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IRS ANNOUNCES TAX-FREE STATUS FOR IDENTITY PROTECTION SERVICES FOR EMPLOYEE-VICTIMS OF DATA BREACH

On August 13, 2015, the Internal Revenue Service (IRS) announced that employers may offer tax-free identity protection services for employees who were affected by a data breach of personal information while in the hands of the employer. Identity protection services include credit reporting, monitoring, identity theft insurance, identity restoration and similar services. Employers, who offer such services, following a data breach experienced by the employer or the employer's agent or service provider, are not required to treat the value of such services as income and the value need not be reported on the Form W-2. However, if the employer provides these services for reasons other than a data breach, such as supplemental employee fringe benefits, the value must be reported as income and properly taxed. If the value of the identity protection services is paid out in cash, in lieu of the services, the exemption from taxation will not apply.

No Action Required

Where identity protection services are offered, employers are responsible for appropriate reporting and taxation and therefore should become familiar with this announcement.

For complete details, see: http://www.irs.gov/pub/irs-drop/a-15-22.pdf

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IRS WITHDRAWS PROPOSED REGULATIONS ON ACA MINIMUM VALUE AND ISSUES OTHER MINIMUM VALUE REGULATIONS

The Internal Revenue Service (IRS) recently withdrew previously released proposed regulations that addressed how to determine minimum value for an employer-provided health plan. Minimum value, or the lack thereof, is used to determine if an Applicable Large Employer (ALE) has met its employer shared responsibility obligations under the Affordable Care Act (ACA) and if not, whether the individual who was not offered an affordable, minimum value plan, is eligible for a premium tax credit to purchase coverage through the Exchange. Proposed regulations released in May 2013 provided that a plan meets the minimum value threshold if its share of the allowed cost of benefits is at least 60%. Subsequently released IRS Notice 2014-69 and the final HHS Payment Parameter Regulations stated that plans failing to provide substantial coverage for both inpatient hospitalization and physician services will not meet minimum value requirements, regardless of whether they met the 60% threshold. As a result of this discrepancy, the IRS withdrew the May 2013 proposed regulations and issued new proposed regulations that incorporate majority of the previously proposed regulations as well as the hospitalization and physician services requirement into the minimum value test. This new rule will apply to all plan years beginning after November 3, 2014. For the employer shared responsibility provisions, the change would not apply before the end of the plan year beginning on or before March 1, 2015. This transition relief will apply if the employer entered into a binding written commitment to adopt noncompliant plan terms or had employees in such plans before November 4, 2014.

Action May be Required

Employers with noncompliant plans should ensure their plans meet the minimum value test in order to avoid employer mandate penalties by the end of the plan year.

For complete details, see: http://www.gpo.gov/fdsys/pkg/FR-2015-09-01/pdf/2015-21427.pdf

HHS ISSUES PROPOSED RULE PROHIBITING DISCRIMINATION AGAINST VULNERABLE POPULATIONS' ACCESS TO HEALTH CARE

The Department of Health and Human Services (HHS) has issued a proposed rule to advance health equity and reduce disparities in health care. The proposed rule, *Nondiscrimination in Health Programs and Activities*, will assist some of the populations that have been most vulnerable to discrimination and will help provide those populations equal access to health care and health coverage. It harmonizes protections provided by existing, well-established federal civil rights laws, and clarifies the standards HHS would apply when implementing Section 1557 of the Affordable Care Act (ACA), which provides that individuals cannot be subject to discrimination based on their race, color, national origin, sex, age, or disability. Section 1557 is the first federal civil rights law to prohibit discrimination on the basis of sex in health care. It extends nondiscrimination protections to individuals enrolled in coverage through the Health Insurance Marketplaces and certain other health coverage plans. It also provides that HHS's health programs are covered by the rule.

HHS Issues Proposed Rule Prohibiting Discrimination against Vulnerable Populations' Access to Health Care (continued)

The basic requirement of the law is that consumers cannot be denied health services or health coverage or discriminated against in other ways in health services or coverage because of their race, color, national origin, sex, age, or disability. The proposed rule addresses some of the populations that have historically been subject to discrimination. For example, the proposed rule includes prohibitions on gender identity discrimination as a form of sex discrimination, enhances language assistance for people with limited English proficiency, and requires effective communication for individuals with disabilities. Overall, the proposed rule ensures consumers have the equal access to health services and health coverage provided by the ACA.

