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Benefits Compliance & Potential Changes to the ACA

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March 23, 2017

Agenda

I. CALIFORNIA LEAVE LAWS

- California Paid Family Leave
- San Diego Sick Leave

II. OVERVIEW OF THE ACA

- Individual Mandate
- Inflationary Adjustments to the Individual Mandate
- IRS Will Accept “Silent” Tax Returns
- Employer Mandate
- Marketplace Notices
- ACA Fees
- Cadillac Tax Plan
- ACA Reporting Requirements

III. CHANGES TO THE ACA

- Executive Order
- The American Health Care Act
  - Ways and Means Bill
  - Energy and Commerce Bill

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I. CALIFORNIA LEAVE LAWS

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California Paid Family Leave

California PFL Wage Replacement to Increase

- California Paid Family Leave (PFL) offers partial (55%) wage replacement of up to six weeks off of work to bond with a new child or care for a sick family member.

2018 Changes

- Beginning in 2018, wage replacement benefit increases to 60% of an employee's wages
- Lower income worker ($20,000 or less annually) would receive 70% wage replacement

California PFL Maximum Weekly Benefit Increases

- The weekly benefit amount was capped at $1,129

2017 Update

- As of January 1, 2017, the California PFL weekly benefit maximum is increased to $1,173
- Effect on other city leave laws (e.g., San Francisco)

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San Diego, California Paid Sick Leave Ordinance

San Diego, California Enacts Paid Sick Leave Ordinance

Covered Employers

- All employers that “exercise control over the wages, hours and working conditions” of a covered employee that works in the City of San Diego.

Covered Employees

- Employees who work at least 2 hours in the City of San Diego for 1 or more calendar weeks of the year
- The Ordinance does not apply to independent contractors, and certain other short-term and camp program employees.

San Diego, California Enacts Paid Sick Leave Ordinance

Accrual of Leave Time

- Employees begin to accrue sick time on their date of hire or July 11, 2016, whichever is later.
- Employers may cap an employee's accrual of earned sick leave at 80 total hours. Employers may limit an employee's use of paid sick leave to 40 hours in a benefit year.
- Employees may carry over accrued but unused sick leave to the following year.
- Methods of Accruing Sick Time

  - Accrual Method
    - Employers must provide employees with 1 hour of paid sick leave for every 30 hours worked in the City of San Diego
  - Frontloading
    - Employers may award an employee no less than 40 hours of paid sick leave at the beginning of each benefit year
    - All 40 hours must be frontloaded regardless of whether the employee is full-time, part-time, or temporary

San Diego, California Enacts Paid Sick Leave Ordinance

Notice by Employer

- Employers must post a notice regarding sick leave entitlement in a conspicuous place at each work facility located in San Diego. The notice must be posted in English and any language spoken by at least 5% of the employees at that job site.

- Employer must provide each employee a notice of the employer's information, as well as the employer's responsibilities under the Ordinance at the time of hire or October 1, 2016, whichever is later.

Notice by Employee

- Employers may require up to 7 days advance notice of an employee's use of paid sick leave when the need is foreseeable, or as soon as possible if the need is not foreseeable.

- If an employee is absent for more than 3 consecutive days, an employer may request reasonable documentation that the employee used the paid sick leave for a permitted reason.

II. OVERVIEW OF THE AFFORDABLE CARE ACT

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Individual Mandate

Individual Mandate Overview

The ACA's Individual Mandate requires that individuals maintain minimum essential health coverage or potentially be subject to a tax penalty, unless that individual qualifies for an exemption.

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Inflationary Adjustments to the Individual Mandate

Inflationary Adjustments to the Individual Mandate

Individual Mandate Penalties and Limits – 2016 (Due on taxes in 2017)

- Individual Mandate Penalty is the **greater** of the **flat dollar amount,** or **percentage of household income**
  - **Flat Dollar**: $695 per adult and $347.50 per child, per year, in the tax household (up to a flat dollar amount of $2,085 for the entire household); or
  - **Percentage of Household Income**: 2.5% of a family's income in excess of the 2016 income tax filing thresholds
- The penalty, however, is **capped at** the **2016 national average premium cost for a bronze plan**, and those amounts are the following:
  - An adjusted cost of $223 per month, per individual ($2,676 annually); and
  - An adjusted cost of $1,115 per month, for a family of five of more members ($13,380 annually)

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IRS Will Accept “Silent” Tax Returns

IRS Will Accept "Silent" Tax Returns

- The Affordable Care Act's (ACA) Individual Mandate requires that individuals maintain minimum essential health coverage or potentially be subject to a tax penalty
- Penalty is assessed by the IRS when taxpayers report in Line 61 of their Form 1040 whether or not they were enrolled in medical coverage
- Individual tax returns that do not provide coverage information in Line 61 are referred to as **"silent"** returns
- IRS will continue **to accept** and process silent returns

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Employer Mandate

Employer Mandate Overview

Applicable Large Employer must offer

1. **Minimum Essential Coverage** to substantially all (95%) of its full-time employees;

2. **Affordable** coverage that provides **minimum value** to all full-time employees

Or potentially be subject to a penalty

Employers Subject to the Mandate - ALEs

Employers with 50 or more:

- Full-time (FT) employees
  - 30 or more hours of service per week, or 130 hours of service per month
- Full-time equivalent (FTE) employees
  - Non-FT employees in any month (add up total hours, up to 120/EE, and divide by 120)

Based on Average Number of Employees in Prior Calendar Year

- Whether an employer is an ALE depends on the average size of their workforce during the **previous calendar year**

Seasonal Workers May Be Excluded From FT/FTE Count If:

- Employer employs 50 FT and/or FTE employees for 120 or fewer days; and
- Employees in excess of 50 FT and/or FTEs are seasonal workers

"Seasonal worker" is vaguely defined as a worker who performs work on a seasonal basis; however, employers are left to apply a reasonable, good faith basis in defining an employee as a seasonal worker

What Medical Benefits Must be Offered to Eligible Full-Time Employees?

Play or Pay – The First Requirement

- "Minimum Essential Coverage" (MEC) must be offered to substantially all (≥ 95%) FT employees and dependent children
- MEC
  - Government sponsored programs, employer-sponsored plans, plans in the individual market, and grandfathered health plans
  - If an employee is eligible for TRICARE because of employment with the Employer, that employee will be considered to have been offered MEC
- If MEC is not offered to substantially all (≥ 95%) FT employees (and dependent children), employer pays **penalty to the IRS of $2,000 (indexed for inflation to $2,160 in 2016) for all FT employees over 30 employees**, if at least one employee:
  - Purchases insurance through an exchange; and
  - Receives a subsidy from the government to purchase the coverage

What Medical Benefits Must be Offered to Eligible Full-Time Employees? (Continued)

Play or Pay – The Second Requirement

- An employer with 50 or more FT/FTE employees must offer to all FT employees
  - "**Affordable" and "Minimum Value (MV)"** medical benefits
- Otherwise, the employer pays a penalty of **$3,000 (indexed for inflation to $3,240 in 2016)** to the IRS for **each** employee who:
  - Is not offered Affordable, MV benefits; and
  - Enrolls in a medical plan through an Exchange; and
  - Receives a subsidy from the government through an Exchange
- Penalties are not tax-deductible

What Medical Benefits Must be Offered to Eligible Full-Time Employees? (Continued)

Play or Pay – The Second Requirement

- **Affordable** means the payroll deductions for employee-only coverage for the least expensive plan offering MV coverage may not exceed 9.5% (**indexed for inflation to 9.66% in 2016 and 9.69% in 2017**) of an employee's "Household Income"

- **Safe Harbors**

  - The employer may use an employee's taxable income (W-2, Box #1)

  OR

  - An hourly employee's hourly rate times 130, and
  - A salaried employee's monthly rate of pay
    - These use gross rather than net pay after pre-tax deductions

