

# ERISA and ACA Compliance

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NAVIGATING THE COMPLIANCE MINEFIELD

# Presenter

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## **Dr. Carlyle Rogers, PsyD, JD**

President and CEO of Business & People Strategy Consulting Group, LLC

Over 25 years of Human Resources, Employment Law & Compliance Experience

Certified Interrogator and member of the Association of Reid Trained Investigators

Author of 'Dirty Little Secrets: Declassifying the Employment Game'

# Agenda

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Overview of ERISA

Laws Impacting ERISA

ERISA Notices and Reporting

SPD and Wrap

Intersection of ERISA, ACA and FLSA

ACA Plan Compliance for ALEs

# ERISA

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Employee Retirements Income Security Act

Federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

Has experienced recent changes under the Patient Protection and Affordable Care Act.

# The Who's

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ERISA covers all private sector employer of all business types who maintain retirement and/or welfare benefit plans for their employees. This includes:

- Corporations
- S Corps
- Partnerships
- LLCs
- Sole Proprietors
- NPOs

Unlike the ACA...there is no small employer exemption.

# The Who Nots

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The following are not subject to ERISA:

- Public sector employees/government entities
- Church plans exempt from tax under IRC 501 and who have not make an election under 410(d)
- Private sector employers not sponsoring any retirement and/or welfare benefit plans

# What ERISA Does

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Requires plans to provide participants with plan information including important information about plan features and funding.

Provides fiduciary responsibilities for those who manage and control plan assets.

Requires plans to establish a grievance and appeals process for participants to get benefits from their plans.

Gives participants the right to sue for benefits and breaches of fiduciary duty.

# Types of Plans That May Be Subject to ERISA

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Accidental Death & Dismemberment

Burial Expense

Business Travel Accident Policies

Cancer Insurance

Daycare Center

Dental Benefits

Disability Insurance

Disease Specific Coverage

EAPs (if medical care is provided)

Flu Shot Programs

Group Term and Universal Life Insurance

Health FSA

HRA

Health Insurance

Health Screenings

Prepaid Legal plans

Vision Plans

Wellness Plans



# Types of Plans That Not Subject to ERISA

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Adoption Assistance Plans

Section 125 Premium Only Plans (although the underlying plans may be subject to ERISA)

Transportation Plans

HSAs

Pet Insurance

Unemployment Compensation (when required to comply with state law)

Financial & Retirement Planning Programs

Fitness Club Memberships

Liability Insurance Plans

Professional Development (if unfunded)

Scholarships (if unfunded)

Tuition Reimbursement

Work Comp (when required to comply with state law)

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# Laws Impacting ERISA

# Compliance with Other Laws

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There are other provisions in ERISA, as well as other Federal and State laws, that affect group health plans.

A fiduciary's responsibilities include making sure the plan complies with ERISA, which includes the COBRA, HIPAA, and other group health plan provisions in the law.

# COBRA

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The COBRA continuation coverage provisions require that participants and their covered dependents have the opportunity to maintain coverage under their group health plan for a limited period of time, which they may be required to pay for, upon the occurrence of certain qualifying events that would otherwise result in a loss of coverage.

# HIPAA

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The HIPAA provisions place limits on preexisting condition exclusions; provide for special enrollment rights for certain events; and prohibit discrimination in eligibility, benefits, or premiums based on a health factor.

Other group health plan provisions in ERISA include the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, MHPAEA and the Mental Health Parity, and the Genetic Information Nondiscrimination Act.

# Affordable Care Act

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The Affordable Care Act (ACA) provides additional protections for benefits under an employment-based group health plan.

Some plan sponsors may have chosen to make only routine changes and generally keep the coverage under their plan the same as it was on March 23, 2010.

These grandfathered health plans are required to comply with some, but not all of the ACA protections under ERISA.

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# ERISA Notices & Reporting

# ERISA Benefit Notices

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All eligible employees must receive ERISA Benefit Notices upon enrollment and re-enrollment in the employer's health plan.

Employers may be required to provide employees with specific notifications based upon the company's size and other criteria.



# Required Group Health Plan Notices

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ERISA requires plan administrators to furnish plan information to participants and beneficiaries and to submit reports to government agencies.

