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2016 Compliance Checklist

The Affordable Care Act (ACA) has made a number of significant changes to group health plans since the law was enacted over four years ago. Many of these key reforms became effective in 2014 and 2015, including health plan design changes, increased wellness program incentives and the employer shared responsibility penalties.

Additional reforms take effect in 2016 for employers sponsoring group health plans. To prepare for 2016, employers should review upcoming requirements and develop a compliance strategy.

This Legislative Brief provides a health care reform compliance checklist for 2016. Please contact Brown & Brown Benefit Advisors for assistance or if you have questions about changes that were required in previous years.

PLAN DESIGN CHANGES

Grandfathered Plan Status

A grandfathered plan is one that was already in existence when the ACA was enacted on March 23, 2010. If you make certain changes to your plan that go beyond permitted guidelines, your plan is no longer grandfathered. Contact Brown & Brown Benefit Advisors if you have questions about changes you have made, or are considering making, to your plan.

Review your plan's grandfathered status:

- ☐ If you have a grandfathered plan, determine whether it will maintain its grandfathered status for the 2016 plan year. Grandfathered plans are exempt from some of the ACA's mandates. A grandfathered plan's status will affect its compliance obligations from year to year.
- ☐ If your plan will lose its grandfathered status for 2016, confirm that the plan has all of the additional patient rights and benefits required by the ACA for non-grandfathered plans. This includes, for example, coverage of preventive care without cost-sharing requirements.
- ☐ If your plan will keep grandfathered status, continue to provide the Notice of Grandfathered Status in any plan materials provided to participants and beneficiaries that describe the benefits provided under the plan (such as the plan's summary plan description and open enrollment materials). Model language is available.

Cost-sharing Limits

Effective for plan years beginning on or after Jan. 1, 2014, non-grandfathered health plans are subject to limits on cost-sharing for essential health benefits (EHB). The ACA's overall annual limit (or an out-of-pocket maximum) applies for all non-grandfathered group health plans, including self-insured health plans and insured plans.

Under the ACA, a health plan's out-of-pocket maximum for EHB may not exceed **$6,850** for self-only coverage and **$13,700** for family coverage, effective for plan years beginning on or after Jan. 1, 2016.

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Health plans with more than one service provider may divide the out-of-pocket maximum across multiple categories of benefits, rather than reconcile claims across multiple service providers. Thus, health plans and issuers may structure a benefit design using separate out-of-pocket maximums for EHB, provided that the combined amount does not exceed the annual out-of-pocket maximum limit for that year. For example, in 2016, a health plan's self-only coverage may have an out-of-pocket maximum of $5,000 for major medical coverage and $1,850 for pharmaceutical coverage, for a combined out-of-pocket maximum of $6,850.

However, effective for the 2016 plan year, the Department of Health and Human Services (HHS) clarified that **the self-only annual limit on cost-sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or family coverage**. This guidance embeds an individual out-of-pocket maximum in family coverage so that an individual's cost-sharing for essential health benefits cannot exceed the ACA's out-of-pocket maximum for self-only coverage.

Note that the ACA's cost-sharing limit is higher than the out-of-pocket maximum for high-deductible health plans (HDHPs). In order for a health plan to qualify as an HDHP, the plan must comply with the lower out-of-pocket maximum limit for HDHPs. In an FAQ, HHS provides guidance on how this ACA rule affects HDHPs with family deductibles that are higher than the ACA's cost-sharing limit for self-only coverage.

According to HHS, an HDHP that has a $10,000 family deductible must apply the annual limitation on cost-sharing for self-only coverage ($6,850 in 2016) to each individual in the plan, even if this amount is below the $10,000 family deductible limit. Because the $6,850 self-only maximum limitation on cost-sharing exceeds the 2016 minimum annual deductible amount for HDHPs ($2,600), it will not cause a plan to fail to satisfy the requirements for a family HDHP.