  OR

  - 9.5% (9.69% for 2017) of the Federal Poverty Level

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Marketplace Notices

Marketplace Notices

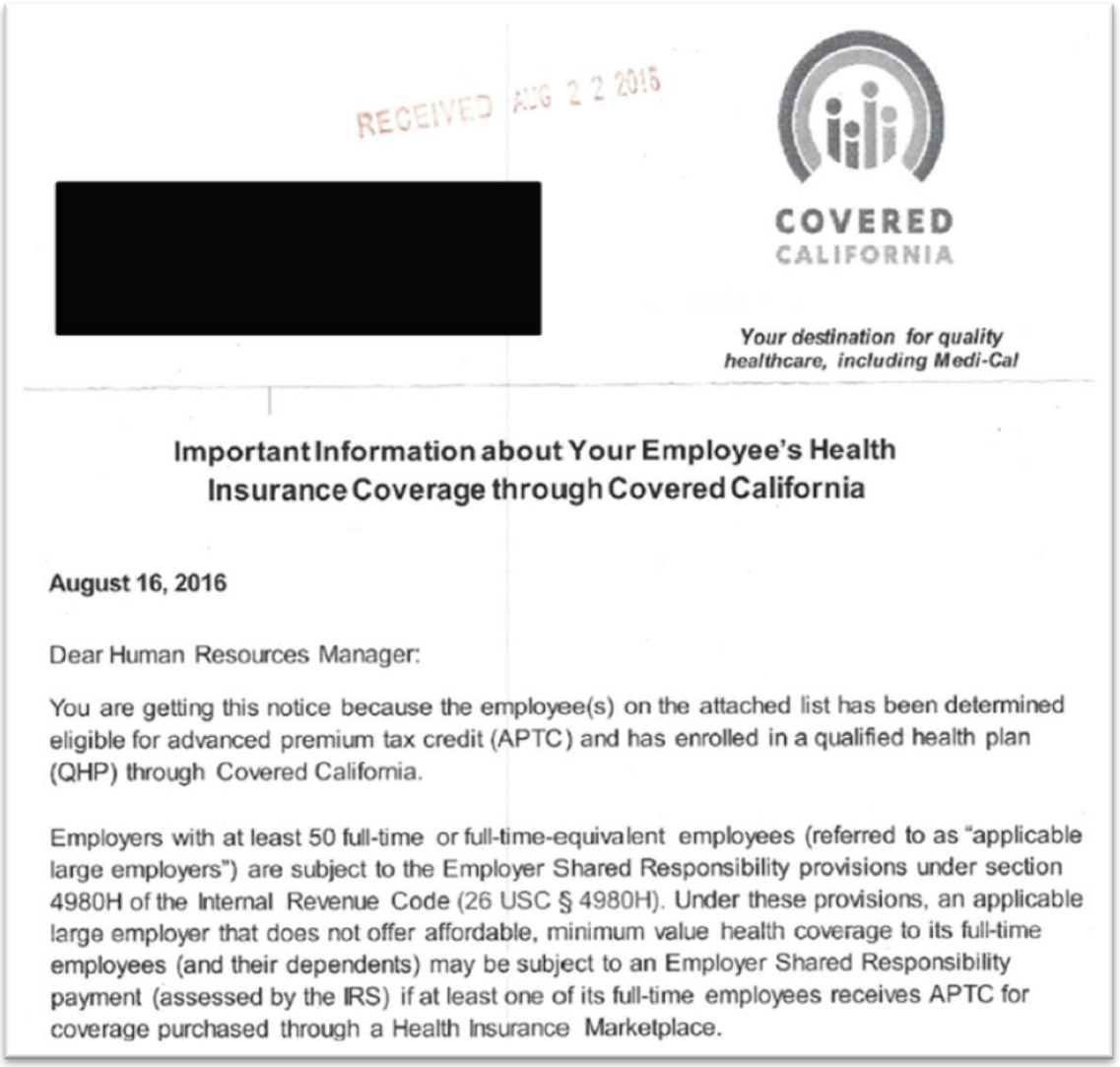
What is a Marketplace Notice?

- A letter from the Department of Health and Human Services (DHHS) explaining that an individual:
  - Claims to be an employee, or former employee, of the employer; and
  - Claims they did not receive an offer of coverage from the employer for at least one month; or
  - Claims the plan was not affordable, or did not provide minimum value coverage;
  - Purchased coverage through the Marketplace; and
  - Was determined to be eligible for a premium tax credit for at least one month.

- Explains employers' appeal rights

- Does not assess penalties (IRS does this separately)

Marketplace Notices



RECEIVED AUG 2 2 2016

[redacted]

COVERED CALIFORNIA

Your destination for quality healthcare, including Medi-Cal

Important Information about Your Employee's Health Insurance Coverage through Covered California

August 16, 2016

Dear Human Resources Manager:

You are getting this notice because the employee(s) on the attached list has been determined eligible for advanced premium tax credit (APTC) and has enrolled in a qualified health plan (QHP) through Covered California.

Employers with at least 50 full-time or full-time-equivalent employees (referred to as "applicable large employers") are subject to the Employer Shared Responsibility provisions under section 4980H of the Internal Revenue Code (26 USC § 4980H). Under these provisions, an applicable large employer that does not offer affordable, minimum value health coverage to its full-time employees (and their dependents) may be subject to an Employer Shared Responsibility payment (assessed by the IRS) if at least one of its full-time employees receives APTC for coverage purchased through a Health Insurance Marketplace.

Marketplace Notices (Continued)

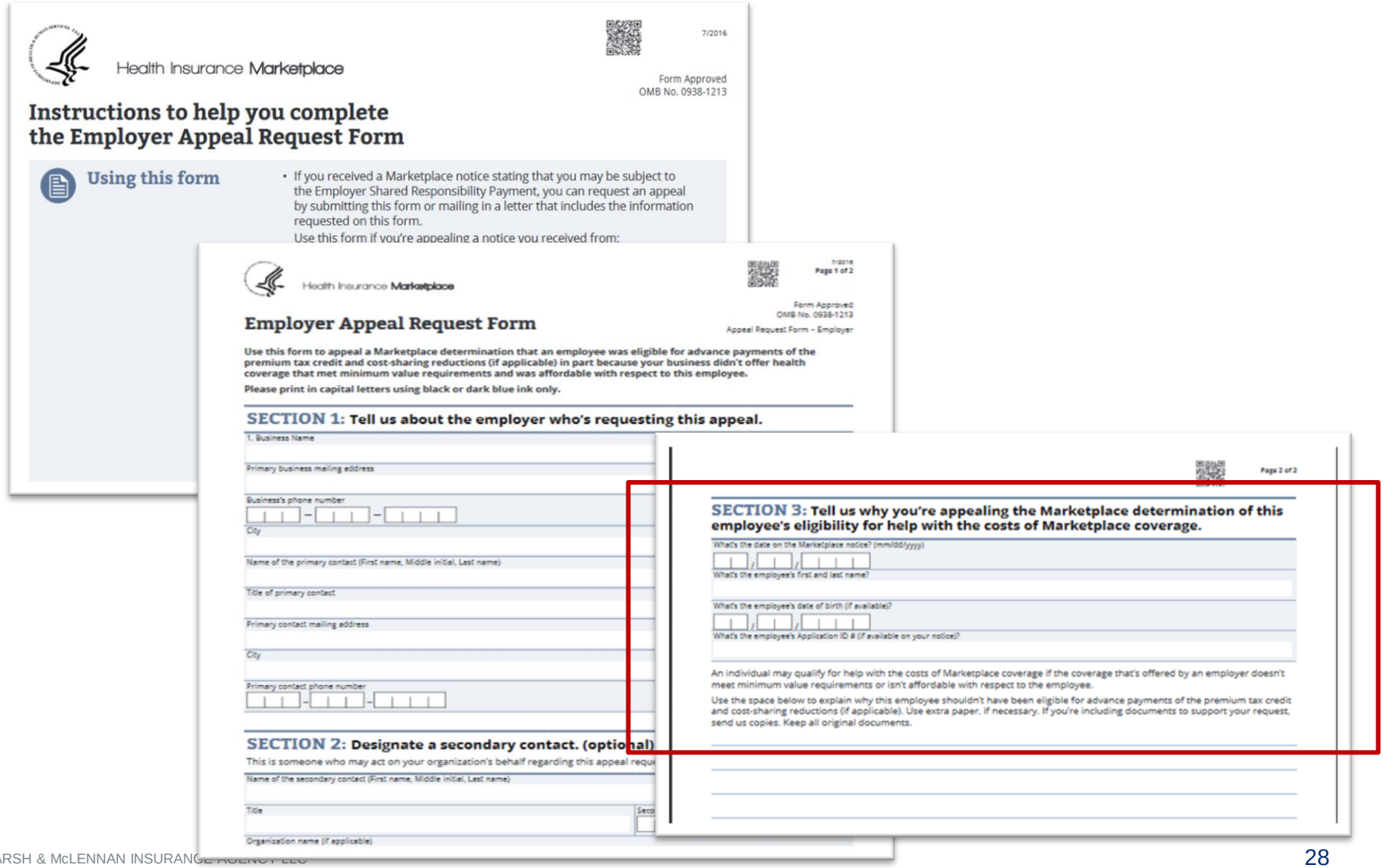
Why Appeal?

