**AFFORDABLE CARE ACT INFORMATION REPORTING RESPONSIBILITIES FOR SELF-FUNDED AND FULLY-INSURED PLANS**

The Affordable Care Act (ACA) includes an individual mandate – most U.S. citizens and legal residents must have healthcare coverage that is considered minimum essential coverage (MEC) or pay a tax penalty. The ACA also includes an employer mandate – applicable large employers (ALEs) must offer substantially all full-time employees (FTEs) and their dependents healthcare coverage that is MEC, satisfies minimum value standards and is affordable or face a potential penalty.

To enforce both mandates, the ACA added new information reporting requirements to the Internal Revenue Code (Code) under sections 6055 and 6056. The purpose of section 6055 reporting is for individuals to establish, and the Internal Revenue Service (IRS) to confirm, that the individuals have MEC and are not subject to the individual mandate penalty. Section 6056 requires ALEs to report to the IRS information about the health care coverage, if any, they offered to FTEs, in order to administer the employer mandate. Section 6056 also requires ALEs to furnish related statements to FTEs that FTEs may use to determine whether, for each month of the calendar year, they may claim on their individual tax returns a premium tax credit for coverage on the Health Insurance Marketplace.

Reporting is mandatory beginning in 2015, with the first returns to the IRS and statements to individuals due in early 2016. Reporting must be done on a calendar year basis, even if the plan or policy operated on a non-calendar year.

Returns and statements generally will be filed and furnished using Forms 1095-B and 1095-C and transmitted to the IRS using Forms 1094-B and 1094-C. The IRS expects to make the Forms available in the near future.


(Continued on page 3)

**IRS ISSUES FAQ EMPHASIZING PROHIBITION ON TAX FREE REIMBURSEMENT OF INDIVIDUAL PREMIUMS**

Recently, the IRS issued a FAQ stressing that employers providing tax-free reimbursement of individual premiums for health coverage obtained inside or outside the Health Insurance Marketplace are violating the Affordable Care Act. The violation carries a potential excise tax of $100/day per applicable employee. The FAQ appears to indicate that arrangements under which employees have after-tax amounts applied toward individual health coverage or take that amount in cash compensation are still permissible. The FAQ can be viewed at [http://www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements](http://www.irs.gov/uac/Newsroom/Employer-Health-Care-Arrangements).
**Benefit Implications of Same Sex Marriage Becoming Legal in Pennsylvania**

U.S. District Court Judge John E. Jones issued an order on May 20, 2014 permanently barring the Commonwealth of Pennsylvania from prohibiting same-sex couples from marrying. One day later, Pennsylvania Governor Tom Corbett said his administration would not appeal the ruling.

In response to the U.S. Supreme Court's June 2013 decision in *Windsor v. United States* striking down Section 3 of the Defense of Marriage Act, the Internal Revenue Service (IRS) had already issued guidance recognizing all same-sex marriages for pre-tax benefits. The IRS guidance applies for federal tax purposes in all 50 states and the District of Columbia to same-sex marriages performed in a U.S. jurisdiction or foreign country where same-sex marriage is recognized as legally valid, regardless of a couple's state of residence. In addition, the IRS issued separate guidance requiring qualified retirement plans to grant similar rights to same-sex spouses as are available to opposite-sex spouses.

The U.S. Department of Labor (DOL) had issued guidance indicating that same-sex marriages performed where legally recognized should be considered valid under the Employee Retirement Income Security Act and Internal Revenue Code, even if the couple resides in a state where same-sex marriage is forbidden. On June 20, 2014, the DOL issued proposed regulations to revise the definition of spouse under the Family and Medical Leave Act in light of the *Windsor* decision. The proposed definition includes same-sex marriages in addition to common law marriages, and will encompass same-sex marriages entered into abroad that could have been entered into in at least one state.