Check your plan's cost-sharing limits:

- ☐ Review your plan's out-of-pocket maximum to make sure it complies with the ACA's limits for the 2016 plan year ($6,850 for self-only coverage and $13,700 for family coverage).
- ☐ If you have an HDHP that is compatible with a health savings account (HSA), keep in mind that your plan's out-of-pocket maximum must be lower than the ACA's limit. For 2016, the out-of-pocket maximum limit for HDHPs is **$6,550** for self-only coverage and **$13,100** for family coverage.
- ☐ If your plan uses multiple service providers to administer benefits, confirm that the plan will coordinate all claims for EHB across the plan's service providers, or will divide the out-of-pocket maximum across the categories of benefits, with a combined limit that does not exceed the maximum for 2016.
- ☐ Confirm that the plan applies the self-only maximum to each individual in the plan, regardless of whether the individual is enrolled in self-only coverage or family coverage.

Health FSA Contributions

Effective for plan years beginning on or after Jan. 1, 2013, an employee's annual pre-tax salary reduction contributions to a health flexible spending account (FSA) must be limited to $2,500. The $2,500 limit does not apply to employer contributions to the health FSA, and does not impact contributions under other employer-provided coverage. For example, employee salary reduction contributions to an FSA for dependent care assistance or adoption care assistance are not affected by the $2,500 health FSA limit.

On Oct. 31, 2013, the Internal Revenue Service (IRS) announced that the health FSA limit remained unchanged at $2,500 for the taxable years beginning in 2014. However, on Oct. 30, 2014, the IRS **increased the health FSA limit to $2,550 for taxable years beginning in 2015**, in Revenue Procedure 2014-61. The health FSA limit for 2016 has not been released yet, but will potentially be further increased for cost-of-living adjustments for later years.

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Update your health FSA's contribution limit:

- ☐ Work with your advisors to monitor IRS guidance on the health FSA limit for 2016.
- ☐ Confirm that your health FSA will not allow employees to make pre-tax contributions in excess of the limit for 2016. Also, communicate the 2016 limit to employees as part of the open enrollment process.

REINSURANCE FEES

Health insurance issuers and self-funded group health plans must pay fees to a transitional reinsurance program for the first three years of the Exchanges' operation (2014 to 2016). The fees will be used to help stabilize premiums for coverage in the individual market. Fully insured plan sponsors do not have to pay the fee directly.

Reinsurance contributions are only required for plans that provide **major medical coverage**. Health FSA coverage is not major medical coverage due to the ACA's annual limit on salary deferrals to a health FSA. Also, coverage that consists solely of excepted benefits under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) is not subject to the reinsurance program (such as stand-alone dental and vision plans). In addition, the following plans and coverage are excluded from reinsurance fees:

- HRAs that are integrated with major medical coverage;
- HSAs (although reinsurance fees will be required for an employer-sponsored HDHP);
- Employee assistance plans, wellness programs and disease management plans that provide ancillary benefits and not major medical coverage;
- Expatriate health coverage;
- Coverage that consists solely of benefits for prescription drugs; and
- Stop-loss and indemnity reinsurance policies.

Also, for 2015 and 2016, self-insured health plans are exempt from the reinsurance fees if they do not use a third-party administrator in connection with the core administrative functions of claims processing or adjudication (including the management of appeals) or plan enrollment.

The reinsurance program's fees will be based on a national contribution rate, which the Department of Health and Human Services (HHS) announces annually. For 2016, HHS announced a national contribution rate of **$27 per enrollee per year** (about $2.25 per month). The reinsurance fee is calculated by multiplying the number of covered lives (employees and their dependents) for all of the entity's plans and coverage that must pay contributions by the national contribution rate for the year.

Determine whether your health plan is subject to reinsurance fees:

- ☐ Taking into account the new exception for self-insured, self-administered health plans, review the health coverage you provide to your employees to determine if the plan is subject to reinsurance fees for 2016.

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HIPAA CERTIFICATION

Health plans must file a statement with HHS certifying their compliance with HIPAA's electronic transaction standards and operating rules. The ACA specified an initial certification deadline of Dec. 31, 2013, for the following transactions: (1) eligibility for a health plan; (2) health care claim status; and (3) health care electronic funds transfers (EFT) and remittance advice.

HHS extended the first certification deadline to **Dec. 31, 2015**, although small health plans may have additional time to comply. However, the initial compliance deadline is tied to the requirement for controlling health plans (CHPs) to obtain health plan identifiers (HPIDs), which was delayed indefinitely until further notice, on Oct. 31, 2014. Due to this delay, many CHPs have not obtained HPIDs. **HHS has not issued guidance to address how the indefinite delay of the HPID requirement impacts the deadline for the initial HIPAA certification**. It is expected that HHS will issue a final rule on the initial HIPAA certification requirement in the future. This final rule will likely address how the indefinite delay of the HPID requirement impacts the deadline for the initial HIPAA certification.