- Provide correct information (e.g., employer offered coverage, but employee waived it)
- Explain situation to DHHS, and provide evidence in case IRS imposes penalty based on erroneous information

How To Appeal

- Instructions and Appeal Form provided with Marketplace Notice
- Employer Appeal Request Form also provided with Marketplace Notice
  - Section 1: Provide business contact info
  - Section 2 (Optional): Designate secondary contact
  - Section 3: Explain why it is appealing
  - Section 4: Sign and date Form
  - Complete and submit within 90 days of the date on the Notice

Marketplace Notices



Health Insurance Marketplace

7/2016

Form Approved
OMB No. 0938-1213

Instructions to help you complete the Employer Appeal Request Form

Using this form

- If you received a Marketplace notice stating that you may be subject to the Employer Shared Responsibility Payment, you can request an appeal by submitting this form or mailing in a letter that includes the information requested on this form.

Use this form if you're appealing a notice you received from:

Health Insurance Marketplace

7/2016
Page 1 of 2

Form Approved
OMB No. 0938-1213

Employer Appeal Request Form

Appeal Request Form – Employer

Use this form to appeal a Marketplace determination that an employee was eligible for advance payments of the premium tax credit and cost-sharing reductions (if applicable) in part because your business didn't offer health coverage that met minimum value requirements and was affordable with respect to this employee.

Please print in capital letters using black or dark blue ink only.

SECTION 1: Tell us about the employer who's requesting this appeal.

1. Business Name

Primary business mailing address

Business's phone number

City

Name of the primary contact (First name, Middle initial, Last name)

Title of primary contact

Primary contact mailing address

City

Primary contact phone number

SECTION 2: Designate a secondary contact. (optional)

This is someone who may act on your organization's behalf regarding this appeal requ

Name of the secondary contact (First name, Middle initial, Last name)

Title

Organization name (if applicable)

Page 2 of 2

SECTION 3: Tell us why you're appealing the Marketplace determination of this employee's eligibility for help with the costs of Marketplace coverage.

What's the date on the Marketplace notice? (mm/dd/yyyy)

What's the employee's first and last name?

What's the employee's date of birth (if available)?

What's the employee's Application ID # (if available on your notice)?

An individual may qualify for help with the costs of Marketplace coverage if the coverage that's offered by an employer doesn't meet minimum value requirements or isn't affordable with respect to the employee.

Use the space below to explain why this employee shouldn't have been eligible for advance payments of the premium tax credit and cost-sharing reductions (if applicable). Use extra paper, if necessary. If you're including documents to support your request, send us copies. Keep all original documents.

Marketplace Notices (Continued)

So, No ACA Penalty?

- Not *yet*.
- The DHHS Marketplace Notice, is just that—a notice.
- IRS makes an independent determination of whether an employer is liable for an ACA penalty.
- IRS will send a separate notice of payment, if this is the case.

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ACA Fees

Taxes & Fees under the ACA

Year	Provision	Insured / Self-funded	Applies to	Fee	Description
2012 to 2019 (temporary)	**Patient-Centered Outcomes Research Fee (Comparative Effectiveness Fee)**	Insured and Self-funded	Medical	$2.17 / covered life for plan policy years ending before 10/1/16 and on or after 10/1/2015 (TBD for future years) $2.26 / covered life for plan policy years ending before 10/1/17 and on or after 10/1/16	• Will be used to fund clinical outcomes effectiveness research • For fully-insured plans, fee paid by insurance company • For self-insured plans, fee paid by plan sponsor (employer) & are due the year after the plan year by July 31
Ongoing 2014 & Beyond (1)	**Health Insurer Fee**	Fully-Insured	Medical, Dental & Vision	Industry fee of $8 billion in 2014, increasing to $14.3 billion in 2018, and increasing each year thereafter at the rate of premium growth. **Approximately 2–5% fee**	• Fee to help pay for premium subsidies and tax credits for qualifying individuals purchasing health insurance through Exchanges • Fee imposed on Health Insurers
2014 to 2016	**Transitional Reinsurance Contribution Program**	Insured and Self-funded	Medical	Aggregate fee of $25 billion over the three-year period. Annual per member fee for 2014 was $63 and **decreased in 2015 to $44 per member; for 2016 the fee is $27 per enrolled member.**	• Used to fund state non-profit reinsurance entities to help finance the cost of high-risk individuals in the individual market • Contributions will be collected on annual basis beginning 01/15/2015 and ending November 2017 • Self-funded Third-party Administrator may remit fee for self-funded plans
Ongoing 2020 & Beyond (2)	**High-Value Plan Tax (Cadillac Tax)**	Insured and Self-funded (guidance pending)	Medical	Plans that annually cost more than $10,200 (single) or $27,500 (family) are subject to a 40% excise tax on the amount above the costs	• Fee assessed on high-premium health plans, including HSA, FSA and HRA • Future guidance expected

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Cadillac Tax Plan

Cadillac Tax Plan

Background

- 40 percent excise tax on the aggregate cost of coverage per month above the threshold applicable dollar limit for an employee for that month
- Annual thresholds for 2018 (maybe 2020?) will be $10,200 for individual coverage, and $27,500 for other than self-only coverage
- All applicable coverage under a Multiemployer plan is to use the “other than self-only coverage” threshold
- 40 percent tax applies to the cost of coverage that exceeds the annual threshold. Cadillac tax liability will be paid by the “coverage provider” in the ratio that the coverage provider bears to the aggregate cost of all applicable coverage provided to the employee

Implementation of the Cadillac Tax delayed an additional two years, until 2020

Cadillac Tax Plan (Continued)

New 2016 Federal Budget Deal Highlights:

- Removes the provision prohibiting the Cadillac Tax from being deducted as a business expense

- Requires a study to be conducted on the age and gender adjustment to the annual limit ($10,200 for self-only and $27,000 for other than self-only)

Cadillac Tax Plan (Continued)

IRS Notices 2015-16

- **Applicable Coverage***
  - Health FSAs
  - Archer MSAs (paid with pre-tax contributions)
  - HSAs (paid with pre-tax contributions)
  - Governmental Plans
  - On-site medical clinics that provide more than de minimis services
  - Retiree coverage
  - Multiemployer plans
  - Specified disease or illness plans/fixed indemnity plans (paid with pre-tax contributions)

*Generally, the cost of coverage will include all coverage under any group health plan which is excludable from the employee's gross income (IRC Section 106). This means even account-based coverage such as HSAs, Archer MSAs, and HRAs need to be included in the cost of coverage, unless they are received as an after-tax benefit by the employee

Cadillac Tax Plan (Continued)

- **Non-Applicable Coverage**
  - Coverage 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 insurance
  - Workers' compensation or similar insurance
  - Automobile medical insurance
  - Credit-only insurance
  - Secondary or incidental to other insurance coverage
  - Long-term care insurance
  - Coverage that substantially consists of either treatment of the mouth or eye
  - Coverage for specified disease or illness and fixed indemnity policies, paid for on a post-tax basis

