTRALIZED COLLECTION PROCESS; NO STATE-BY-STATE DATA REPORTING REQUIRED

The Final Rule provides that HHS will collect all contributions from health insurers and self-insured plans, even where a state decides to operate its own reinsurance program. This is intended to help streamline the collection process so that insurers and self-insured plans are not responsible for making payments to each individual state. HHS indicates that a centralized collection process for all contributing entities will facilitate the allocation and disbursement of funds, and will streamline the contribution submissions process for health insurance issuers that operate in multiple states. HHS expects to distribute the proceeds to states based on need.

Comment: Initially, HHS considered matching the reinsurance contribution with each subject enrollee to ensure that the reinsurance contribution is delivered to the state in which the enrollee resides. This would have raised significant issues for employers and issuers alike as it would have required employers to report to HHS not only aggregate enrollee count data, but also a state-by-state breakdown of where covered enrollees reside. Thankfully, HHS has changed course and this state-by-state reporting will not be required of issuers and plan sponsors.

ABILITY OF STATES TO COLLECT ADDITIONAL AMOUNTS FROM ISSUERS AND SELF-FUNDED PLANS

The Final Rule, like the December 2012 Proposed Rule, provides that a state operating its own reinsurance program (expected to be only Maryland and Connecticut in 2014) may elect to collect more than the amounts based on the national contribution rate set forth in the annual HHS notice of benefit and payment parameters for administrative expenses of the applicable reinsurance entity or additional reinsurance payments. If a state establishes a reinsurance program and elects to collect more than the amounts that would be collected based on the national contribution rate for administrative expenses or for additional reinsurance payments, then the state must set forth the additional contribution rate it intends to collect in the state notice of benefit and payment parameters. The Final Rule eliminates a provision in the December 2012 Proposed Rule that would have required states electing to collect additional amounts to notify HHS within 30 days after publication of the proposed annual HHS notice of benefit and payment parameters of the additional contribution rate that it elected to collect for administrative expenses. This provision was not included in the Final Rule because HHS will no longer collect additional contributions for a state, as discussed below, and will not immediately need this information.

Comment: The preamble to the Final Rule provides that the national reinsurance payment parameters are calculated to expend all reinsurance contributions collected under the national contribution rate. The preamble also provides that, similarly, the additional funds collected by a state for reinsurance payments or additional state funds are to be reasonably calculated to cover all additional reinsurance payments projected to be made under the state supplemental payment parameters.

The March 2012 Final Rule provided that a state establishing a reinsurance program may either directly collect additional reinsurance contributions for administrative expenses and reinsurance payments when a state elects to collect from health insurance issuers or may have HHS collect contributions from health insurance issuers for administrative expenses. The Final Rule, in accordance with the December 2012 Proposed Rule, changes this policy, providing that a state operating its own reinsurance program will no longer be permitted to have HHS collect additional funds. The Final Rule confirms that states may use additional funds, which were not collected as additional reinsurance contributions, to make supplemental reinsurance payments under the state supplemental reinsurance payment parameters, which would allow states to use other revenue sources, such as funds collected for state high-risk pools.

The preamble to the Final Rule also states that, although a state may elect to collect additional reinsurance contributions for administrative expenses or reinsurance payments, nothing in Section 1341 or the Final Rule gives a state the authority to collect any funds – whether under the national contribution rate or under an additional state

contribution rate - from self-insured group health plans covered by the Employee Retirement Income Security Act ("ERISA"), and that federal law generally preempts state law that relates to an ERISA-covered plan.

Comment: In likely reliance upon the flush language of Section 1341(b)(3)(B)(3), which states that, "[n]othing . . . shall be construed to preclude a State from collecting additional amounts *from issuers* on a voluntary basis," HHS states in the preamble to the Final Rule that, "nothing in Section 1341 of the Affordable Care Act or [the Final Rule] gives a State the authority to collect any funds – whether under the national contribution rate or under an additional State contribution rate - from self-insured group health plans covered by ERISA." The statutory language and the statement in the preamble indicate that states should have difficulty finding authority by reason of Section 1341 to collect additional contributions from self-funded plans and their sponsors.