CHPs are responsible for providing the initial HIPAA certification on behalf of themselves and their subhealth plans, if any. Based on HHS' definition of CHPs, an employer's self-insured plan will likely qualify as a CHP, even if it does not directly conduct HIPAA-covered transactions. For employers with insured health plans, the health insurance issuer will likely be the CHP responsible for providing the certification. However, more definitive guidance from HHS on this point would be helpful.

Analyze your obligations for the HIPAA certification:

- ☐ Confirm whether your health plan is a CHP that is required to provide the initial HIPAA certification.
  - If you have a self-insured plan, work with your third-party administrator (TPA) to complete the certification by the deadline.
  - If you have an insured plan, confirm that the issuer will be providing the HIPAA certification on your plan's behalf.
- ☐ Work with your advisors to monitor additional guidance from HHS on the HIPAA certification requirement.

EMPLOYER PENALTY RULES

Under the ACA's employer penalty rules, applicable large employers (ALEs) that do not offer health coverage to their full-time employees (and dependent children) that is affordable and provides minimum value will be subject to penalties if any full-time employee receives a government subsidy for health coverage through an Exchange. The ACA sections that contain these requirements are known as the "employer shared responsibility" or "pay or play" rules.

These employer penalty provisions, and the related reporting requirements, took effect for most ALEs on **Jan. 1, 2015**. The first penalties will be assessed beginning in 2016. However, eligible ALEs with fewer than 100 full-time employees (including FTEs) have an additional year, until 2016, to comply with the employer shared responsibility rules. In addition, certain employers that have non-calendar year plans may be able to delay compliance with these rules until the beginning of their 2015 plan year.

On Feb. 10, 2014, the IRS released final regulations implementing the ACA's employer shared responsibility rules. Among other provisions, the final regulations establish an additional one-year delay for medium-sized ALEs, include transition relief for non-calendar year plans and clarify the methods for determining employees' full-time status.

This checklist will help you evaluate your possible liability for an employer shared responsibility penalty for 2016. *Please keep in mind that this summary is a high-level overview of the employer shared responsibility rules. It does not*

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provide an in-depth analysis of how the rules will affect your organization. Please contact Brown & Brown Benefit Advisors for more information on the employer penalty rules and how they may apply to your situation.

Applicable Large Employer Status

The ACA's employer penalty rules apply only to applicable large employers (ALEs). ALEs are employers with **50 or more** full-time employees (including full-time equivalent employees, or FTEs) on business days during the preceding calendar year. Employers determine each year, based on their current number of employees, whether they will be considered an ALE for the following year.

Under a special rule to determine ALE status for 2015, an employer could select a period of **at least six consecutive calendar months** during the 2014 calendar year (rather than the entire 2014 calendar year) to count its full-time employees (including FTEs). However, **this special rule applied for determining ALE status in 2015 only**. To determine ALE status for 2016, employers will have to use the entire 2015 calendar year.

Determine your ALE status for 2016:

- ☐ Calculate the number of full-time employees for all 12 calendar months of 2015. A full-time employee is an employee who is employed on average for at least 30 hours of service per week.
- ☐ Calculate the number of FTEs for all 12 calendar months of 2015 by 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 full-time employees for that month and dividing the total hours of service by 120.
- ☐ Add the number of full-time employees and FTEs (including fractions) calculated above for all 12 calendar months of 2015.
- ☐ Add up the monthly numbers from the preceding step and divide the sum by 12. Disregard fractions.
- ☐ If your result is 50 or more, you are likely an ALE for 2016.
- ☐ Keep in mind that there is a special exception for employers with seasonal workers. If your workforce exceeds 50 full-time employees (including FTEs) for 120 days or fewer during the 2015 calendar year, and the employees in excess of 50 who were employed during that time were seasonal workers, you do not qualify as an ALE for 2016.