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ACA Reporting Forms

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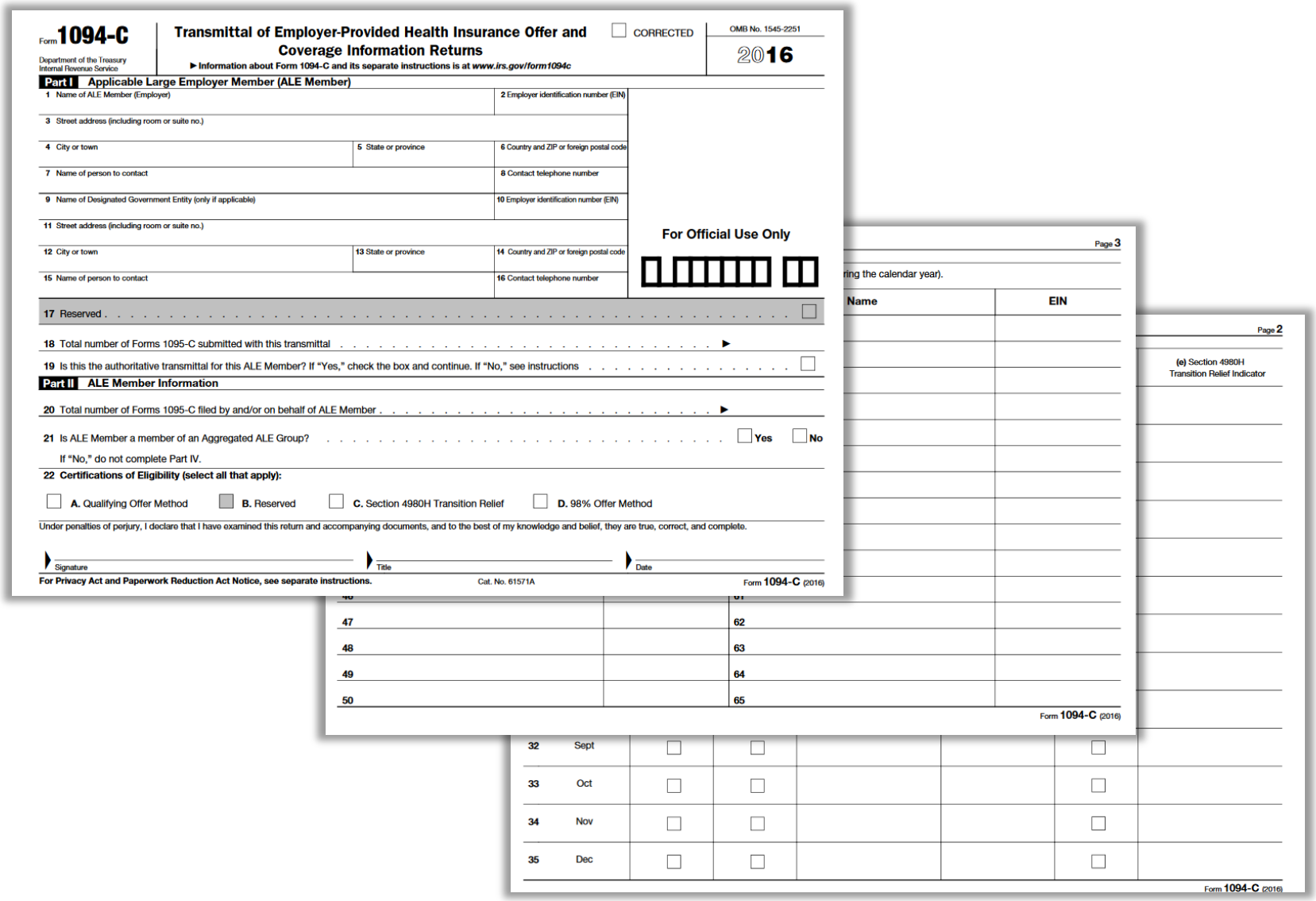
Form 1094-C, Transmittal to IRS

Form 1094-C



Form **1094-C**
Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

▶ Information about Form 1094-C and its separate instructions is at *www.irs.gov/form1094c*

☐ CORRECTED

OMB No. 1545-2251

2016

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)
2 Employer identification number (EIN)
3 Street address (including room or suite no.)
4 City or town
5 State or province
6 Country and ZIP or foreign postal code
7 Name of person to contact
8 Contact telephone number
9 Name of Designated Government Entity (only if applicable)
10 Employer identification number (EIN)
11 Street address (including room or suite no.)
12 City or town
13 State or province
14 Country and ZIP or foreign postal code
15 Name of person to contact
16 Contact telephone number

For Official Use Only

17 Reserved ☐

18 Total number of Forms 1095-C submitted with this transmittal ▶

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions ☐

Part II ALE Member Information

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member ▶

21 Is ALE Member a member of an Aggregated ALE Group? ☐ Yes ☐ No

If "No," do not complete Part IV.

22 **Certifications of Eligibility (select all that apply):**

☐ **A.** Qualifying Offer Method ☐ **B.** Reserved ☐ **C.** Section 4980H Transition Relief ☐ **D.** 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

Signature ▶ Title ▶ Date ▶

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2016)

Page **3**

ring the calendar year).

Name	EIN

47			62			
48			63			
49			64			
50			65			

Form **1094-C** (2016)

Page **2**

						(e) Section 4980H Transition Relief Indicator
32	Sept	☐	☐			☐
33	Oct	☐	☐			☐
34	Nov	☐	☐			☐
35	Dec	☐	☐			☐

Form **1094-C** (2016)

Form 1094-C Overview

Purpose of Form:

- The 1094-C is the “cover sheet” for all of the 1095-C employee forms that are associated with the ALE member. Every ALE member must file an authoritative transmittal, and an ALE member of a Controlled Group may file an authoritative transmittal on behalf of other ALE members.

Part I, ALE Member

- Lines 1-16: ALE Member Information (Name, Address, Contact Person, etc.)
- Line 17: Reserved. (No response needed)
- Line 18: How many Forms 1095-C are attached to **this** Transmittal Form?
- Line 19: Is this the **Authoritative** Transmittal Form?

Part II, ALE Member Information

- Line 20: **Total** Forms 1095-C filed by the ALE Member?
- Line 21: Member of Aggregated ALE Group?
- Line 22: Indicate status of coverage offered to full time employees ***(Change from 2015 Forms: Box “B” is Reserved)***

Form 1094-C Overview

Part III, ALE Member Information – Monthly

- **Column (a)**: Indicate whether MEC was offered to the employee for that month. MEC is employer sponsored coverage that does not include HIPAA excepted benefits. To avoid § 4980H(a), offer MEC to 95% (for 2016 and beyond) of FT employees (and dependent children)
- **Column (b)**: # of FT employees of ALE (Leave Blank if 98% Offer)
- **Column (c)**: Total employee count (PT and FT EEs) for ALE; count must be made consistently (first day or last day of each month)
- **Column (d)**: Months ALE member was part of a Controlled Group/Affiliated Services Group
- **Column (e)**: Indicate eligibility for transitional relief in 2016. Enter "A" to indicate delay of penalties and eligibility for Transition Relief because of size (50-99 FT/FTE EEs), and employer did not substantially reduce health benefits. Enter "B" if employer qualifies for transition relief to delay penalties for a non-calendar year plan (100 or more FT/FTE EEs, offered or covered significant # of EEs prior to February 9, 2014)

Part IV, Other ALE Members of Aggregate ALE Group

- Leave blank if **not** in a Controlled Group/Affiliated Services Group
- Otherwise, list all ALE members, in descending order in the number of EEs, starting with the ALE member with the most EEs

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Form 1095-C, ALE Report/Statements

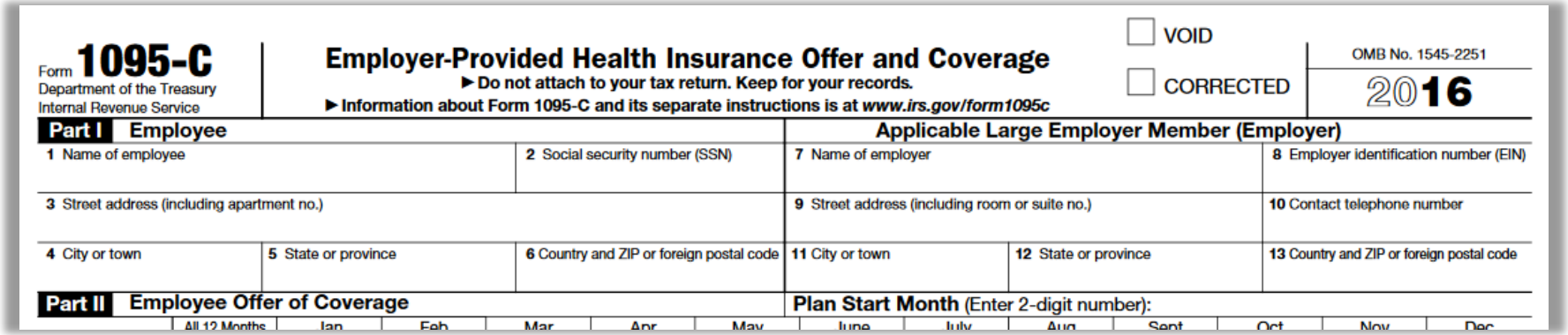
Form 1095-C, Part I: Employee Information

Purpose of Form:

- Form 1095-C identifies all FT employees (and covered individuals of a self-funded plan) of an ALE member. These statements will be delivered to employees, and attached to an ALE member's Form 1094-C. Part I contains information about the employee and ALE member.