The following documents must be automatically furnished to participants and beneficiaries.

1. Summary Plan Description
2. Summary of Material Modification
3. Summary Annual Report

# Other Group Health Plan Notices

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There are notices required under other provisions in ERISA (i.e., the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Newborns' and Mothers' Health Protection Act (Newborns' Act), and the Women's Health and Cancer Rights Act (WHCRA)).

Some of these notices may be included in the SPD and others must be provided separately due to the timeframes for when they are required to be provided.

# Reporting to the Government

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- Plan administrators generally are required to file a Form 5500 Annual Return/Report with the Federal Government.
- The Form 5500 reports information about the plan, its finances, and its operation.
- Participants and beneficiaries can receive a copy of the Form 5500 upon request from the plan.
- Depending on the number of participants covered and plan design, there may be exemptions from the full filing requirements.
- A group health plan with fewer than 100 participants that is either fully insured or self-funded (or a combination of both) does not need to file an annual report.
- Plans with 100 or more participants that are fully insured or self-funded (or a combination) can file a limited report.

# Qualified Medical Child Support Orders

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- Plans may receive either private medical child support orders (MCSO) or an order from a state agency regarding an employee's medical child support obligations.
- Plans must have procedures to receive, process, and implement qualified medical child support orders.
- If a plan receives an MCSO, the plan administrator has to provide a notice to the participant and any child named in the MCSO (and the child's representative) of the receipt of the MCSO and the plan administrator's determination whether the MCSO is qualified.
- The notice must be furnished within a reasonable time period after receipt of the MCSO.

# ERISA Notices

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Medicare Part D Notice

CHIP (Children's Health Insurance Program; if applicable in your state)

Wellness Program Disclosure

Women's Health & Cancer Rights

Hospital Stay Rights for Childbirth

Mental Health & Parity Act

Notice of Special Enrollment Rights

Michelle's Law Enrollment Notice

Summary of Material Modification

# ERISA Notices

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Mental Health & Parity Act

HIPAA Notice

Summary Plan Documents

Summary Annual Report

Disclosure of Grandfathered Status

COBRA Rights – Initial Notice

COBRA Election Notice

Employer Notice to Employees of Coverage Options

# ERISA Qualifying Event Notices

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In the event of certain qualifying events, required notices may include:

- COBRA Qualifying Event Letter
- HIPAA Breach Notice
- Medical Child Support Order Notice (MCSO)
- National Medical Support Notice (NMS)

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# SPD and Wrap





# Summary Plan Document (SPD)

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The SPD is an important document that tells participants what the plan provides and how it operates.

It provides the following information:

1. When an employee can begin to participate in the plan
2. How service and benefits are calculated
3. When benefits becomes vested
4. When and in what form benefits are paid
5. How to file a claim for benefits

# SPD Important Note

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If a plan is changed, participants must be informed, either through a revised summary plan description, or in a separate document, called a Summary of Material Modifications (SMM), which also must be given to participants free of charge.

# SPD Notice

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## **Who**

- Participants and those pension plan beneficiaries receiving benefits.

## **When**

- Automatically to participants within 90 days of becoming covered by the plan and to pension plan beneficiaries within 90 days after first receiving benefits.
- However, a plan has 120 days after becoming subject to ERISA to distribute the SPD.
- Updated SPD must be furnished every 5 years if changes made to SPD information or plan is amended.
- Otherwise must be furnished every 10 years.

# SPD Requirements

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An employer must have a written Summary Plan Description (SPD) for each separate welfare benefit plan, informing participants of:

1. Eligibility requirements
2. Benefits
3. Claims
4. Appeals procedures
5. Rights under ERISA

# SPD Important Note

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Insurers may provide **some but not all information required** for SPD compliance.

It is a common mistake for employers to think the summary insurance information they receive from their insurance provider meets the SPD requirements.

# Potential Solution

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Combine all SPDs into one overall SPD Wrap notice, tying in the required ERISA language and simplifying the SPD notice process.

# Quick Note

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Employers subject to ERISA often have certificates of insurance or benefit booklets for the plans they offer to their employees.