One-year Delay for Medium-sized ALEs

Eligible ALEs with fewer than 100 full-time employees (including FTEs) have an additional year, until 2016, to comply with the shared responsibility rules. This delay applies for all calendar months of 2015 plus any calendar months of 2016 that fall within the 2015 plan year. However, ALEs that change their plan years after Feb. 9, 2014, to begin on a later calendar date are not eligible for the delay. In addition, to qualify for this delay, an ALE:

1. Must have employed a **limited workforce** of at least 50 full-time employees (including FTEs), but fewer than 100 full-time employees (including FTEs) during 2014
2. May not have **reduced its workforce size or overall hours of service** of its employees in order to satisfy the limited workforce size condition during the period beginning on Feb. 9, 2014, and ending on Dec. 31, 2014
3. May not have **eliminated or materially reduced the health coverage**, if any, it offered as of Feb. 9, 2014, during the period ending Dec. 31, 2015 (or the last day of the plan year that begins in 2015)

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An ALE must certify that it meets the three eligibility conditions to be eligible for this transition relief, as part of the transmittal form (Form 1094-C) that the ALE is required to file with the IRS under the Code Section 6056 reporting requirements. Code Section 6056 requires ALEs subject to the employer shared responsibility rules to report to the IRS certain information about the health care coverage offered to the employer's full-time employees for the calendar year. ALEs eligible for the additional one-year delay will still report under Section 6056 for 2015.

Determine whether you qualify for the one-year delay for medium-sized ALEs:

- ☐ Review whether you have fewer than 100 full-time employees (including FTEs) for 2014 and meet the other requirements for the one-year delay.
- ☐ Work with your advisors to monitor IRS information on the certification process for medium-sized ALEs.
- ☐ Keep in mind that ALEs eligible for the one-year delay must still report under Section 6056 for 2015.

Full-time Employees

A full-time employee is an employee who was employed on average at least **30 hours of service per week.** The final regulations generally treat 130 hours of service in a calendar month as the monthly equivalent of 30 hours of service per week. The IRS has provided two methods for determining full-time employee status—the monthly measurement method and the look-back measurement method.

Monthly Measurement Method	Involves a month-to-month analysis where full-time employees are identified based on their hours of service for each month. This method is not based on averaging hours of service over a prior measurement method. Month-to-month measuring may cause practical difficulties for employers, particularly if there are employees with varying hours or employment schedules, and could result in employees moving in and out of employer coverage on a monthly basis.
Look-back Measurement Method	An optional safe harbor method for determining full-time status that is intended to give employers flexible and workable options and greater predictability for determining full-time status. The details of the safe harbor vary based on whether the employees are ongoing or new, and whether new employees are expected to work full time or are variable, seasonal or part-time. This method involves a **measurement period** for counting hours of service, an **administrative period** that allows time for enrollment and disenrollment, and a **stability period** when coverage may need to be provided, depending on an employee's average hours of service during the measurement period. **If an employer meets the requirements of the safe harbor, it will not be liable for penalties for employees who work full time during the stability period, if they did not work full-time hours during the measurement period.**

Determine your full-time employees:

- ☐ Use the monthly measurement method or the look-back measurement method to confirm that health plan coverage will be offered to all full-time employees (and dependent children). If you have employees with varying hours, the look-back measurement method may be the best fit for you. To use the look-back measurement method, you will need to select your measurement, administrative and stability periods. Please contact Brown & Brown Benefit Advisors for more information on the look-back measurement method.

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Calculate Penalties for 2015

An ALE is only liable for a penalty under the pay or play rules if at least one full-time employee receives a premium tax credit or cost-sharing reduction for coverage purchased through an Exchange. Employees who are offered health coverage that is affordable and provides minimum value are generally not eligible for these Exchange subsidies.

Depending on the circumstances, one of two penalties may apply under the employer shared responsibility rules—the **4980H(a) penalty** or the **4980H(b) penalty**.

The 4980H(a) Penalty—Penalty for ALEs Not Offering Coverage

Under Section 4980H(a), an ALE will be subject to a penalty if it does not offer coverage to "substantially all" full-time employees (and dependents) and any one of its full-time employees receives a premium tax credit or cost-sharing reduction toward his or her Exchange plan. The 4980H(a) penalty will not apply to an ALE that intends to offer coverage to all of its full-time employees, but that fails to offer coverage to a few of these employees, regardless of whether the failure to offer coverage was inadvertent. The final regulations provide **transition relief** that will phase in the "substantially all" requirement over two years. Thus, an ALE will satisfy the requirement to offer minimum essential coverage to "substantially all" of its full-time employees and their dependents if it offers coverage to:

- **At least 70 percent**—or fails to offer coverage to no more than 30 percent—of its full-time employees (and dependents) for each calendar month during 2015 (and any calendar months during the 2015 plan year that fall in 2016); and
- **At least 95 percent**—or fails to offer coverage to no more than 5 percent (or, if greater, five)—of its full-time employees (and dependents) in 2016 and beyond. According to the IRS, the alternative margin of five full-time employees is designed to accommodate relatively small employers, because a failure to offer coverage to a handful of full-time employees might exceed 5 percent of the employer's full-time employees.