Self-funded plans: ALE will file Form 1095-C for EACH FT EMPLOYEE, in addition to ANY individual who ENROLLS in the self-funded coverage.

Fully-Insured plans: ALE will file 1095-C Form for EACH FT EMPLOYEE (Generally, unless the above Self-funded rule applies).



Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
► Do not attach to your tax return. Keep for your records.
► Information about Form 1095-C and its separate instructions is at *www.irs.gov/form1095c*

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2016

Part I Employee

1 Name of employee	2 Social security number (SSN)
3 Street address (including apartment no.)	
4 City or town	5 State or province / 6 Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	10 Contact telephone number
11 City or town	12 State or province / 13 Country and ZIP or foreign postal code

Part II Employee Offer of Coverage

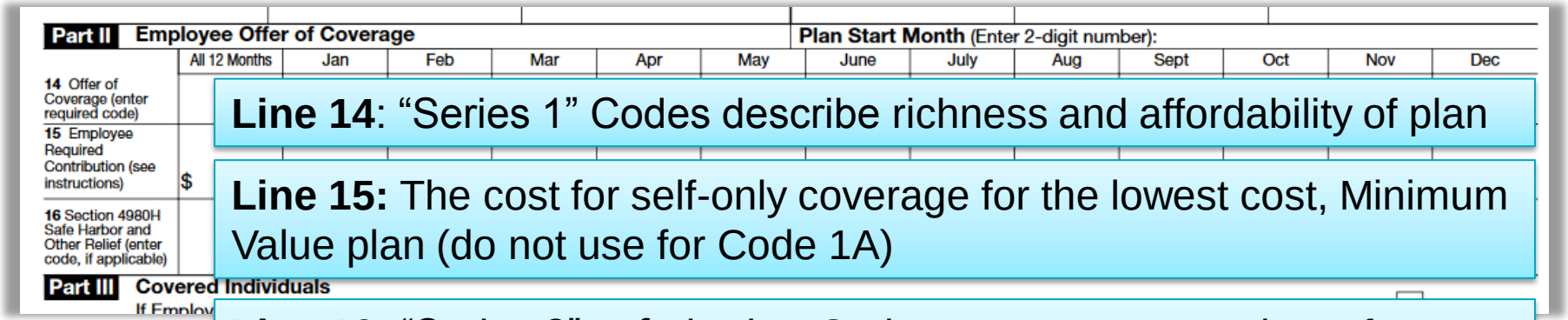
Plan Start Month (Enter 2-digit number):

All 12 Months | Jan | Feb | Mar | Apr | May | June | July | Aug | Sept | Oct | Nov | Dec

Form 1095-C, Part II: Employee Offer and Coverage

Part II Overview:

Part II is a report on 1) the kind of coverage offered and 2) to whom the coverage was offered. This information will be reported in the form of a Code, and an employer may be required to include the cost of coverage to the employee for the lowest cost, Minimum Value (MV) plan. Finally Row 16 of Part II will be used to indicate whether a penalty would be assessed against the employer, or the employer would not be subject to a penalty because of a safe-harbor rule.



Part II Employee Offer of Coverage — **Plan Start Month** (Enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Required Contribution (see instructions)	$												
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

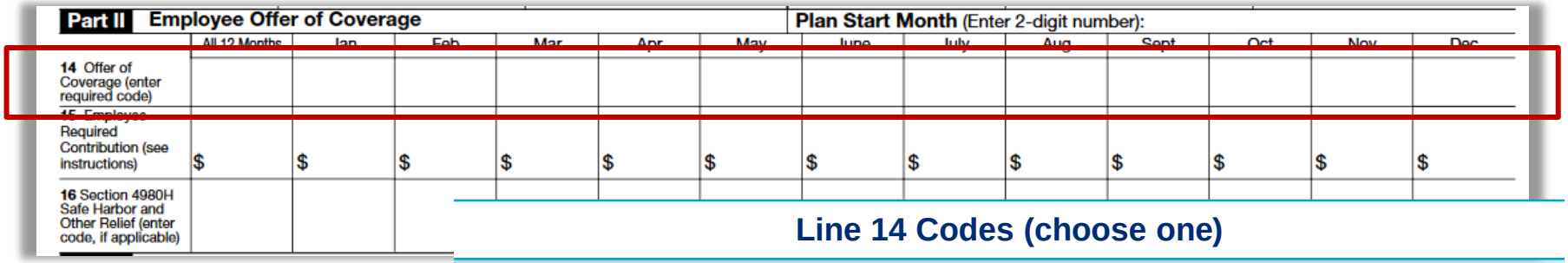
Part III Covered Individuals

Line 14: "Series 1" Codes describe richness and affordability of plan

Line 15: The cost for self-only coverage for the lowest cost, Minimum Value plan (do not use for Code 1A)

Line 16: "Series 2" safe-harbor Codes may protect employer from penalties if EE was not offered MEC, or coverage was not affordable, or did not provide MV coverage

Form 1095-C, Part II: Employee Offer and Coverage (Continued)



Part II Employee Offer of Coverage	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Note: A code must be entered for each calendar month, even if they are not a FT employee for all months. Enter ACTUAL coverage offered, not TREATED as offering.

Line 14 Codes (choose one)

1A: Affordable (9.5% of FPL) and MV (60%+) Plan to FT EE + MEC offered to Spouse & Children

1B: MV (60%+) Plan to EE only

1C: MV (60%+) Plan to EE + MEC offer to Children only

1D: MV (60%+) Plan to EE + MEC to Spouse only

1E: MV (60%+) Plan to EE + MEC to Spouse & Children

1F: MEC offered to EE; or EE + Spouse; or EE+ S&C

1G: Non-FT EE enrolled in SF Plan for any month

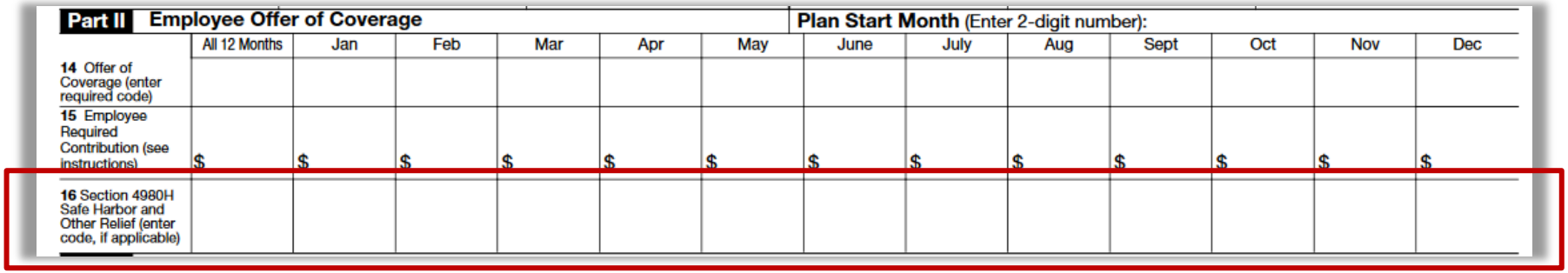
1H: No offer of MEC to EE

~~**1I: Code reserved; 2015 QO Transition Relief no longer available**~~ ***(2016 Update)***

1J: MEC + MV Plan to EE, MEC conditionally offered to Spouse, MEC not offered to Children ***(2016 Update)***

1K: MEC + MV Plan offered to EE, MEC conditionally offered to Spouse, MEC offered to Children ***(2016 Update)***

Form 1095-C, Part II: Employee Offer and Coverage (Continued)



Part II Employee Offer of Coverage	Plan Start Month (Enter 2-digit number):												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Line 16 is designed to help determine how penalties may or may not apply to a specific1095-C employee. Series 2 Codes notify the employee and the government of whether the employee may or may not have been entitled to a subsidy. For example, if coverage was not offered to a variable hour employee during their initial measurement period, 2D is entered for that month.

