UBA ComplianceAdvisor

Compliance Recap

August 2016

August remained relatively quiet in the employee benefits world, with only new draft versions of the instructions for Forms 1095-C, 1095-C, 1094-B and 1095-B. The new draft versions of the specific forms were released in July. The IRS also released the annual contribution limits for health savings accounts (HSAs) and the deductible minimums and out-of-pocket limits for high deductible health plans (HDHPs). Finally, the IRS issued proposed regulations on reporting minimum essential coverage (MEC).

UBA Updates

UBA released seven new advisors in August:

- Are Opt Outs on the Way Out?
- How HIPAA Applies to Health and Welfare Benefit Brokers
- HIPAA Phase 1 Audits
- HIPAA Phase 2 Audits
- State Guide to COBRA Requirements
- Wellness Program Regulations Flow Chart
- Nondiscrimination Rules for Cafeteria Plans

UBA updated existing guidance:

- Additional Medicare Withholding for High Earners
- Highlights of the Small Employer Tax Credit
- IRS Liberalizes Health FSA Carryover Rule
- MLR Rebate Considerations (Private Plans)
- Excepted Benefits - Limited Scope Dental, Vision, EAPs
- FAQ about Eligibility Waiting Periods
- FAQ about the Exchange Notice
- What is My State Doing with Exchanges and Medicaid
- EHBs, MEC, MVC - What's the Difference?
- FAQ about the Health Marketplace
- Option to Renew Policies that Do Not Fully Meet ACA Standards

Reporting Minimum Essential Coverage

Minimum essential coverage (MEC) is the type of coverage that an individual must have under the Patient Protection and Affordable Care Act (ACA). Employers that are subject to the ACA's shared responsibility provisions (often called "play or pay") must offer MEC coverage that is affordable and provides minimum value. In fall 2015, the IRS issued Notice 2015-68 stating it was planning to propose regulations on reporting MEC coverage that would, among other things, require health insurance issuers to report coverage in catastrophic health insurance plans, as described in section 1302(e) of the ACA, provided through an Affordable Insurance Exchange (Exchange, also known as a Health Insurance Marketplace).

In August 2016, the IRS released the anticipated proposed regulations, incorporating the guidance given in Notice 2015-68. These regulations are generally proposed to apply for taxable years ending after December 31, 2015, and may be relied on for calendar years ending after December 31, 2013.

Read more about the proposed regulations.

2017 HSA and HDHP Limits Released

For calendar year 2017, the annual limitation on HSA deductions for an individual with self-only coverage under a high deductible health plan is $3,400. For calendar year 2017, the annual limitation on HSA deductions an individual with family coverage under a high deductible health plan is $6,750.

For calendar year 2017, a "high deductible health plan" is a health plan with an annual deductible that is not less than $1,300 for self-only coverage or $2,600 for family coverage, and the annual out-of-pocket expenses (deductibles, copayments, and other amounts, but not premiums) do not exceed $6,550 for self-only coverage or $13,100 for family coverage.

Draft Reporting Instructions Released

The IRS released the draft reporting instructions for Forms 1094-C and 1095-C, and Forms 1094-B, and 1095-B. 1095-C Forms are due to employees by January 31, 2017. Paper filings are due to the IRS by February 28, 2017, and electronic filings are due by March 31, 2017. Penalties per form (for failure to file) have increased from $250 to $260.

1094-C

The 1094-C instructions provide clarification on applicable large employers and controlled group reporting.

An ALE Member is, generally, a single person or entity that is an applicable large employer, or if applicable, each person or entity that is a member of an Aggregated ALE Group.

A Form 1094-C must be filed when an ALE Member files one or more Forms 1095-C. An ALE Member may choose to file multiple Forms 1094-C, each accompanied by Forms 1095-C for a portion of its employees, provided that a Form 1095-C is filed for each employee for whom the ALE Member is required to file. If an ALE Member files more than one Form 1094-C, one (and only one) Form 1094-C filed by the ALE Member must be identified on line 19, Part I as the Authoritative Transmittal, and, on the Authoritative Transmittal, the ALE Member must report certain aggregate data for all full-time employees and all employees, as applicable, of the ALE Member.

1095-C

The instructions indicate Line 14 should never be left blank, even for months prior to and after an individual's employment. Two new codes are available for Line 14.

New codes 1J and 1K address conditional offers of spousal coverage (also referred to as coverage offered conditionally). A conditional offer is an offer of coverage that is subject to one or more reasonable, objective conditions (for example, an offer to cover an employee's spouse only if the spouse is not eligible for coverage under Medicare or a group health plan sponsored by another employer). Using new codes 1J and 1K, an ALE Member may report a conditional offer to a spouse as an offer of coverage, regardless of whether the spouse meets the reasonable, objective condition. A conditional offer generally would affect a spouse's eligibility for the premium tax credit under section 36B only if all conditions to the offer are satisfied (that is, the spouse was actually offered the coverage and was eligible for it). To help employees (and spouses) who have received a conditional offer determine their eligibility for the premium tax credit, the ALE Member should be prepared to provide, upon request, a list of any and all conditions applicable to the spousal offer of coverage.

The instructions also provide new information on reporting offers of COBRA coverage. Former employees (and their spouses or dependents) offered COBRA due to termination of employment would be reported as not being offered coverage on the 1095-C, without regard to their enrollment in COBRA. Employees offered COBRA during their employment are reported as having offers of coverage.

Employers who have more than 250 1095-C returns and who are not prepared to file electronically may file their first 250 forms on paper, and then pay the penalty for the missing remaining forms.

If you are required to file 250 or more information returns, you must file electronically. The 250-or-more requirement applies separately to each type of form filed and separately for original and corrected returns. For example, if you must file 500 Forms 1095-B and 100 Forms 1095-C, you must file Forms 1095-B electronically, but you are not required to file Forms 1095-C electronically. If you have 150 Forms 1095-C to correct, you may file the corrected returns on paper because they fall under the 250 threshold. However, if you have 300 Forms 1095-C to correct, they must be filed electronically. The electronic filing requirement does not apply if you apply for and receive a hardship waiver. The IRS encourages you to file electronically even though you are filing fewer than 250 returns. If you are required to file electronically but fail to do so, and you do not have an approved waiver, you may be subject to a penalty of $260 per return for failure to file electronically unless you establish reasonable cause. However, you can file up to 250 returns on paper; those returns will not be subject to a penalty for failure to file electronically. The penalty applies separately to original returns and corrected returns.

1094-B and 1095-B

Health insurance issuers are encouraged to report catastrophic health plan coverage for Marketplace plans for calendar year 2016. Form 1095-B now contains the language "Do not attach to your tax return. Keep for your records." The instructions were updated to reflect the fact that a taxpayer identification number (TIN) may be used on the 1095-B, Part I, lines 2 and 3, and Part IV, columns (b) and (c).

Question of the Month

Q. If an active employee is enrolled in the employer's group health plan and their spouse is Medicare eligible due to disability (not end stage renal disease), does Medicare or the group health plan pay first for the spouse's claims?

A. If the employer has 100 or more employees, the group health plan will pay first and Medicare will pay second. If the employer has fewer than 100 employees, Medicare will pay first and the group health plan will pay second.

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The UBA Compliance Advisors help you to stay up to date on regulatory changes to help simplify your job and mitigate compliance risk.