However, ALEs that qualify for the transition relief from the 4980H(a) penalty for 2015 plan years are still subject to potential 4980H(b) penalties for that time period (for example, if the health plan coverage is unaffordable or does not provide minimum value).

Under the ACA, the monthly penalty assessed on ALEs that do not offer coverage to substantially all full-time employees and their dependents will be equal to **the ALE's number of full-time employees (minus 30) X 1/12 of $2,000, for any applicable month**. After 2014, the penalty amount will be indexed by the premium adjustment percentage for the calendar year. This adjustment mechanism is not affected by the one-year delay for the employer shared responsibility rules. Therefore, the IRS has indicated that the penalty amount for 2015 will be adjusted. However, adjusted penalty amounts have not been announced.

The final regulations include **transition relief for 2015** that allows ALEs with 100 or more full-time employees (including FTEs) to reduce their full-time employee count by 80, instead of by 30, when calculating the penalty. This relief applies for 2015 plus any calendar months of 2016 that fall within the ALE's 2015 plan year.

The 4980H(b) Penalty—Penalty for ALEs Offering Coverage

Employers that do offer coverage to substantially all full-time employees (and dependents) may still be subject to penalties if at least one full-time employee obtains a premium tax credit or cost-sharing reduction through an Exchange because:

- The employer did not offer coverage to all full-time employees; or
- The employer's coverage is unaffordable or does not provide minimum value.

The monthly penalty assessed on an ALE for each full-time employee who receives a premium credit will be **1/12 of $3,000 for any applicable month**. However, the total penalty for an employer would be limited to the 4980(a) penalty amount. After 2014, the penalty amounts will be indexed by the premium adjustment percentage for the

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calendar year. This adjustment mechanism is not affected by the one-year delay for the employer shared responsibility rules. Therefore, the IRS has indicated that the penalty amount for 2015 will be adjusted. However, adjusted penalty amounts have not been announced.

Affordability of Coverage

Under the ACA, an employer's health coverage is considered affordable if the employee's required contribution to the plan does not exceed **9.5 percent** of the employee's household income for the taxable year (adjusted to **9.66 percent** for plan years beginning in 2016). "Household income" means the modified adjusted gross income of the employee and any members of the employee's family.

Because an employer generally will not know an employee's household income, the IRS provided three affordability safe harbors that employers may use to determine affordability based on information that is available to them. These safe harbors allow an employer to measure affordability based on the employee's **W-2 wages**, the employee's **rate of pay** or the **federal poverty level** for a single individual.

Note that ALEs using an affordability safe harbor **may have to continue using a contribution percentage of 9.5 percent** (instead of the adjusted affordability percentage) to measure their plan's affordability.

Minimum Value

Under the ACA, a plan provides minimum value if the plan's share of total allowed costs of benefits provided under the plan is **at least 60 percent** of those costs. The IRS and HHS provided the following three approaches for determining minimum value:

A Minimum Value (MV) Calculator	Design-based Safe Harbor Checklists	Actuarial Certification

In addition, any plan in the small group market that meets any of the "metal levels" of coverage (that is, bronze, silver, gold or platinum) provides minimum value.

On Nov. 4, 2014, the IRS issued Notice 2014-69 to clarify that plans that do not provide inpatient hospitalization or physician services (referred to as Non-Hospital/Non-Physician Services Plans) **do not provide minimum value**. HHS and the IRS will issue proposed regulations shortly that will prohibit an employer from using the MV Calculator (or any actuarial certification or valuation) to demonstrate that a Non-Hospital/Non-Physician Services Plan provides minimum value. As a result, **a Non-Hospital/Non-Physician Services Plan should not be adopted for the 2015 plan year or beyond**. Transition relief was available for certain employers that adopted a Non-Hospital/Non-Physician Services Plan prior to Nov. 4, 2014. **Plans adopted after Nov. 4, 2014, must cover inpatient hospitalization or physician services in order to provide minimum value**.