Line 16 Codes (choose one)

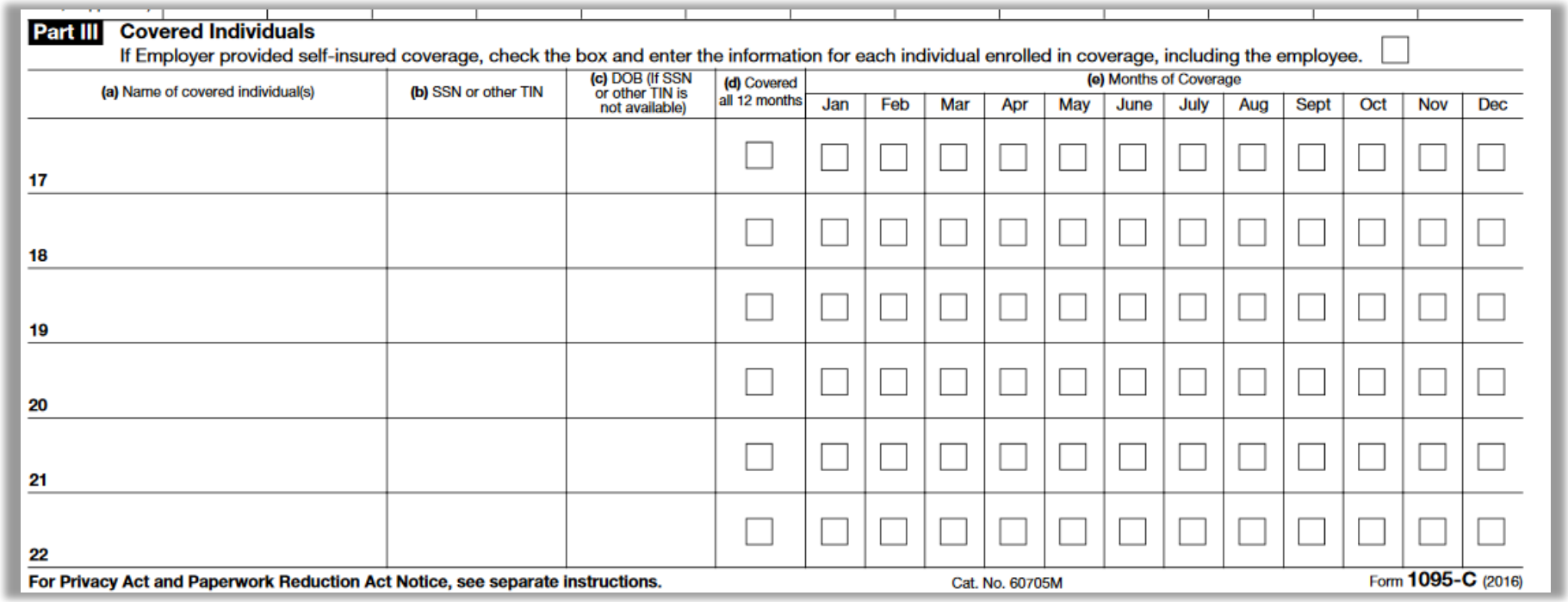
2A. EE not employed in month
2B. EE non-FT employee
2C. EE enrolled in coverage (do NOT put other Codes)
2D. EE in Limited Non-Assessment Period (LNP) (LNPs located on next slide)
2E. Multi-Employer Transition Relief
2F. Safe Harbor Affordable coverage-Form W-2 Method
2G. Safe Harbor Affordable coverage-FPL Method
2H. Safe Harbor Affordable coverage-Rate of Pay Method
~~2I. TR for non-CY months prior to EE being offered MV/Affordable coverage (avoids 4980H(b) penalty)~~ ***(2016 Update)***

Form 1095-C, Part II: Employee Offer and Coverage (Continued)

Line 16 "Safe Harbor" Codes	Notes/Penalties
2A. EE not employed in month	No penalty would be assessed for the month
2B. EE non-FT employee	No penalty would be assessed for the month
2C. EE enrolled in coverage (do NOT put other Codes)	No penalty would be assessed for the month
2D. EE in Limited Non-Assessment Period (LNP)	No penalty would be assessed for the month
2E. Multi-Employer Transition Relief	No penalty would be assessed for the month
2F. Safe Harbor Affordable coverage-Form W-2 Method	Penalty may still be assessed for the month if MV coverage was not offered
2G. Safe Harbor Affordable coverage-FPL Method	Penalty may still be assessed for the month if MV coverage was not offered
2H. Safe Harbor Affordable coverage-Rate of Pay Method	Penalty may still be assessed for the month if MV coverage was not offered

Form 1095-C, Part III: Covered Individuals

Part III need ONLY be completed if an employee (or other individual) is covered by a **self-funded** employer plan. Add employee, spouse, and dependent children covered under the self-funded plan during all or part of the year.



Part III **Covered Individuals**

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2016)

MEC and ALE Reporting: Recap

	MEC Reporting	ALE Reporting
Purpose	Individual Mandate	Employer Mandate and subsidy eligibility
Recipient	“Responsible individual”	Any EE or individual who receives a 1095-C
Filer	Insurer for insured plan Plan Sponsor of self-funded	ALE (insured or self-insured)
Forms	Insurers & Self-Funded non-ALEs: 1094-B and 1095-B	1094-C and 1095-C
Deadlines	Employee Reporting: **1/31** Transmittal: **2/28** (paper) or **3/31** (electronic)	Same
Essential Information	Who was enrolled in MEC by month + employer offer information	Who was offered what kind of Coverage, and for which months

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2016 Updates to Forms 1094/1095-C and Instructions

IRS Issues 2016 Instructions for 1094/1095-C Forms

Filing Deadlines

- "**New**" Filing Deadlines
  - Form 1095-C must be furnished to employees by **January 31, 2017**
  - Forms 1094-C and 1095-C must be filed with the IRS by **February 28, 2017** for paper filing of the Forms, or **March 31, 2017** if Forms are filed electronically.
  - Employers may request extensions using Form 8809, but extensions are not automatic.
  - Employers required to file electronically may request a waiver from electronic submission, using Form 8508

IRS Issues 2016 Instructions for 1094/1095-C Forms (Continued)

Filing Deadlines

- Existing Multiemployer Plan Relief Extended
  - The 2016 Instructions extend the existing interim relief for multiemployer plans for another year. An ALE Member that is required to contribute to a multiemployer plan on behalf of the employee for that month is treated as having offered coverage (provided the plan is affordable to the employee, provides minimum value to the employee, and offers dependent children coverage), regardless of whether the employee was eligible for, or enrolled in coverage under the multiemployer plan.
  - Identical to the 2015 Form 1095-C Instructions, qualifying ALE Members can enter Code “1H” (no offer of coverage) on Line 14 for any month that they enter Code “2E” (multiemployer interim relief) on Line 16.
  - **However, the 2016 Instructions caution that this approach may change for 2017**.

IRS Issues 2016 Instructions for 1094/1095-C Forms (Continued)

Clarification of COBRA Continuation Coverage

- ALE Members offering COBRA coverage to former employees should report Code “1H” (no offer of coverage) in Line 14, and “2A” (employee not employed during the month) in Line 16. However, ALE Members offering COBRA coverage to employees that **remain employed** should report this as an offer of coverage.

- An ALE Member is treated as having offered coverage to the employee’s dependents for the entire plan year so long as the ALE Member gave the employee an effective opportunity to enroll dependents at least once during the plan year, even if the employee declined to enroll the dependents, and as a result, the dependents did not receive an offer of COBRA coverage.

- Finally, post-employment (non-COBRA) coverage offers should not be reported as offers of coverage on Line 14 of Form 1095-C (i.e., ALE Members may use “1H” in Line 14 and “2A” in Line 16).

IRS Issues 2016 Instructions for 1094/1095-C Forms (Continued)

Additional Form 1095-C Codes and Clarifications

- "1A" in Line 14: ALE Members that properly enter Code "1A," (Qualifying Offer Method) on Line 14 of Form 1095-C, do not need to fill out related boxes on Line 15 or Line 16.
- "1I" in Line 14 and "2I" in Line 16: These codes are no longer applicable, and have been reserved.
- "1J" and "1K" in Line 14: These new codes report an ALE Member's conditional offer of coverage to an employee's spouse. A conditional offer of coverage is one that is subject to one or more reasonable, objective conditions (e.g., an offer that is available to a spouse only if the spouse certifies that she/he does not have access to health care coverage from another employer). These conditions attached to an offer of coverage to a spouse may impact the spouse's eligibility for a tax credit. Previously, all offers to an employee's spouse were reported in the same manner.