The certificate of insurance and booklets do not comply with ERISA plan document requirements when they stand alone.

# ERISA Wrap

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Wrap plans are a function of complying with ERISA's plan document requirements.

It incorporates one or more insurance certificates/booklets into a Plan Document that complies with ERISA requirements (health and welfare benefit plans wrapped into one plan).

Provides the required ERISA language as a supplement to the information found in the insurance policy, certificate or booklet.



# Wrap Plan Solutions

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## Simple Wrap Plan



## Wrapping Multiple Plans



# Customized SPD & Wrap

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**A customized SPD Wrap must include the:**

Name of the plan

Plan sponsor

Plan administrator

Plan year

Employer tax identification number

Type of welfare plan

Type of administration

Summary of the benefits

Detailed description of plan benefits for group health plans

Provider network availability for group health plans

Procedures for Qualified Medical Child Support Orders (QMCCOS)

COBRA rights

Plan contributions

claims procedures

Statement of ERISA Rights

# SPD & Wrap Distribution

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The SPD and Wrap must be distributed to newly-enrolled participants within **90 days of when coverage started**, or within **120 days of a new plan being established**.

# Considerations

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- One Wrap plan = One Wrap plan to maintain for changes and updates.
- The components of the Wrap will still have document and SPD requirements.
- Wrap plans don't eliminate the need to make sure the components of the plan are up to date.
- Some plans on their own would not trigger a Form 5500 filing requirement, although it can be convenient to only have one Form 5500 filing.
- Someone will have to maintain the plan and provide updates.
- Decisions will have to be made related to benefits in and outside of the Wrap plan.
- **Wrap plans can be a method for defining plan eligibility rules required by the ACA, simplify Form 5500 filing and simplify plan administration.**

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# ERISA, ACA & FLSA

# ACA §1558

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§1558 of the Affordable Care Act, through §18C of the FLSA, created an anti-retaliation provision that:

1. Prevents employers from interfering with an employee's right to receive federal tax credit or subsidies for enrollment in ACA exchanges and
2. Protects whistleblowing related to ACA violations.

# FLSA §18C

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FLSA §18C prohibits an employer from discriminating against an employee with respect to his/her compensation, terms, conditions or other privileges of employment because the employee **received a premium tax credit.**

# ERISA §510

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ERISA §510 makes it unlawful for a person (a term which encompasses corporations and partnerships) to interfere with the attainment of any right a participant may become entitled to under a plan.



# The ACA

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The ACA's Pay or Play Mandate only applies to full-time employees (those employees who average 30 or more hours of service per week).

If an employee accumulates less than 30 hours of service per week, the employer does not have to worry about the employee for the Pay or Play Mandate.

However, if the employee works more than 30 hours a week, the employer must offer the employee minimum essential coverage or pay a \$2,000 penalty for each full-time employee.

Many employers have engaged (or intend to) the strategy of limiting a certain segment of their workforce's hours of service to less than 30 hours per week so that segment of employees will not count for purposes of the Pay or Play Mandate.

# The Issue

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Many employers have engaged (or intend to) the strategy of limiting a certain segment of their workforce's hours of service to less than 30 hours per week so that segment of employees will not count for purposes of the Pay or Play Mandate.

ERISA Section 510 and the ACA's whistleblower provision may pose risks to employers that are looking to workforce realignments as a means of responding to the employer mandate.

# Section 510 Claim

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The Section 510 claim that likely poses the greatest risk to employers is one alleging that employees who were classified as full-time—or who were working sufficient hours to qualify for health benefits before the mandate took effect—were reclassified to part-time status or had their hours cut such that they no longer qualified for employer health coverage, allowing the employer to escape the employer mandate penalties for not offering minimum essential coverage to this class of employees (and their dependents).

Another area of potential Section 510 risk involves employees who are newly hired by a company after a workplace realignment/hours management system has been adopted, and who are told they will work less than 30 hours—and therefore will not be eligible for benefits.