DEDUCTIBILITY OF TRANSITIONAL REINSURANCE CONTRIBUTIONS

Recently issued Internal Revenue Service Frequently Asked Questions address the deductibility of the reinsurance contribution fee, providing that taxpayers will be able to treat reinsurance contributions as ordinary and necessary business expenses.[5] This will help reduce the overall cost to subject employers.

Comment: The deductibility of the reinsurance contribution is to be distinguished from that of the PCORI fee. Unlike the reinsurance contribution, which is tax-deductible as a bona fide business expense, the PCORI fee is an excise tax set forth in Code sections 4375 and 4376 and, as such, is not tax-deductible (which has the effect of increasing the cost of the PCORI fee to the extent of the plan sponsor's or issuer's marginal tax rate).

ABILITY TO PAY REINSURANCE CONTRIBUTIONS FROM ERISA PLAN ASSETS

The preamble to the Final Rule states that "[t]he Department of Labor advised HHS … that paying reinsurance contributions would constitute a permissible expense of the plan for purposes of Title I of the ERISA because the payment is required by the plan under the Affordable Care Act…." Accordingly, plan sponsors may elect to reimburse the cost of the annual fee from the respective plan, as permitted by ERISA and guidance issued thereunder.

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[5] *See* PPACA Section 1341 Transitional Reinsurance Program FAQs, *available at* http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs.

PENALTIES FOR FAILURE TO PAY TRANSITIONAL REINSURANCE CONTRIBUTIONS

The transitional reinsurance fee was enacted as a stand-alone provision of PPACA, and it is not expressly included in the PHSA, despite the fact that HHS has authority to issue regulations with respect to the fee. Pursuant to PPACA Section 1321, which indicates that the enforcement provisions of the PHSA will apply for purposes of the transitional reinsurance fee, it appears that the typical PHSA enforcement mechanisms and penalties will apply to a health insurance issuer or a group health plan that does not remit the required transitional reinsurance contributions to the state or HHS, as appropriate. In general, the maximum monetary penalty that may be imposed appears to be $100 per day per affected individual.

For more information, please contact Seth Perretta, Allison Ullman or Via Boppana at Crowell & Moring LLP at (202) 624-2500.

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IRS Issues Updated Guidance on Mandatory Form W-2 Informational Reporting of Employer-Sponsored Health Coverage

By Seth Perretta, Allison Ullman and Joel Wood of Crowell & Moring LLP

On January 3, 2012, the Internal Revenue Service ("IRS") issued Notice 2012-9 ("Notice"), which amends and restates the interim guidance initially provided to employers in Notice 2011-28 regarding the new Form W-2 reporting requirement for employer-sponsored group health coverage. This requirement was added to the Internal Revenue Code ("Code") by the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-149 ("Affordable Care Act").

The IRS states in Notice 2012-9 that it will continue to consider comments submitted regarding Notice 2011-28 as it works toward issuing additional guidance (including regulations). Notice 2012-9 modifies some of the Q&As provided in Notice 2011-28 and also provides additional guidance through new Q&As.

Background Regarding the Affordable Care Act and the New Form W-2 Reporting Requirement

Section 6051(a) of the Code generally requires that an employer provide a written statement to each employee on or before January 31st of the succeeding year showing the remuneration paid to that employee during the calendar year. Form W-2 is used to provide this information to employees.

The Affordable Care Act added a new reporting requirement to the Code that requires employers to report the cost of employer-provided health care coverage on the Form W-2. Code section 6051(a)(14) generally provides that the "aggregate cost" of all "applicable employer-sponsored coverage" provided to an employee must be included on the employee's Form W-2. The "aggregate cost" is determined under rules similar to those set forth in Code section 4980B(f)(4), *i.e.*, the rules regarding the calculation of COBRA premiums. As discussed below, the term "applicable employer-sponsored plan" is defined very broadly to generally include coverage under any subject group health plan, regardless of whether such coverage is excludable from the employee's gross income under Code section 106 or whether it is paid for directly by the employer in the form of a premium subsidy or by the employee on either a pre-tax (through a cafeteria plan) or after-tax basis.