IRS Issues 2016 Instructions for 1094/1095-C Forms (Continued)

Additional 1095-C Codes and Clarifications

- Expiration of Certain Transition Relief for 2015 Plan Years
  - The 2016 Instructions only include information on transition relief available to qualifying non-calendar year plans for 2016 calendar months.
  - This clarifies that several forms of transitional relief previously available for 2015 calendar year plans, or the 2015 plan year, are no longer available for 2016.

IRS Issues 2016 Instructions for 1094/1095-C Forms (Continued)

Increased Penalties

- The Instructions explain that the penalties for improper filings are now $260 per form (previously $250 per form for 2015 filings). Employers that are required to file electronically but fail to do so may be subject to a penalty of $260 per return. The penalty applies separately to original returns and corrected returns.

- Fortunately, employers who accidently file paper returns that are required to do so electronically, can file up to 250 returns on paper without penalty (i.e., the employer will only be liable for the $260 per return penalty for each return after 250). Employers may be able to avoid the penalty if they show reasonable cause for improper filing.

- However, the “good faith” penalty relief available to ALE Members for incorrect or incomplete statements appears to be limited to filings in 2016 (for 2015 calendar year reporting), is no longer available in 2017.

III. CHANGES TO THE ACA

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Executive Order

Executive Order Summary

- On January 20, 2017, President Trump signed an Executive Order which could potentially begin the process of repealing the Patient Protection and Affordable Care Act (ACA).
- The Executive Order is fairly broad, and does not specify which parts of the ACA will be repealed.
- States will be given more flexibility and control over the healthcare market, and the administration will encourage interstate commerce through the development of a free and open market of healthcare services and insurance.
- The Executive Order does **not** specifically provide relief to “employers” from a “cost, tax, penalty, or regulatory burden” that may be currently imposed on them, **so employers should continue to comply with employer requirements under the ACA**, until further notice.

Executive Order

- The executive branch will take all action necessary to “minimize the unwarranted economic and regulatory burdens of the ACA” to the “maximum extent permitted by law.”
- In order to rescind/repeal existing regulations within the ACA, the agencies must comply with the guidelines under the Administrative Procedures Act (APA)
  - Any new regulations, including any regulations which may not yet have taken effect, can be suspended.
  - The President’s Chief of Staff has instructed agencies to cease issuing new regulations and withdraw any rules which have been sent to the Office of the Federal Registrar until they can be reviewed by the new agency heads.
- The executive order is broken up into 6 parts

Executive Order (Continued)

Section 1 – Pending Repeal

- Section 1 provides that the intent of the Executive Order is to begin the process of the repeal of the ACA

- The executive branch will minimize any “unwarranted economic and regulatory burdens of the ACA,” to allow States more flexibility and control to encourage a more “free and open” healthcare market.

Executive Order (Continued)

Section 2 – Waive, Defer, Grant Exemptions from Fiscal Burdens of the ACA

- Secretary of Health and Human Services (HHS) and the heads of other executive departments and agencies under the ACA have authority to "waive, defer, grant exemptions from, or delay the implementation of any provision or requirement" of the ACA that imposes a "fiscal burden" on a State or a "cost, fee, tax, penalty, or regulatory burden on individuals, families, healthcare providers, health insurers, patients, recipients of healthcare services, purchasers of health insurance, or makers of medical devices, products, or medications."

- Indicates that the intent of the Trump Administration is to relieve as many of the financial burdens associated with the ACA on the healthcare market as possible

Executive Order (Continued)

Section 3 – Greater Flexibility to States

- The Secretary of HHS and all other heads of other executive departments and agencies shall exercise all authority and discretion to create more flexibility for States and shall "cooperate with them in implementing healthcare programs."

Executive Order (Continued)

Section 4 – Free and Open Market

- The head of each department or agency shall encourage the development of a “free and open market” in the offering of healthcare services and health insurance, with the goal of providing options for patients and consumers through interstate commerce

Executive Order (Continued)

Section 5 – Compliance with the Administrative Procedures Act

- The Executive Order will follow the requirements of the Administrative Procedures Act (APA), which requires that any future revision of the regulations will be done through notice-and-comment rulemaking.

Executive Order (Continued)

Section 6 – Does not Affect Certain Other Laws

- The Executive Order:
  - Shall not affect the authority already granted by law to the heads of an executive department or agency
  - Shall not affect the functions of the Director of the Office of Management and Budget
  - Shall be implemented consistent with applicable law, subject to the availability of appropriations
  - Is not intended to, and does not, create any “right or benefit, substantive or procedural, for a party against the United States, its departments, agencies, entities, its officers, employees, or agents, or any other person.”

Executive Order Conclusion

- From an employer perspective, until further regulatory guidance is released, the final regulations implementing the Employer Mandate and its reporting requirements remain in effect and are subject to enforcement by the IRS.

- Once President Trump's appointments to the regulatory agencies occur, new regulations will most likely be proposed to ease the ACA's economic and administrative burdens, although the process will take some time.

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The American Health Care Act

AHCA

- On March 9, 2017, the House of Representatives' Ways and Means Committee and the Energy and Commerce Committee approved the American Health Care Act (AHCA)
- The AHCA is a collection of budget reconciliation bills designed to repeal and replace the Patient Protection and Affordable Care Act (ACA).
- At the moment, it is unclear which of the above provisions will remain, and which provisions will be amended.
- Until a final version of the AHCA is approved by both houses of Congress and signed into law by President Trump, the ACA remains in effect.

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Ways and Means Bill

Ways and Means Bill

- The budget reconciliation bill advanced by the Ways and Means Committee contains five (5) components:
  - Health-Related Tax Policy
  - Tanning Tax
  - Net Investment Tax
  - Remuneration from Certain Insurers
  - Consumer Taxes

Ways and Means Bill (continued)

Repealing and Replacing Health-Related Tax Policy

Employer Mandate

- The Employer Mandate requires employers to offer affordable, Minimum Value coverage, to their full-time employees, or potentially be subject to a tax penalty.

- The bill would effectively repeal the Employer Mandate by reducing the tax penalty for failure to offer minimum essential coverage to $0
  - Effective for months beginning **after December 31, 2015**
  - This would provide retroactive relief to employers who may be subject to the Employer Mandate penalty in 2016.

- The bill proposes simplified employer reporting of offers of coverage on employees' W-2s.

Ways and Means Bill (continued)

Repealing and Replacing Health-Related Tax Policy (continued)

Individual Mandate

- Requires that individuals maintain minimum essential health coverage or potentially be subject to a tax penalty.

- This section effectively repeals the Individual Mandate by reducing the tax penalty for failure to maintain minimum essential coverage to $0
  - Effective for months beginning **after December 31, 2015**
  - This would provide retroactive relief to individuals from the Individual Mandate penalty in 2016.

Ways and Means Bill (continued)

Repealing and Replacing Health-Related Tax Policy (continued)

Premium Tax Credits for the Purchase of Coverage in the Marketplace/Exchange

- Currently, individuals and families (with a household income of no more than 400% of the federal poverty level (FPL)) are eligible for a refundable premium tax credit to assist them with the payment of health insurance premiums purchased through their State Marketplace/Exchange.
  - If the income of a household increases during the tax year, a household may receive greater premium tax credit than they may be entitled to
  - Currently, households must repay excess credits **over a certain threshold**

- This bill would require **full** repayment of any excess premium tax credits paid to a household

- Premium tax credits limited to “catastrophic only” plans

- Disallow use of premium tax credits on policies that cover elective abortions.

Ways and Means Bill (continued)

Repealing and Replacing Health-Related Tax Policy (continued)

Refundable Tax Credit for Health Insurance

- The bill creates a new advanceable and refundable age-adjusted tax credit for eligible individuals to use to purchase individual health insurance

- The tax credit amount the lesser of:
  - (1) the actual amount taxpayers paid for coverage for themselves and their families or
  - (2) 1/12 of the annual age-adjusted tax credit amount for the taxpayer and family members.

- The annual age-adjusted tax credits are as follows:
  - Under age 30: $2,000
  - Age 30 to 39: $2,500
  - Age 40 to 49: $3,000
  - Age 50 to 59: $3,500
  - Over age 60: $4,000

- The credits are additive for a family, up to an annual maximum of $14,000

- The full amount of the tax credit is available to individuals making $75,000 per year ($150,000 for joint filers).
  - Tax credit phases out by $100 for every $1,000 in income above the $75,000 threshold.

Ways and Means Bill (continued)

Repealing and Replacing Health-Related Tax Policy (continued)

Small Business Tax Credit

- Currently, certain small businesses are eligible for a healthcare tax credit of up to 50% of premium costs.
- This section repeals that small tax credit beginning January 1, 2020.
- Between 2018 and 2020, this small business tax credit would not be available with respect to qualified health plans that provide coverage for elective abortion services.