Employers sponsoring insured health plans in states, like Pennsylvania, where same-sex marriage is legally valid will have to conform to the eligibility requirements dictated by the insurance laws in their state. Since the Equal Employment Opportunity Commission has signaled that it might regard the exclusion of coverage for same-sex spouses as discriminatory, employers sponsoring self-funded health plans that deny coverage to same-sex spouses should be prepared to defend sex discrimination suits filed under Title VII of the Civil Rights Act.

**ACA Health Plan IDs Required**

Under the Affordable Care Act’s (ACA) administrative simplification rules, health plans including self-funded employer plans are required to obtain a Health Plan ID (HPID).

HPIDs will be used beginning November 7, 2016 to simplify various HIPAA Transactions, between payor, providers and other health care entities such as:

- Claims (837)
- Enrollment (834)
- Authorization (278)
- Eligibility (270/271)
- Payment/Remittance Advice (835)
- Claim Status (276/277)

Large health plans defined as those with annual health care claims >$5M must obtain their HPID by **November 5, 2014**. Small health plans have an additional year for compliance and are defined as plans with annual claims <$5M. Although no formal guidance has been issued, plans may want to follow the same plan size determinations used to file form 5500. If the plan combines all plans subject to HIPAA and files under one 5500, it may consider claims for all health related benefits (medical, dental, vision etc.) to determine plan size for HPID purposes.

The HPID final rule makes a distinction between Controlling Health Plans (CHPs) and Sub Health Plans (SHP).

A CHP is a health plan that controls its own business activities, actions, or policies or is controlled by an entity that is not a health plan (i.e., self-funded employer plan controlled by the plan sponsor.) A SHP is a plan whose business activities, actions or policies are directed by a CHP.

A CHP must apply for the HPID for itself and on behalf of its SHPs. SHPs are not required to obtain an HPID but can do so voluntarily.


If you have questions about HPID or the application process, please contact Dana Albright at 800-433-3746 ext 209.
AFFORDABLE CARE ACT INFORMATION REPORTING RESPONSIBILITIES FOR SELF-FUNDED AND FULLY-INSURED PLANS (CONTINUED FROM PAGE 1)

Highlights of the Section 6055 Reporting Requirements

Every sponsor of a self-funded health plan is responsible for 6055 reporting, although the obligation can be delegated to a third party such as a third party administrator. Each member of a controlled group must separately comply with the 6055 reporting requirements, although the reporting may be coordinated by a single entity.

All individuals enrolled in MEC must be included in the reporting. Reporting is not required for integrated health reimbursement arrangements (HRAs) that supplement health plans that provide MEC.

Using IRS Form 1095-B, the following information must be filed with the IRS, as well as furnished to each primary insured individual.

<table>
<thead>
<tr>
<th>Return Filed with the IRS (transmitted with IRS Form 1094-B)</th>
<th>Statement Furnished to Each Primary Insured Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Name, address and EIN of the reporting entity (the plan sponsor for a self-funded plan or insurer for an insured plan)</td>
<td>Same as the information filed with the IRS, except the following must added:</td>
</tr>
<tr>
<td>• Name, address and EIN of the plan sponsor and whether the coverage is a qualified health plan enrolled in through the Small Business Health Options Program (SHOP) and the SHOP's unique identifier (only for an insured plan)</td>
<td>• Telephone number for a person designated as the reporting entity's contact person and policy number, if any.</td>
</tr>
<tr>
<td>• Name, address and TIN of the primary insured individual (e.g., the employee or former employee)</td>
<td></td>
</tr>
<tr>
<td>• Name, address and TIN of each covered individual (date of birth is acceptable if a reasonable effort, as described in the final regulations, to obtain the TIN fails)</td>
<td></td>
</tr>
<tr>
<td>• For each covered individual, the months for which, for at least one day, the individual was enrolled in coverage and entitled to receive benefits</td>
<td></td>
</tr>
</tbody>
</table>

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QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN/HEALTH SAVINGS ACCOUNT SHOULD NOT BE INTRODUCED DURING A GENERAL PURPOSE HEALTH FSA PLAN YEAR

For many employers, adding a qualified high deductible health plan (QHDHP)/health savings account (HSA) option is a viable way to offer a lower cost plan. This is especially true for small employers since the $2,000 single/$4,000 family deductible limits imposed by the Affordable Care Act on the small group market were repealed.