Although the new Form W-2 reporting requirement was scheduled to become effective for the 2011 tax year, the IRS issued Notice 2010-69 on October 12, 2010. Notice 2010-69 provided employers with a one-year reprieve from the new rule by making the new requirement optional for purposes of 2011. Employers that voluntarily choose to report the cost of coverage on 2011 Forms W-2 may rely on the interim guidance provided in Notice 2012-9. Significantly, as discussed below, the Notice provides an exception for qualifying small employers unless and until further guidance is issued.

Highlights of the Interim Guidance

- ***The Reporting Requirement Is for Informational Purposes Only and Does NOT Result in Additional Wages or Tax Liability for Form W-2 Recipients.*** The Notice reiterates that the new reporting requirement to employees "is for their information only . . . and does not cause excludable employer-provided health care coverage to become taxable." As set forth in the Notice, the stated purpose of the reporting is "to provide useful and comparable consumer information to employees on the cost of their health care coverage."

  Comment: Employers are likely to receive many questions from employees regarding the implications of the additional amounts being reported on their Forms W-2. Employers may consider providing specific notice and/or explanation to employees of the new reporting requirement either in advance of, or in conjunction with, the issuance of 2012 Forms W-2.

- ***When Reporting Use "Code DD" in Box 12.*** The Notice provides that, for purposes of listing the aggregate cost in Box 12 of the Form W-2, employers should use "code DD."

- ***Special Reporting Rules Apply with Respect to Forms W-2 Requested and Issued Mid-Year.*** The Notice provides that an employer may apply any reasonable method of reporting the cost of coverage for an employee who terminates employment during the calendar year, so long as the method is used consistently for all employees receiving coverage under the same plan who terminate employment during the plan year and continue or otherwise receive coverage after the termination of employment. Additionally, and perhaps more importantly, the Notice provides that, "regardless of the method of reporting used by the employer for other terminated employees, an employer is not required to report any amount . . . for an employee who . . . has requested to receive a Form W-2 before the end of the calendar year during which the employee terminated employment" (emphasis added).

  Comment: An employer who finds itself the recipient of such a request can rest assured that it is not required to comply with the new reporting requirement in such an instance. Some employers as a matter of policy provide a Form W-2 to an employee at the time of termination, regardless of whether the employee requests a Form W-2. It is unclear whether such employers are required to report the aggregate cost with respect to such a terminated employee.

- ***The Reporting Requirement Applies Broadly to Most Employers.*** The Notice reiterates the statement in Notice 2011-28 that generally all employers that provide applicable employer-sponsored coverage are subject to the new reporting requirement. This includes, among others: federal, state, and local government entities, churches and other religious organizations, and employers that are not subject to the COBRA continuation coverage requirements under Code section 4980B (but see discussion below regarding a special exception for self-funded plans that are not subject to federal COBRA).

> ***Comment:*** To the extent future guidance applies the reporting requirement to additional employers or coverage types, the Notice states that such application will be prospective and will not become effective for any calendar year beginning within six months following publication of such guidance. Hence, it appears that guidance issued after July 1st of any year will not apply in either the year of issuance or the following year.

- ***Qualifying Small Employers Enjoy Limited Exceptions from the Reporting Requirement.*** The guidance provides transition relief for certain qualifying small employers. Specifically, it provides that, unless and until the IRS issues further guidance, employers filing fewer than 250 Forms W-2 for the preceding calendar year are not subject to the reporting requirement ("Small-Employer Exception"). The Notice states that whether an employer files fewer than 250 Forms W-2 for a calendar year is determined without regard to the employer's use of an agent to fulfill its Form W-2 filing responsibilities.

> ***Comment:*** The Notice states that the Small-Employer Exception is based on the exception from electronic return filing for small employers set forth in Code section 6011(e). The Notice does not specify whether application of the Small-Employer Exception is determined based on the employer's controlled group. It is our understanding that the IRS intends for the Small-Employer Exception to apply on an entity-level basis rather than on a controlled-group basis.

- ***Indian Tribal Governments and Certain Related Corporations Also Enjoy Limited Exceptions from the Reporting Requirement.*** The Notice excludes employers that are federally-recognized Indian tribal governments. In addition, until further guidance is issued, employers that are tribally chartered corporations wholly-owned by federally-recognized Indian tribal governments also are not subject to the reporting requirement.