# Section 1558 Claim

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Section 1558 and its implementing regulation make clear that an employer may not terminate, demote, or discipline an employee who receives a premium tax credit or cost-sharing reduction for coverage on the Exchange—which is clearly designed to protect fulltime employees whose eligibility for subsidized Exchange coverage may trigger the assessment of a penalty on the employer under Code Section 4980H.

The regulation provides that an employer can escape liability only by providing by clear and convincing evidence that it would have taken the adverse employment action without regard to the protected activity, which is higher standard than the employee must satisfy.

# Steps for Minimizing Liability Risks

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Avoid making public statements concerning their political feelings about the employer mandate or their strategies to address it.

Employers and HR should carefully craft written materials concerning an employer's strategy options with respect to the employer mandate.

Employers should involve experienced ERISA counsel in the vetting of benefit strategy options to address employer mandate issues, so that counsel can preemptively identify potential liability risks associated with the options under consideration.

# Steps for Minimizing Liability Risks

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Employers that are planning on reducing employee hours may want to consider exceptions for existing employees who are currently eligible for health care benefits.

With respect to new employees who are hired for less than full-time positions (e.g., part-time, variable hour, or seasonal employees), employers should clearly communicate to such employees, in writing, that they will not be eligible for benefits under the employer's plan.

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# ACA Plan Compliance for the ALE

# The Future Impact of the ACA

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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 need to know the upcoming requirements and develop a compliance strategy.



# Grandfathered Plan Status

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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.

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.

# Cost-Sharing Limits

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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.

# Cost-Sharing Limits: Multiple Providers

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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.

# Cost-Sharing Limits: Multiple Providers

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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.

# Tips

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1. 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).
2. 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.
3. 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.
4. 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

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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) was subject to limitations.

The limit does not apply to employer contributions to the health FSA, and does not impact contributions under other employer-provided coverage (e.g., dependent care, adoption care).

Oct. 30, 2014, the IRS increased the health FSA limit to \$2,550 for taxable years beginning in 2015.

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.

# Health FSA in 2016 (Tips)

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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.

Communicate the 2016 limit to employees as part of the open enrollment process.

# HIPAA Certification

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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
3. Health care electronic funds transfers (EFT) and remittance advice



# HIPAA Certification and CHPs

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CHPs are responsible for providing the initial HIPAA certification on behalf of themselves and their sub-health 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.

# HIPAA Certification

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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.

# Affordability of Coverage

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Under the ACA, an employer's health coverage is considered affordable if the employee's required contribution to the plan does not exceed 9.56 percent of the employee's household income for the taxable year (adjusted to 9.66 percent for plan years beginning in 2016) or 9.5% if using a safe harbor method.

“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.

# Safe Harbor

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These safe harbors allow an employer to measure affordability based on:

1. Employee's W-2 wages
2. Employee's rate of pay
3. 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.

# Examples

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Employee earns \$10/hour on the first day of coverage period.

Calculation:  $(\$10 \times 130) \times 9.5\% = \$1,300 \times 9.5\% = \$123.50$

Max monthly premium is \$123.50

Employee earns \$20/hour on the first day of coverage period.

Calculation:  $(\$20 \times 130) \times 9.5\% = \$2,600 \times 9.5\% = \$247.00$

Max monthly premium is \$247.00

# Minimum Value

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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:

1. Minimum Value Calculator
2. Design-Based Safe Harbor Checklists
3. Actuarial Certification

Additionally, 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.

# Important Notes

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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.

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 November 4, 2014.

Plans adopted after November 4, 2014, must cover inpatient hospitalization or physician services in order to provide minimum value.

# Tips

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Analyze your obligations for the HIPAA certification:

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



# ALE Status

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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.

# New for 2016

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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 ALE Status for 2016

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Calculate the number of **full-time employees for all 12 calendar months of 2015**.

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.

# Aggregate ALEs

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Companies with a common owner or that are otherwise related under certain rules of section 414 of the Internal Revenue Code are generally combined and treated as a single employer for determining ALE status.

If the combined number of full-time employees and full-time-equivalent employees for the group is large enough to meet the definition of an ALE, then each employer in the group (called an ALE member) is part of an ALE and is subject to the employer shared responsibility provisions, even if separately the employer would not be an ALE.