However, employers that sponsor a general purpose health flexible spending arrangement (general purpose health FSA) should avoid introducing a QHDHP/HSA before the start of the health FSA plan year. General purpose health FSA coverage disqualifies participants from making HSA contributions because it pays for their medical expenses before the QHDHP deductible is satisfied.

The IRS does not recognize the mid-year addition of the QHDHP/HSA as a qualified change in status that would permit general purpose health FSA participants who select the QHDHP/HSA to drop or modify their health FSA coverage (such as switching to a limited purpose health FSA that reimburses only dental/vision expenses) until the beginning of the next FSA plan year.

Significa Benefit Services has been providing FSA administration services since 1993. We are prepared to assist you with any questions you may have about the complexities of FSA plan design and regulatory compliance.
Highlights of the Section 6056 Reporting Requirements

ALEs (generally employers with at least 50 FTEs, including full-time equivalent employees) are responsible for ALE reporting whether the health coverage they sponsor is self-funded or fully insured. The reporting function can be assigned to a designated agent such as a third party administrator. Reporting may be coordinated by a single entity, but each member of a controlled group must separately comply with the ALE reporting requirements.

Simplified section 6056 reporting, detailed in the final regulations, is available to ALEs that offer sufficient coverage to make it unlikely that they will be subject to an employer mandate penalty because their FTEs will generally be ineligible for a premium tax credit. Otherwise, using IRS Form 1095-C, the following information must be filed with the IRS and provided to each full-time employee (FTE), regardless of whether they were offered the coverage.

Return Filed with the IRS (transmitted with IRS Form 1094-C) | Statement Provided to Each FTE
---|---
- Name, address and EIN of the ALE | - Name, address and EIN of the ALE
- Name and telephone number of the ALE’s contact person (can be a third party designee) | - The information required to be shown on the section 6056 return to the IRS with respect to the FTE
- Calendar year for which the information is reported | - Certificate as to whether the ALE offered its FTEs (and their dependents) the opportunity to enroll in MEC, by calendar month
- Certification as to whether the ALE offered its FTEs (and their dependents) the opportunity to enroll in MEC, by calendar month | - The months during the calendar year for which MEC under the plan was available
- The months during the calendar year for which MEC under the plan was available | - Each FTE's share of the lowest cost monthly premium (self-only) for coverage providing minimum value offered to that FTE, by calendar month
- Each FTE's share of the lowest cost monthly premium (self-only) for coverage providing minimum value offered to that FTE, by calendar month | - The number of FTEs for each month during the calendar year
- The number of FTEs for each month during the calendar year | - Name, address and TIN of each FTE during the calendar year and the months, if any, during which the employee was covered under the plan
- Name, address and TIN of each FTE during the calendar year and the months, if any, during which the employee was covered under the plan | - Name, address and EIN of the ALE

ALEs that provide MEC on a self-funded basis are subject to the reporting requirements of both section 6055 and section 6056. They may file a combined IRS return and individual statement on Form 1095-C.

Reporting Due Dates

If mailed, reporting must be sent to the IRS by February 28 following the end of the calendar year being reported. If e-filed, the deadline is March 31 following the end of the calendar year being reported. E-filing is mandatory if at least 250 Forms are being transmitted to the IRS. Reporting generally must be provided to primary insured individuals and FTEs by January 31 following the end of the calendar year being reported.

Action Items

Employers should determine what reporting requirements apply and who will be responsible for filing and furnishing the returns and statements. Significa Benefit Services is developing services that will assist our clients with their reporting obligations. We anticipate a rollout of the services once the final Forms and instructions are made available by the IRS. Please contact our Marketing Department if you have any questions about the new 6055 and 6056 reporting requirements.