- ***The Reporting Requirement Applies to "Applicable Employer-Sponsored Coverage."*** The Notice provides that the "aggregate cost" with respect to all "applicable employer-sponsored coverage" must be reported on the employee's Form W-2. The term "applicable employer-sponsored coverage" is broad and encompasses group health plan coverage that is, or would be, excludable from an employee's income by reason of Code section 106 (with certain limited exceptions described below).

- ***"Applicable Employer-Sponsored Coverage" Includes Certain Dependent Coverage and Domestic Partner Coverage.*** The term "applicable employer-sponsored coverage" includes not only coverage that is employer-provided coverage that is excludable from an employee's income by reason of Code section 106, but also coverage that, <u>if it had been provided to an employee</u>, would have been employer-provided coverage excludable from an employee's income by reason of Code section 106. Thus, it seems to be the case that employer-provided coverage of non-spouse, non-dependent beneficiaries constitutes "applicable employer-sponsored coverage" and thus would be subject to the new Form W-2 reporting requirement.

Comment: The Notice provides that "applicable employer-sponsored coverage" can encompass coverage that applies to individuals other than employees (and their Code section 152 dependents). Although it does not specifically address the issue of domestic partners or same-sex spouses, it appears that coverage of such domestic partners or same-sex spouses would be "applicable employer-sponsored coverage" and thus will need to be valued and reported on the related employee's Form W-2. This is because, if the domestic partner or same-sex spouse were an employee, his or her coverage would be excludable by reason of Code section 106. As discussed above, coverage can be "applicable employer-sponsored coverage" regardless of whether it is paid for on a pre-tax or after-tax basis. Thus, the fact that an employer may impute as wages to an employee the cost of domestic partner or same-sex spouse coverage would not change the analysis with respect to application of the new reporting requirement.

- The broad definition of "applicable employer-sponsored coverage" means that very many types of employer-sponsored coverage, whether provided through insurance or otherwise, are subject to reporting. These include:

  - Major medical
  - "Mini-med" plans
  - On-site medical clinics
  - Medicare supplemental
  - Medicare Advantage
  - Employer flex credits contributed to a Code section 125 health flexible spending arrangement ("Health FSA")

Comment: With respect to Health FSAs, the Notice provides that employer flex credits, as defined in Proposed Treasury Regulation section 1.125-5(b), are subject to reporting. Amounts contributed by an employee via salary reduction are not subject to reporting. Notably, if the amount of an employee's salary reduction (for all qualified benefits) equals or exceeds the amount of the Health FSA for the plan year, the employer does not include the amount of the Health FSA for that employee in the aggregate cost. If the amount of an employee's Health FSA for the plan year exceeds his or her salary reduction, then the amount of that employee's Health FSA minus his or her salary reduction election for the Health FSA must be included in the aggregate cost.

- The Notice provides that the following are NOT subject to reporting:

  - Stand-alone dental or vision coverage (if the coverage satisfies the requirements for being an excepted benefit under HIPAA)

Comment: Because of a statutory reference to excepted dental or vision coverage being pursuant to a "separate policy, certificate, or contract of insurance," many had wondered whether the statutory exception would only apply to insured stand-alone dental or vision. Per guidance issued to date, the exception appears to apply to insured and/or self-insured stand-alone dental and vision coverage. Note: The guidance makes clear that the exception ONLY applies to stand-alone coverage, *i.e.*, coverage that is not integrated into a group health plan providing for additional coverage.

- Long-term care coverage or insurance
- Amounts salary reduced by employees into a Health FSA (see note above regarding employer flex credits)
- Contributions to a Health Savings Account ("HSA") or Archer MSA
- Health reimbursement arrangement ("HRA")

Comment: The Notice appears to go beyond the statute in excepting certain medical savings accounts from the reporting requirement. As noted above, the Notice excepts from reporting all amounts contributed to an HSA or Archer MSA. Based on the express language of new Code section 6051(a)(14), many had expected the guidance to require reporting of all employer contributions to HSAs and Archer MSAs (whether made directly by the employer or via an employee's salary reduction through a cafeteria plan). The Notice, however, excepts all contributions to these accounts, whether made by an employer or by an employee on an after-tax basis. Similarly, many expected HRAs to be subject to reporting. The guidance, however, provides a broad exception for HRAs.