# Controlled Groups

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There are three primary types of controlled groups for aggregating purposes:

1. Parent-subsidiary
2. Brother-sister
3. Combined

# Parent-Subsidiary Controlled Group

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When one or more companies are connected through stock ownership with a common parent corporation, and:

1. 80% of the stock of each company (except the common parent) is owned by one or more corporations in the group, and
2. The common parent company owns 80% of at least one other company

# Example: Parent-Subsidiary

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ABC Corporation owns:

1. 90% of the stock of DEF Corporation
2. 80% of the stock of GHI Corporation
3. 65% of the stock of JKL Corporation

Unrelated persons own the percentage of stock not owned by ABC Corporation.

ABC Corporation owns 80% or more of the stock of the DEF and GHI Corporations.

Therefore, ABC Corporation is the common parent of a parent-subsubsidiary group consisting of ABC, DEF, and GHI.

JKL Corporation is not a member of the group because ABC Corporation's ownership is less than 80%.

# Brother-Sister Controlled Group

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A group of two or more companies where **five or fewer common owners** (including individuals, estates, or trusts) **own directly or indirectly** (through the attribution rules under the Code) a **controlling interest of each group and have “effective control”**:

- 1. Controlling interest:** generally means at least 80% of each company (but only if such common owner owns stock in each company), and
- 2. Effective control:** generally means more than 50% of the stock of each company, taking into account the ownership only to the extent such ownership is identical with respect to each company.



# Attribution

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Attribution is the concept of treating a person as owning an interest in a business that is not actually owned by that person.

When there is a **brother-sister controlled group**, the various attribution rules apply with certain family and business relationships under certain circumstances, e.g. spouse, child, parent and grandparent.

In essence, stock owned by a spouse, parent or child is often deemed to be owned by one person.

# Attribution Example

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John owns 70% of the stock in the ABC Corporation.

Jane owns 20% of the stock and four other individuals who each own less than 5% own the remaining 10%.

The ABC Corporation has a 30% stock ownership in the XYZ Corporation.

The XYZ stock is attributed to John and Jane in proportion to their ownership interests in the ABC Corporation as follows:

- John is treated as a 21% owner of XYZ Corporation.
- $70\% \text{ (interest in ABC)} \times 30\% \text{ (ABC's interest in XYZ)}$
- Jane is treated as a .06 % owner of XYZ Corporation.
- $20\% \text{ (interest in ABC)} \times 30\% \text{ (ABC's interest in XYZ)}$

Since each of the four remaining shareholders of ABC Corporation own less than 5%, they are not treated as owning any interest in XYZ Corporation.

# Example: Brother-Sister

2 of the shareholders of Company A also own a percentage of Company B, thus 5 or fewer shareholders own more than 80% of each corporation and the same 5 or fewer own more than 50% of both corporations.

Brother-Sister Controlled Group			
Shareholder	Ownership Percentage		Identical Ownership
	Company A	Company B	
A	<b>40%</b>	<b>40%</b>	<b>40%</b>
B	<b>45%</b>	<b>50%</b>	<b>45%</b>
C	0%	10%	0%
F	15%	0%	0%
			85%

# Combined Group

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A group of three or more corporations, each of which is a member of a group of corporations, and:

1. Each company is a member of either a parent-subsidary or brother-sister group, and
2. At least one company is the common parent of a parent-subsidary and is also a member of a brother-sister group.

# QSLOBs

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A QSLOB (qualified separate lines of business) rules are used to allow different subsidiaries or divisions of a corporation to be tested separately under the nondiscrimination rules.

In essence, a portion of a controlled group that is treated differently for purposes of meeting certain tests for minimum coverage and standards for age and service eligibility requirements.

Under very complex IRS regulations, certain plans can be aggregated

**Employers who file as QSLOBs for other employee benefit purposes cannot rely on the QSLOB rules for purposes of the ACA Employer Shared Responsibility provisions.**

# Full-Time Employees

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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

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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.

# Hours of Service

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An employer can use one of three methods, including two equivalency methods, to determine hours of service:

1. Actual hours of service per month (which may not be available for salaried each week in employees)
2. Each day in which at least one hour is worked equals eight hours of service
3. which in at least one hour is worked equals 40 hours of service

An employer can use different equivalency methods for different classifications of non-hourly employees, provided the classifications are reasonable and consistently applied.