Calculate potential penalties for 2015:

- ☐ Review the cost of your health plan coverage to determine whether it's affordable for your employees by using one or more of the affordability safe harbors. Coverage is affordable if the employee portion of the premium for the lowest-cost, self-only coverage that provides minimum value does not exceed 9.5 percent of an employee's W-2 wages, rate-of-pay income or the federal poverty level for a single individual. The cost of family coverage is not taken into account.
- ☐ Determine whether the plan provides minimum value by using one of the four available methods (minimum value calculator, safe harbor checklists, actuarial certification or metal level).
- ☐ Calculate any penalties that may apply under Section 4980H(a) or 4980H(b) using the formulas above.

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2016 Compliance Checklist

REPORTING OF COVERAGE

The ACA requires ALEs to report information to the IRS and to employees regarding the employer-sponsored health coverage. The IRS will use the information that ALEs report to verify employer-sponsored coverage and to administer the employer shared responsibility provisions. This reporting requirement is found in **Code Section 6056**.

All ALEs with full-time employees—even medium-sized ALEs that qualify for the additional one-year delay from the employer shared responsibility rules—must report under Section 6056 for 2015.

In addition, the ACA requires every health insurance issuer, sponsor of a self-insured health plan, government agency that administers government-sponsored health insurance programs and any other entity that provides minimum essential coverage (MEC) to file an annual return with the IRS reporting information for each individual who is provided with this coverage. Related statements must also be provided to individuals. This reporting requirement is found in **Code Section 6055**.

Both of these reporting requirements took effect in 2015. **The first returns will be due in 2016 for health plan coverage provided in 2015.**

- Returns must be filed with the IRS by Feb. 28 (or March 31, if filed electronically) of the year after the calendar year to which the returns relate. The first returns are due to the IRS on or before **Feb. 29, 2016** (Feb. 28, 2016, being a Sunday), or by **March 31, 2016**, if filed electronically.
- Written statements must be provided to employees no later than Jan. 31 of the year following the calendar year in which coverage was provided. The first statements must be furnished no later than **Feb. 1, 2016** (Jan. 31, 2016, being a Sunday).

ALEs with self-funded plans will be required to comply with both reporting obligations, while ALEs with insured plans will only need to comply with Section 6056. To simplify the reporting process, the IRS will allow ALEs with self-insured plans to use a single combined form for reporting the information required under both Section 6055 and 6056.

ALEs that sponsor **self-insured plans**	**ALEs** that sponsor **insured plans**	**Non-ALEs** that sponsor **self-insured plans**	**Non-ALEs** that sponsor **insured plans**
Must report: (1) Information under Section 6055 about health coverage provided; and (2) Information under Section 6056 about offers of health coverage.	Must report information under Section 6056. These employers are not required to report under Section 6055.	Must report information under Section 6055. These employers are not required to report under Section 6056.	These employers are not required to report under either Section 6055 or Section 6056.

Forms Used for Reporting

Under both Sections 6055 and 6056, each reporting entity will be required to file all of the following with the IRS:

- A separate **statement** for each individual; and
- A single **transmittal form** for all of the returns filed for a given calendar year.

Under Section 6055, reporting entities will generally file Forms 1094-B (a transmittal) and 1095-B (an information return). Under Section 6056, entities will file Forms 1094-C (a transmittal) and 1095-C (an information return) for

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each full-time employee for any month. Entities that are reporting under both Sections 6055 and 6056 will file using a combined reporting method, using **Form 1094-C** and **Form 1095-C**.

On Feb. 8, 2015, the IRS released **final 2014 versions of forms and instructions** that employers will use to report under Sections 6055 and 6056 for 2014 (Forms 1094-B and 1095-B, with related instructions, and Forms 1094-C and 1095-C, with related instructions). **These forms are not required to be filed for 2014**, but reporting entities may voluntarily file them in 2015, related to 2014 coverage.

On June 16, 2015, the IRS **released draft 2015 versions of Forms 1094-B, 1095-B, 1094-C and 1095-C**. Instructions for the 2015 forms have not yet been released. Except for a few minor changes, the 2015 draft forms are largely unchanged from the 2014 versions. **These 2015 forms and instructions are draft versions only, and should not be filed with the IRS or relied upon for filing**.