- Hospital or fixed indemnity insurance but only if it qualifies as "HIPAA-excepted" insurance and is paid for on an after-tax basis by the employee
- Specified disease or illness insurance but only if it qualifies as "HIPAA-excepted" insurance and is paid for on an after-tax basis by the employee

Comment: Notice 2012-9 clarifies that an employer is not required to include the cost of coverage provided under hospital indemnity or other fixed indemnity insurance, or the cost of coverage for specified disease or illness, if those benefits are offered as independent, non-coordinated benefits and the employee pays the full amount of the premium with after-tax dollars. The cost must be included if the employer makes a contribution to the cost of coverage that is excludable under Code section 106 or an employee purchases the coverage on a pre-tax basis through a Code section 125 plan.

- Any coverage (whether through insurance or otherwise) described in Code section 9832(c)(1) (other than on-site medical clinics described in subsection (G) thereof); this

includes the following coverages so long as they qualify as "HIPAA-excepted":

- Accident
- Accidental death and dismemberment
- Disability
- Liability
- Workers' compensation and similar
- Automobile medical payment
- Credit-only

- Any self-insured coverage that is not subject to federal COBRA

Comment: As noted above, the Notice provides a reporting exception for self-insured coverage that is not subject to federal COBRA. Given that plans sponsored by church entities may be self-insured and generally are not subject to federal COBRA, some church employers may find themselves with little to no reporting obligation. Additionally, federal COBRA generally only applies to governmental plans if the entity sponsoring the plan receives funding by reason of the Public Heath Service Act ("PHSA"). A great many states receive funding through the PHSA. Thus, federal COBRA likely applies to governmental plans (as would the new Form W-2 reporting requirement). There may be limited instances where this is not the case, however.

- Coverage provided to an employee through a multiemployer plan
- Excess reimbursements to highly compensated individuals under Code section 105(h)
- Payments or reimbursements of health insurance premiums for a 2% shareholder-employee of an S-corporation who is required to include the premium payments in gross income
- Coverage provided by governments primarily for members of the military and their families
- Amounts reported on a Form W-2 furnished by a third-party sick pay provider

Comment: The guidance clarifies that an employer may report the cost of coverage that is not required to be reported under guidance issued to date, including the cost of coverage under an HRA, a multiemployer plan, an employee assistance program ("EAP"), a wellness program, or an on-site medical clinic, provided the calculation of such costs satisfies the requirements of guidance issued to date and constitutes applicable employer-sponsored coverage.

- ***Notice 2012-9 Clarifies Treatment of "Split" Programs.*** Notice 2012-9 provides new guidance regarding how to calculate the reportable cost under a program providing both benefits that constitute applicable employer-sponsored coverage and benefits that do not constitute applicable employer-sponsored coverage. As an example of such coverage, the Notice references long-term disability programs that also offer some medical benefits.

  The Notice provides that an employer may use any reasonable allocation method to determine the cost of the portion of the program providing applicable employer-sponsored coverage. Where the medical benefits provided are "incidental" to the non-medical benefits provided, neither portion is required to be reported on the Form W-2. Where the non-medical benefits provided are "incidental" to the medical benefits provided, the non-medical portion may, but is not required to, be reported on the Form W-2 (notwithstanding the otherwise-applicable prohibition on reporting coverage that is not applicable employer-sponsored coverage).

  Comment: The new guidance seems to require that coverage be bifurcated into the portion that constitutes applicable employer-sponsored coverage and the portion that does not. Unless the portion that constitutes applicable employer-sponsored coverage is "incidental" to the portion that does not, an employer would be required to report the cost of the portion that constitutes applicable employer-sponsored coverage as part of the aggregate reportable cost.