Employers are allowed to change the method each calendar year.



# Look-Back Measurement Method

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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.

# Look-Back Measurement Method

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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 Full-Time Employees

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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.

# Example (Monthly)

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Employer ABC

Total Employees = 87

35 FT Ees (30+ hrs/wk) + 37 PT EEs (105 hrs/mo) + 15 PT Ees (65 hrs/mo)

= 35 + [ (37 X 105) + (15 X 65) ] / 120

= 35 + [ (3,885 + 975) / 120] = 35 + 40.5 = **35 FT + 40 FTEs = 75**

Most likely subject to ACA

# Break in Service (< 13 Weeks)

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Under the **look-back measurement** rules, where an employee has a break with no hours of service and that **break in service is less than 13 weeks**, the employee must be **treated as an ongoing employee** when they resume work.

The employee does not have to be credited with any hours of service during the break, but they are placed back into the applicable measurement and stability period as though they never left.

If that rule causes the employee to return as **ACA-FT and they had health coverage before the break in service** (or would have had an opportunity to elect coverage during the break in service, e.g. due to open enrollment), then the employee **must be given the opportunity to enroll in coverage no later than the first day of the calendar month following their resumption of service** if the employer wants to ensure it avoids a “play or pay” penalty.

# Break in Service (13+ Weeks)

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If an employee returns to work following a break in service that is 13 weeks or longer, then the look-back measurement rules allow you to treat that individual as a new hire and apply the new hire measurement rules.

- **Full-time new hire:** You can wait until the end of the standard waiting period before offering coverage.
- **Part-time, variable or seasonal new hire:** You can start an initial measurement period and wait until the end of that period to determine if the employee is ACA-FT or not.

# Leaves of Absence

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To compute an employee's average hours for special unpaid leave during the standard measurement period, the employer will need to either **ignore periods where no hours were worked** or **credit hours to the employee based on the average number of hours worked** by the employee during the remainder of the measurement period (the result is the same under either method).

Unpaid leaves include FMLA, USERRA, and jury duty.

# Delay for Medium Sized ALEs

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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**.



# Delay Eligibility

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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)

# Reporting

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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 rule...must report under Section 6056 for 2015.

# Reporting

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The 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).

# Overview of Reporting

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**ALEs that sponsor self-insured plans** must report: (1) Information under Section 6055 about health coverage provided; and (2) Information under Section 6056 about offers of health coverage.

**ALEs that sponsor insured plans** must report information under Section 6056. These employers are not required to report under Section 6055.

**Non-ALEs that sponsor self-insured plans** must report information under Section 6055. These employers are not required to report under Section 6056.

**Non-ALEs that sponsor insured plans** are not required to report under either Section 6055 or Section 6056.

# Forms

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

1. A separate statement for each individual; and
2. 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 and 1095-B.

Under Section 6056, entities will file Forms 1094-C and 1095-C for 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.

# Electronic Reporting

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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).

# Employer Penalty Rules

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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.

# Employer Penalty Rules

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The employer penalty provisions and related reporting requirements took effect for most ALEs on Jan. 1, 2015.

However, eligible ALEs with fewer than 100 full-time employees (including FTEs) were given until 2016, to comply with the employer shared responsibility rules.

Additionally, 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.



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# Final Thoughts



# Summary

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Knowledge and familiarity of...

- Compliance requirements,
- Complete documentation, and
- Policies that show good faith efforts to comply

...are the best way to be prepared for an audit and survive litigation (as well as to avoid one in the first place).

# QUESTIONS

# Thanks for Attending!

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## Contact Information

Dr. Carlyle Rogers, President and CEO

Business & People Strategy Consulting Group, LLC

Website: [www.bpscllc.com](http://www.bpscllc.com)

Phone: 1.844.322.3300, 661.621.3662, 661.312.7737

Email: [services@bpscllc.com](mailto:services@bpscllc.com), [carlyle@bpscllc.com](mailto:carlyle@bpscllc.com)

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