The proposed rule explains consumers' rights under the law and provides clarity regarding insurer obligations. Section 1557 has been in effect since its enactment in 2010 and the HHS Office for Civil Rights (OCR) has been enforcing the provision since it was enacted. Highlights may be found below.

Protections against Sex Discrimination

The proposed rule requires that women have equal access to the health care they receive and the insurance they obtain. Moreover, the rule makes clear that sex discrimination includes discrimination based on gender identity. For example:

- Individuals cannot be denied health care or health coverage based on their sex, including their gender identity
- Individuals must be treated consistent with their gender identity, including in access to facilities
- Sex-specific health care cannot be denied or limited just because the person seeking such services identifies as belonging to another gender. For example, a provider may not deny an individual treatment for ovarian cancer, based on the individual's identification as a transgender man, where the treatment is medically indicated
- Explicit categorical exclusions in coverage for all health care services related to gender transition are facially discriminatory. Other exclusions for gender transition care will be evaluated on a case-by-case basis

HHS is seeking feedback and public comment on the proposed rule. With regard to the proposed rule's provisions on sex discrimination, for example:

- The proposed rule makes clear HHS's commitment, as a matter of policy, to banning discrimination based on sexual orientation, and requests comment on how a final rule can incorporate the most robust set of protections against discrimination that are supported by the courts on an ongoing basis
- The proposed rule also requests comment on whether Section 1557 should include an exemption for religious organizations and what the scope of any such exemption should be. Nothing in the rule would affect the application of existing protections for religious beliefs and practices, such as provider conscience laws and the regulations issued under the ACA related to preventive health services

Communication with Individuals with Limited English Proficiency and with Individuals with Disabilities

The proposed rule adopts the longstanding principle that covered entities must take reasonable steps to provide meaningful access to individuals with limited English proficiency. In determining what the standard requires, OCR will evaluate each case on its facts, including the nature of the communication, and, as applicable, how often the entity encounters individuals who speak the language at issue and the resources of the entity.

Under the proposed rule, covered entities would be required to:

- Post a notice of consumer rights providing information about communication assistance; and
- Post taglines in the top 15 languages spoken by individuals with Limited English Proficiency (LEP) nationally, indicating the availability of such assistance

HHS Issues Proposed Rule Prohibiting Discrimination against Vulnerable Populations' Access to Health Care (continued)

Communication with Individuals with Limited English Proficiency and with Individuals with Disabilities (continued)

To reduce burden and costs, OCR will provide a sample notice and translated taglines for use by covered entities. In addition, OCR will translate the notice into 15 languages and provide the translated notices to covered entities, should they wish to post one or more of those notices for their consumers.

Consistent with existing requirements, the proposed rule also requires covered entities to provide effective communication for individuals with disabilities by providing access to auxiliary aids and services, including alternative formats and sign language interpreters, unless the entity can show an undue burden or a fundamental alteration. The notice that covered entities must post provides information about these services as well. The proposed rule also incorporates familiar requirements related to the accessibility of facilities and technology and requires reasonable modifications of policies and practices where necessary to provide equal access for people with disabilities.

Coverage of Health Insurance in Marketplaces and Other Health Plans

The proposed rule prohibits discrimination in health insurance coverage on the basis of race, color, national origin, sex, age, or disability. Among other things, this means that an issuer that participates in the Marketplace cannot deny, cancel, limit, or refuse to issue or renew any of its insurance policies or employ marketing practices or benefit designs that discriminate on any of these bases. The Marketplaces themselves must also operate in a nondiscriminatory way. And hospitals and certain other health care providers that receive federal financial assistance from HHS are also accountable for discrimination in the health plans they offer to their employees.

No Action Required

For complete details, see: http://www.hhs.gov/ocr/civilrights/understanding/section1557/nprmsummary.html; and, http://www.gpo.gov/fdsys/pkg/FR-2015-09-08/pdf/2015-22043.pdf

DID YOU KNOW?

ACA Employer Reporting is Right around the Corner!