Reporting entities must file information returns with the IRS and furnish statements to individuals, as follows:

Requirement	File with the IRS:	Furnish to each individual:
Section 6055	• One Form 1094-B; and • A separate Form 1095-B for each responsible individual	A copy of his or her Form 1095-B
Section 6056	• One Form 1094-C; and • A separate Form 1095-C for each full-time employee	A copy of his or her Form 1095-C
Both Section 6055 & 6056	• One Form 1094-C; and • A separate Form 1095-C for each full-time employee and each responsible individual	A copy of his or her Form 1095-C

Electronic Reporting

Any reporting entity that is required to file at least 250 returns under Section 6055 or Section 6056 must file electronically. The 250-or-more requirement applies separately to each type of return and separately to each type of corrected return. Entities filing fewer than 250 returns during the calendar year may choose to file in paper form, but are permitted (and encouraged) to file electronically. Individual statements may also be furnished electronically if certain notice, consent and hardware and software requirements are met (similar to the process currently in place for the electronic furnishing of employee Forms W-2).

Electronic filing will be done using the ACA Information Returns (AIR) Program. On June 9, 2015, the IRS issued an updated Draft Publication 5165, *Guide for Filing ACA Information Returns for Software Developers and Transmitters*, which provides very detailed technical information regarding standards for software developers and transmitters that plan to facilitate this electronic reporting. More information on the AIR Program is available on the IRS website. The AIR System is expected to be available for production in the fall of 2015.

Penalties

A reporting entity that fails to comply with the Section 6055 or Section 6056 reporting requirements may be subject to the general reporting penalties for:

- Failure to file correct information returns (under Code Section 6721); and
- Failure to furnish correct payee statements (under Code Section 6722).

However, penalties may be waived if the failure is due to reasonable cause and not to willful neglect. Penalties may be reduced if the reporting entity corrects the failure within a certain period of time. Also, lower annual maximums apply for reporting entities that have average annual gross receipts of up to $5 million for the three most recent taxable years.

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Signed into law on June 29, 2015, the **Trade Preferences Extension Act of 2015** **increases the penalties** under either Section 6055 or Section 6056. **These changes are effective for information returns and individual statements required to be filed or provided after Dec. 31, 2015**.

The increased penalty amounts are as follows:

Penalty Type	Per Violation		Annual Maximum		Annual Maximum for Employers with ≤$5 Million in Gross Receipts	
	Old Amount	New Amount	Old Amount	New Amount	Old Amount	New Amount
General	$100	**$250**	$1.5 million	**$3 million**	$500,000	**$1 million**
Corrected within 30 days	$30	**$50**	$250,000	**$500,000**	$75,000	**$175,000**
Corrected after 30 days, but before Aug. 1	$60	**$100**	$500,000	**$1.5 million**	$200,000	**$500,000**
Intentional disregard	$250*	**$500***	None		N/A	

**For failures due to intentional disregard of the filing requirement, the penalty will be equal to the greater of either the listed penalty amount or 10 percent of the aggregate amount of the items required to be reported correctly.*

Short-term Relief from Penalties

Short term relief from penalties is available to allow additional time to develop appropriate procedures for data collection and compliance with these new reporting requirements. **For returns and statements filed and furnished in 2016 to report offers of coverage in 2015, the IRS will not impose penalties on reporting entities that can show they made good faith efforts to comply with the information reporting requirements**.

This relief is provided only for incorrect or incomplete information reported on the return or statement, including Social Security numbers, TINs or dates of birth. No relief is provided for reporting entities that do not make a good faith effort to comply with these regulations or that fail to timely file an information return or statement.

Prepare for Health Plan Reporting:

- ☐ Determine which reporting requirements apply to you and your health plans.
- ☐ Determine the information you will need for reporting and coordinate internal and external resources to help compile the required data.
- ☐ If you are filing electronically, complete the e-Services Registration on the AIR Program to obtain log-in credentials, and then log in within 28 days to confirm registration and activate your IRS user account.
- ☐ Complete the appropriate forms. Furnish statements to individuals on or before Feb. 1, 2016, and file returns with the IRS on or before Feb. 29, 2016 (March 31, 2016, if filing electronically).

This Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

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