  This apparent bifurcation requirement is likely to raise many issues for issuers and plan sponsors, including with regard to what constitutes an "incidental" level of medical benefits, and how to properly value the qualifying medical versus non-medical benefits offered under the coverage. In addition, the IRS's perceived view that coverage should be bifurcated could have implications beyond those directly related to the Form W-2 reporting requirement, specifically with respect to COBRA continuation coverage requirements. This is because the apparent bifurcation requirement would appear to require that coverage be divided into that portion that constitutes "applicable employer-sponsored coverage" and that portion that does not. Notably, the preamble of Notice 2012-9 states that the interim guidance in the Notice applies solely for Code section 6051(a)(14) and no inference should be drawn concerning any other provision of the Code. However, with the proposed bifurcation of coverage, the IRS may be setting the stage (whether intentionally or not) for the concept to work its way into other areas.

- ***The Notice Provides Guidance Regarding the Treatment of EAPs, Wellness Programs, and On-Site Medical Clinics.*** The Notice provides new guidance regarding the treatment of employee assistance programs ("EAPs"), wellness programs, and on-site medical clinics. The Notice states that coverage under such a program is only included in the aggregate reportable cost to the extent that it constitutes "applicable employer-sponsored coverage." Moreover, the Notice provides that if an employer does not charge a separate premium for continuation coverage (such as COBRA) provided under an EAP, wellness program or on-site medical clinic, then the coverage is not subject to the Form W-2 reporting requirement for either active or terminated employees. If, however, an employer does charge a separate premium for such continuation coverage, then the coverage is subject to the Form W-2

reporting requirement for both active and terminated employees.

> ***Comment:*** The Notice does not address the treatment of EAPs, wellness programs, and on-site medical clinics where an employer does not provide such coverage as part of continuation coverage. This is interesting given that, in practice, certain employers may not offer continuation coverage for EAPs, wellness programs, and/or on-site medical clinics (based on varying legal theories).
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> Additionally, although the Notice seems to suggest that EAPs, wellness programs, and on-site medical clinics – or at least a portion of such – may qualify as "applicable employer-sponsored coverage," the Notice provides no guidance for issuers and plan sponsors in terms of making such determinations. As noted above, the Notice provides that an employer need not report the value of coverage if the portion of coverage that constitutes "applicable employer-sponsored coverage" is "incidental" to the non-medical portion of the coverage. This rule may be helpful for employers seeking to not value and report the cost of EAPs and wellness programs, to the extent the medical component of such programs is only "incidental." This rule would seem to be unhelpful with respect to on-site medical clinics where most if not all of the benefits provided in connection therewith likely qualify as medical care.

- ***Aggregate Cost Includes Both the Employee and Employer Share of Premium.*** As anticipated, the Notice provides that the manner in which coverage is paid for does not affect whether the coverage is subject to reporting. Specifically, it provides that the aggregate cost "includes the cost of coverage under the employer-sponsored group health plan of the employee and any person covered by the plan because of a relationship to the employee, including any portion of the cost that is includible in an employee's gross income. Thus, the aggregate reportable cost is not reduced by the amount of the cost of coverage included in the employee's gross income."

> ***Comment:*** Based on the foregoing, to the extent coverage qualifies as "applicable employer-sponsored coverage," it generally must be reported by an employer on an employee's Form W-2 regardless of whether it is paid for (i) directly by the employer in the form of a premium subsidy, (ii) by an employee via salary reduction through a cafeteria plan, or (iii) by an employee on an after-tax basis, *i.e.*, by payroll deduction. Accordingly, coverage that may be imputed to employees as additional wages for purposes of federal tax law (such as with respect to certain adult children or nondependent domestic partners and same-sex spouses and their children) generally will be subject to reporting.

- ***When Calculating Aggregate Cost, the Employer May Use the "COBRA Applicable Premium Method" or Alternatives.*** Under the COBRA applicable premium method, the reportable cost for a period equals the COBRA applicable premium for that coverage for that period. The Notice goes on to state that "[i]f the employer applies this method, the employer must calculate the COBRA applicable premium in a manner that satisfies the requirements under [Code section] 4980B(f)(4)," *i.e.*, the general requirements regarding determining the cost of coverage for purposes of setting COBRA rates.

Comment: Many had hoped the notices to be preceded by or to include new rules for employers regarding how to determine the COBRA applicable premium, *i.e.*, COBRA rates. Neither Notice 2011-28 nor Notice 2012-9, however, includes any new rules for employers in determining a plan's COBRA applicable premium, but instead requires employers to use reasonable, good faith efforts in applying the existing regulations.