Delay of the Cadillac Tax

- The Cadillac Tax is a 40% excise tax on high cost employer-sponsored health plans, which is assessed on every dollar above a specified threshold set by the government.
- Under the bill, the Cadillac Tax would not apply for any taxable period beginning after December 31, 2019 and before January 1, 2025. In other words, the Cadillac Tax may still apply for taxable periods beginning **after December 31, 2024**.

Ways and Means Bill (continued)

Repealing and Replacing Health-Related Tax Policy (continued)

Non-Taxable Accounts for Health Care

Health Savings Accounts

- The bill:
  - Reduces the tax penalty from 20% to 10% for non-qualified health expenses that are paid from an HSA.
  - Increases the HSA maximum contribution limit to equal the high-deductible health plan (HDHP) out-of-pocket (OOP) (for 2017, the HDHP OOP limit is $6,550 for individual coverage and $13,100 for family coverage), effective on **January 1, 2018**.
  - Spouses (age 55 or older) would be permitted to make their catch-up contributions to the same HSA, beginning **January 1, 2018** (currently, spouses can only make catch-up contributions to their **own**, **separate** HSA account).
  - HSA funds may be used to pay for qualified medical expenses incurred **before** an HSA is actually established (currently this is left to a State to decide on when HSA funds may be used).

Ways and Means Bill (continued)

Repealing and Replacing Health-Related Tax Policy (continued)

Non-Taxable Accounts for Health Care (continued)

Flexible Spending Accounts

- Currently, FSAs were limited to an annual employee contribution amount of $2,500 (indexed for inflation).

- The bill would provide employees with an ability to contribute an unlimited amount to an FSA, for taxable years beginning **after December 31, 2017**.

Over-the-Counter Medications and Non-Taxable Accounts for Health Care

- Currently, individuals cannot use funds from an HSA, FSA or HRA, to pay for over-the-counter medications.

- The bill would allow monies from a tax-advantaged health care account (HSA, FSA, HRA) to pay for over-the-counter medication, which would be effective **January 1, 2018**.

Ways and Means Bill (continued)

Repealing and Replacing Health-Related Tax Policy (continued)

Retiree Drug Subsidies

- Employers would be permitted to take a business-expense deduction for an employer sponsored retiree drug prescription plan without having to reduce the deduction by the amount of the federal subsidy under the Retiree Drug Subsidy program (which is currently disallowed under the ACA).

Decrease in Percentage of Medical Expense Deduction

- Currently, taxpayers who itemize their deductions may deduct qualifying medical expenses for expenses that exceed 10% of the taxpayer's adjusted gross income (AGI). There is also a temporary special rule that if a taxpayer or their spouse is age 65 or older, the AGI threshold is 7.5%.
- This bill decreases the AGI threshold to 7.5% for **all** (including those age 65 or older) taxpayers beginning in **2018**.

Ways and Means Bill (continued)

Repeal of Other Taxes

- Repeals the current 2.3% excise tax on the sale of certain medical devices beginning **January 1, 2018**
- Repeals the 10% sales tax on tanning services beginning in **2018**
- Repeals the 3.8% tax on net investment income of high income individuals, estates, and trusts with income above a certain threshold ($200,000 for a single individual) beginning in **2018**
- Repeals the Additional Medicare tax of 0.9% for high income ($200,000 for a single individual) earning employees (or a self-employed individual's income) beginning in **2018**
- Repeals the tax on certain brand pharmaceutical manufacturers for years beginning **January 1, 2018**
- Repeals the Health Insurance Providers Fee beginning **January 1, 2018**

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Energy and Commerce Bill

Energy and Commerce Bill

- The budget reconciliation bill advanced by the Energy and Commerce Committee (ECC Bill) contains four (4) major components:
  - Patient Access to Public Health Programs
  - Medicaid Program Enhancement
  - Per Capita Allotment for Medical Assistance
  - Patient Relief and Health Insurance Market Stability

Energy and Commerce Bill (continued)

Patient Access to Public Health Programs

- The Prevention and Public Health Fund
  - The PPHF provides funding for public wellness initiatives, including Alzheimer's disease prevention, education, and outreach, diabetes prevention, and suicide prevention.
  - The bill does away with the PPHF program effective 2019, and rescinds any funds remaining in that program at the end of 2018.
- Committee Health Center Program
  - The ACA established the Community Health Center Fund and provided $11 billion over five (5) years for operating and expanding health centers
  - The Fund awards grants to Federally Qualified Health Centers (FQHCs) which provide outpatient medical, dental, mental health, and reproductive services to medically underserved populations.
  - This section would increase funding for the Community Health Center Fund.
- Federal Payments to States
  - One-year freeze on mandatory funding from Medicaid and the Children's Health Insurance Program (CHIP) to certain prohibited entities, such as Planned Parenthood.

Energy and Commerce Bill (continued)

Medicaid Program Changes

- Repeal of Medicaid Provisions and Expansions
  - The bill:
    - Narrows States' authority to make presumptive eligibility determinations (except for children, pregnant women, and patients with breast cancer or cervical cancer),
    - Reverts the mandatory Medicaid income eligibility for children living in poverty back to 100% of the FPL (currently, income eligibility may be 300% of the FPL or greater for children living in poverty).
    - Repeals the ACA's increased six (6) percent of Federal assistance to States
    - Revokes the option to extend coverage to individuals with incomes above 133% of the FPL, effective **January 1, 2020**.
    - Repeals the enhanced Federal assistance to States for newly eligible beneficiaries on **December 31, 2019**.
    - Repeals the requirement that State Medicaid plans provide essential health benefits (required for Exchange plans) starting **January 1, 2020**.

Energy and Commerce Bill (continued)

Medicaid Program Changes (continued)

- Reducing State Medicaid Costs
  - The bill would limit Medicaid eligibility for individuals with home equity above the statutory minimum (set at $500,000 in 2010, plus inflation), beginning with eligibility determinations made more than 180 days **after** this bill is enacted
  - Lottery winnings would no longer be included in determining MAGI
  - For Medicaid applications submitted on and after October 1, 2017, the bill limits retroactive coverage only to the month of the application (currently allow up to 3 months of retroactive benefits)
  - Individuals would be required to provide documentation of citizenship or lawful presence in the U.S. before obtaining Medicaid coverage

Energy and Commerce Bill (continued)

Medicaid Program Changes (continued)

- Per Capita Allotment for Medical Assistance
  - This section creates a per capita cap model which caps Federal payments to States per enrollee, effective January 1, 2019
  - States that spend more than their targeted amount (calculated using each state's 2016 spending as a base year) in one year will have their Medicaid funding reduced the following year
  - Certain individuals are exempt from these caps, including CHIP recipients, patients receiving medical assistance through an Indian Health Service facility, and those covered under the Breast and Cervical Cancer Early Detection Program

Energy and Commerce Bill (continued)

Patient Relief and Health Insurance Market Stability

- Repeal of Cost-Sharing Subsidy
  - The ACA implemented a cost-sharing subsidy program which lowers the out-of-pocket costs for deductibles, coinsurance, and copayments for individuals who purchased Silver plans through the Exchange
  - The bill would do away with the ACA's cost-sharing subsidy

- Continuous Health Insurance Coverage Incentive
  - The bill imposes a flat, thirty percent (30%) late-enrollment premium **surcharge/penalty** on individuals who go **longer** than **63 days** without continuous health insurance coverage in the last 12 months, beginning with special enrollment period applicants in 2018
  - This premium surcharge would replace the Individual Mandate penalty imposed by the ACA

Energy and Commerce Bill (continued)

Patient Relief and Health Insurance Market Stability (continued)

- Increasing Coverage Options
  - The bill does away with the requirement that plan issuers use an actuarial value calculation in order to label their plans as Bronze, Silver, Gold, and Platinum

- Change in Permissible Age Variation in Health Insurance Premium Rates
  - Currently, insurance carriers in the Exchange and small group market are permitted to charge older policyholders premiums up three times higher than premiums charged to younger policyholders

  - The bill **increases** the ratio from 3-to-1 to **5-to-1**, meaning potentially, carriers can charge a sixty (60) year old policyholder **five times** the premium charged to a twenty (20) year old. The bill does give States the flexibility to set their own ratio

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Questions?