- Reporting is required for all Applicable Large Employers (ALE) who averaged 50 or more "Full-Time" plus "Full-Time Equivalent" employees in 2014 (section 6056) and any employer offering Minimum Essential Coverage (MEC) to employees (section 6055)
- Reporting required for all months of 2015, even if the Employer Mandate is not effective for the employer until some month after January 2015 (due to transition relief) or the Employer Mandate does not apply to them
- Reporting required for common-law employees who worked at least one month of the year as a Full-Time employee (i.e., the employer intended the employee to work at least 30 hours per week, or 130 hours in any given month)
  - Form 1094-C provides information to the government regarding the employer, the offer of coverage by the employer, and whether the employer is part of a larger set of employers under common control
  - Form 1095-C, provides information on the employee and the offer of coverage they received, and whether they took such coverage
  - Form 1094-B (filed by a non-ALE with self-funded plans) provides basic information to the government about the insurer and the number of individual statements that the insurer is submitting with this transmittal
  - Form 1094-C (filed by a non-ALE with self-funded plans) provides information to the employee about the employer, the insurer, whether coverage was purchased through a SHOP Exchange and months of coverage for each covered individual
- When reporting, employers are responsible for gathering names and Social Security numbers of all the individuals **receiving** MEC (for self-funded plans), including spouses and/or dependents receiving coverage
  - Where a covered family member's Social Security number cannot be obtained, that person's date of birth may be used instead, so long as the reporting entity makes a reasonable effort (to avoid penalty) to obtain the Social Security number (following three attempts to obtain the Social Security number)

Employer Size	Group Health Plan	Form	Due
Under 50 FTEs	Self-insured Fully-Insured	1094-B and 1095-B No ACA Reporting Required	1094-B must be transmitted to the IRS by February 29, 2016, or March 31, 2016, if filing electronically.
50-99 FTEs	Self-insured Fully-insured	1094-C and 1095-C	1095-C must be provided to the employee by January 31st each year. For 2015 filings, the date is February 1st. 1094-C, along with all employee Form 1095-Cs must be transmitted to the IRS by March 31st (if filing electronically). The 'B' form may alternatively be used where Social Security numbers are not obtained.
100+ FTEs	Self-insured Fully-insured	1094-C and 1095-C	

Note: Employers who issue less than 250 returns of the specific form they are filing in 2015 may file paper copies of the Forms, but paper filings must be transmitted to the IRS by February 29, 2016.

Trade Preferences Extension Act of 2015, Penalty Increase

- The Trade Preferences Extension Act of 2015 increased the reporting penalty from $100 to $250 per form with the maximum penalty increasing from $1.5M to $3M annually
- Good faith compliance for processing year 2015 filing will NOT result in a penalty, if timely filed and the employer is able to show they made an attempt, in good faith, to comply
- Proposed legislation is currently going through the Senate and House seeking to delay reporting. Bipartisan support provides a good chance it could pass; however, nothing is binding until/if passed

New Draft Forms 1094/95-C & B, with instructions: http://www.irs.gov/pub/irs-dft/i109495c--dft.pdf; and, http://www.irs.gov/pub/irs-dft/i109495b--dft.pdf

IRS Q&As on 1094/95-C: http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-about-Information-Reporting-by-Employers-on-Form-1094-C-and-Form-1095-C

QUESTION OF THE MONTH

Q: Our Company's cafeteria plan includes a health FSA that has always been funded solely by employee salary reductions. For next year, however, we are thinking about adding an employer contribution feature to the health FSA, such as a matching or seed contribution. Would these employer contributions count toward the limit that applies to health FSAs?

A: The statutory limit (which was $2,500 for plan years beginning in 2013 and 2014, and is $2,550 for plan years beginning in 2015) applies only to health FSA salary reduction contributions. Non-elective employer contributions such as matching or seed contributions generally do not count toward the limit. But if employees may elect to receive the employer contributions in cash or as a taxable benefit, then the contributions will be treated as salary reductions and will count toward the limit if contributed to the health FSA.

Note that employer contributions also raise other compliance issues. For example, if the employer contribution amount varies among employees, the plan could fail to comply with the Code's nondiscrimination rules. Also, for a health FSA to qualify as an excepted benefit, the maximum benefit payable for the year must not exceed two times the employee's health FSA salary reduction election for the year or, if greater, the amount of the employee's health FSA salary reduction election for the year plus $500. (A health FSA's failure to qualify as an excepted benefit will subject the employer to potential penalties under health care reform and will trigger additional obligations under COBRA and other laws.) Health FSAs funded exclusively by employee salary reductions (with annual coverage capped by the amount of the annual salary reduction election) will, by definition, satisfy this maximum benefit condition. But if employer contributions can also be allocated to employees' health FSAs, care must be taken to ensure those contributions do not cause the health FSA to fail to meet the condition. Note that employer contributions that an employee can also elect to receive in cash or as a taxable benefit are treated as salary reductions for purposes of this condition, and that other requirements must also be met for a health FSA to qualify as excepted.

Source: Thomson/Reuters