One of the reasons many were expecting new rules on setting COBRA premiums is because there have been some long-standing questions regarding how to determine COBRA premiums in the context of self-insured arrangements; specifically, where the cost to the plan of providing the coverage might be materially less than the fair market value of the coverage being provided. Up until now, this has not been all that significant. Given the new reporting requirement (and beginning in 2018, the 40% high-cost excise tax), this issue takes on new importance since individuals with the same coverage could result in different reported aggregate costs depending on whether the coverage is insured or self-insured, or, more generally, whether an employer who self-insures determines its COBRA applicable premium based on its cost versus fair market value. Notably, unless a system is developed to take account of differences in risk characteristics across employer groups more generally, differing rates with respect to similar coverage are to be expected.

- ***If the Applicable Employer-Sponsored Coverage Is Fully Insured, the Employer May Use the Alternative "Premium Charged Method."*** If the coverage is fully insured, the Notice provides that the employer may determine aggregate cost for an employee based on the premium charged by the employer for that employee's coverage.

- ***Where the Employer Subsidizes the COBRA Coverage or Charges for the Current Year Equal the "COBRA Applicable Premium" from Last Year, the Employer May Use the Alternative "Modified COBRA Premium Method."*** The Notice states that if the employer subsidizes the cost of COBRA coverage, the employer may determine the reportable cost for a period based upon a reasonable good faith estimate of the COBRA applicable premium for that period, if the employer uses such reasonable good faith estimate as the basis for determining the subsidized COBRA premium. Likewise, if the actual premium charged by the employer to COBRA-qualified beneficiaries for each period in the current year is equal to the premiums for each period in a prior year, the employer may use the COBRA applicable premium for each period in the prior year as the basis for reportable costs in the current year.

- ***The Notice Provides Some Helpful Guidance for Employers that Charge a Composite Rate***. The Notice addresses situations where (i) there is a single coverage class under the plan (*i.e.*, if an employee elects coverage, all individuals eligible for coverage under the plan because of their relationship to the employee are included in the elections and no greater amount is charged to the employee regardless of whether the coverage will include only the employee or the employee plus others) ("Single Class Coverage"), or (ii) there are different types of coverage under a single plan (for example, self-only and family coverage, or self-plus-one and family coverage), but employees are charged the same premium for each type of coverage ("Blended Rate Coverage"). The Notice provides that, with respect to Single Class Coverage, the employer may use the same reportable cost for a period for all of the

coverage provided under the plan. The Notice further provides that, with respect to Blended Rate Coverage, the employer may use the same reportable cost for a period for all of the coverage subject to the same rate. If the employer chooses to use one of these methods, the method must be applied to all types of coverage provided under the plan. The Notice provides the following example:

> For example, if a plan charges one premium for either self-only coverage, or self-and-spouse coverage (the first coverage group), and also charges one premium for family coverage regardless of the number of family members covered (the second coverage group), an employer may calculate and report the same reportable cost for all of the coverage provided in the first coverage group, and the same reportable cost for all of the coverage provided in the second coverage group. In such a case, the reportable costs under the plan must be determined under one of the methods described in Q&A-25 through Q&A-27 for which the employer is eligible.

Comment: Notice 2012-9 clarifies that if an employer is using a composite rate with respect to the premium charged to active participants, but not the premium charged to COBRA continuation coverage beneficiaries, then the employer may use either the composite rate or the applicable COBRA premium for determining the aggregate cost of coverage, provided that the same method is used consistently for all active employees and is used consistently for all qualifying beneficiaries receiving COBRA coverage.

- ***"Aggregate Cost" Can Include Period of Continuation Coverage.*** The Notice provides that in determining aggregate cost, an employer may choose to include any continuation coverage provided to an individual following his or her termination of employment during a calendar year.

Comment: The Notice makes clear that for purposes of the new reporting requirement an employer can either include or otherwise disregard continuation coverage provided to an individual post-termination. Where an employer seeks to include such continuation coverage, however, it is not entirely clear whether the employer can use the active employee rate for purposes of valuing such continuation coverage or whether the employer must account for any increased premium charged to an employee during the continuation coverage period.

- ***What If An Employee Commences, Changes, or Terminates Coverage During the Calendar Year?*** Employers are required to take into account any changes in cost of coverage by reason of employee action. The Notice provides that the reportable cost with respect to a given employee must reflect the different reportable costs for the coverage elected by the employee for the different periods of election. The Notice provides the following example:

> Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the calendar year 2012 is $500, and that the monthly reportable cost under the same group health plan for self-plus-spouse

> coverage for the calendar year 2012 is $1,000. Employee is employed by Employer for the entire calendar year 2012. Employee had self-only coverage under the group health plan from January 1, 2012 through June 30, 2012, and then had self-plus-spouse coverage from July 1, 2012 through December 31, 2012. For purposes of reporting for the 2012 calendar year, Employer must treat the 2012 reportable cost under the plan for Employee as $9,000 (($500 x 6) + ($1,000 x 6)).

The Notice provides that, where a change occurs during a period (for example, during the middle of a month where costs are determined on a monthly basis), an "employer may use any reasonable method to determine the reportable cost for such period, such as using the reportable cost at the beginning of the period or at the end of the period, or averaging or prorating the reportable costs, provided that the same method is used for all employees with coverage under that plan." As an example of this rule, the Notice provides:

> Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the calendar year 2012 is $500. Employee commences employment and self-only coverage under the group health plan on March 14, 2012, and continues employment and self-only coverage through the remainder of the calendar year. For purposes of reporting for the 2012 calendar year, Employer treats the cost of coverage under the plan for Employee for March 2012 as $250 ($500 x 1/2). Because Employer's method of calculating the reportable cost of under the plan for March 2012 by prorating the reportable cost for March 2012 to reflect Employee's date of commencement of coverage is reasonable, Employer must treat the 2012 reportable cost under the plan for Employee as $4,750 (($500 x 1/2) + ($500 x 9)).

- ***What If the Cost of Coverage Changes During the Calendar Year?*** Employers are required to take into account changes in the cost of coverage that occur during the course of a plan year. As discussed in the section above, where a change occurs during a period (for example, during the middle of a month where costs are determined on a monthly basis), the Notice provides that an employer may use any reasonable method to determine the reportable cost for such period. The Notice provides the following example regarding cost of coverage changes:

> Employer determines that the monthly reportable cost under a group health plan for self-only coverage for the period October 1, 2011 through September 31, 2012 is $500, and that the monthly reportable cost under a group health plan for self-only coverage for the period October 1, 2012 through September 31, 2013 is $520. Employee is employed by employer for the entire calendar year 2012 and had self-only coverage under the group health plan for the entire year. For purposes of reporting for the 2012 calendar year, Employer must treat the 2012 reportable cost under the plan for Employee as $6,060 (($500 x 9) + ($520 x 3)).

Comment: Notice 2012-9 clarifies that the aggregate reportable cost for a calendar year on Form W-2 may be based on information available to the employer as of December 31st of the calendar year. In addition, Notice 2012-9 clarifies how an employer may treat a coverage period, such as the final payroll period of a calendar year, that continues into a subsequent calendar year for purposes of allocating the cost of coverage.

Comment: The Notice provides that if an employer uses a 12-month determination period that is not the calendar year for purposes of determining COBRA rates, it will need to measure reportable cost across the calendar year for purposes of the new reporting requirement. For employers in this situation, they should carefully review the above examples as well as Q&A-29 and Q&A-30 in the Notice.

- ***Application of Form W-2 Reporting Requirement to Employee of Multiple Employers.*** In the case of an individual who is an employee of multiple employers within a calendar year, each employer providing employer-sponsored coverage must report the aggregate reportable cost of the coverage it provides. However, if the employers are related employers within the meaning of Code section 3121(s) and one employer is a common paymaster within the meaning of Code section 3121(s), then the common paymaster must include the aggregate reportable cost of coverage of all employers for whom it serves as the common paymaster. Where there is not a common paymaster, then the related employers may either report the entire aggregate reportable cost on one of the Forms W-2 provided to the employee, or they may allocate the aggregate reportable cost among the employers that concurrently employ the employee using any reasonable method of allocation.

For more information, please call us at (202) 624-2500.