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# Benefits Report

MAY 2015

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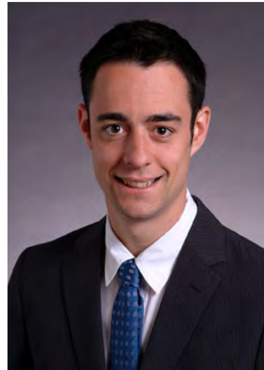

## DOL Proposed Fiduciary Rule: A Significant Second Take

ROBERT R. GOWER

After years back at the drawing board following the withdrawal of proposed fiduciary regulations issued in 2010, on April 20, 2015, the United States Department of Labor ("DOL") issued a new proposed rulemaking package that more broadly defines the circumstances in which a person who provides "investment advice" may be considered a "fiduciary" to an employee benefit plan, including an individual retirement account ("IRA"), or its participants or beneficiaries. The proposed rulemaking package would replace the original five-part test from regulations issued in 1975 that must be satisfied before a person can be considered a fiduciary investment adviser with a much broader test, and would provide for new proposed prohibited transaction exemptions ("PTEs") and amendments to existing PTEs applicable to certain conduct of persons treated as fiduciary investment advisers. If adopted as proposed, the rules could have a significant impact on the retirement industry and, thus, will be the subject of intense discussion in the coming months. The proposed package includes the following noteworthy changes:

- Expansion of the fiduciary rules to investment advisers of IRA owners.
- A carve-out from fiduciary status for certain service providers, including those that furnish appraisals, fairness opinions, or statements of value to an employee stock ownership plan ("ESOP"), an investment fund or pooled separate account, a plan, plan fiduciary, plan participant or beneficiary, or IRA or IRA owner, solely to comply with ERISA's reporting requirements.
- A new "Best Interest Contract" PTE, relating to the receipt of variable compensation by fiduciaries who provide investment advice to participants, beneficiaries, IRA holders, and small plans that do not provide participant-direction of investments.

### Background — The Internal Revenue Code and 1975 Regulation

Under ERISA, fiduciaries are subject to heightened standards of conduct, including the requirements to act prudently and solely in the interest of participants and

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beneficiaries and to avoid conflicts of interest. ERISA § 404(a). Fiduciaries who breach this standard of care may be personally liable to the plan, and if so, must restore any losses and return any profits made from the improper use of any plan asset. A person who renders investment advice is considered a "fiduciary" under ERISA to the extent that the person has or exercises any discretionary authority or control over plan administration (for example, an investment manager) or "renders investment advice for a fee or other compensation…with respect to any moneys or other property of [a] plan, or has any authority to do so…" ERISA § 3(21)(A).

### *Current 1975 Regulations Regarding Investment Advisers*

When the DOL first issued regulations defining a "fiduciary" in 1975, the retirement plan landscape was significantly different — there was no such thing as a participant-directed 401(k) plan, investment products and services were less complex, and participants were not rolling over their fiduciary-protected plan assets into IRAs. The 1975 regulations introduced a narrow five-part test that an investment adviser must satisfy to have "fiduciary" status. Under the current rules, an investment adviser who does not have discretionary authority or control with respect to the purchase or sale of plan securities or other property is nevertheless considered a "fiduciary" if the adviser renders advice:

- as to the value of securities or other property, or makes recommendations as to the advisability of investing in, purchasing or selling securities or other property;
- on a regular basis;
- pursuant to a mutual agreement, arrangement or understanding with the plan or a plan fiduciary;
- that will serve as a primary basis for investment decisions with respect to plan assets; and
- that will be individualized based on the particular needs of the plan.

The DOL noted in the preamble to the proposed new rule that many advisers, brokers and valuation firms currently operate without any of the accountability required by ERISA of "fiduciaries", and the "specific elements of the [above] five-part test — which are not found in the text of [ERISA] or the Code — now work to frustrate statutory goals and defeat advice recipients legitimate expectations."

## 2015 Proposed Rulemaking Package

### *An Updated Definition of Investment Advice*

The 2015 proposed rulemaking package includes a broad four-part definition of "investment advice", with seven significant "carve-outs". Under the proposed definition, an individual will be considered a "fiduciary" providing "investment advice" with respect to moneys or other property of a retirement plan (*e.g.,* a defined benefit plan or 401(k) plan) or IRA if such person acknowledges that they are acting as a fiduciary with respect to investment advice, or such person:

- renders investment advice;
- such advice is pursuant to a written or verbal agreement, arrangement or understanding;
- such advice is individualized to, or specifically directed to the recipient of the advice; and
- such advice is for consideration in making investment or management decisions.

The proposed rule also expands on the definition of "investment advice" to include the following recommendations:

- a recommendation as to the advisability of acquiring, holding, disposing or exchanging securities or other property, including a recommendation to take a distribution of benefits or a recommendation as to the investment of securities or other property to be rolled over or otherwise distributed;
- a recommendation as to the management of securities or other property, including securities or other property to be rolled over or otherwise distributed from a retirement plan or IRA;
- an appraisal, fairness opinion, or similar statement (whether verbal or written) concerning the value of securities or other property, if provided in connection with a specific transaction or transactions involving the disposition, or exchange, of such securities or other property by a retirement plan or IRA; and

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- a recommendation from a person who is receiving a fee or other compensation for providing such advice.

With respect to persons who might otherwise be considered fiduciaries under the new definition, the proposal carves out the following exceptions:

- **Product or Service Sellers.** A person involved in a sale of products or services with a responsible plan fiduciary to a large ERISA plan (a plan with 100 or more participants or plan assets of at least $100 million) who is not compensated directly by the plan or independent fiduciary, and who obtains or provides certain statements and disclosures regarding the independent fiduciary's sufficient expertise to evaluate whether the transaction is prudent and in the best interest of participants, and that the person is not acting in an impartial or fiduciary capacity in the transaction.
- **Swap Sellers.** A person who is involved with the sale of swaps or security-based swaps to an independent fiduciary of an employee benefit plan who obtains a written representation from the independent fiduciary that the fiduciary will not rely on recommendations provided by that person.
- **Employees.** An employee of a plan sponsor who provides advice to a plan fiduciary in his or her employment capacity, as long as the employee does not receive additional compensation for providing such advice.
- **Platform Providers.** A person who merely markets and makes available an investment platform to a plan (without regard to the individualized needs of the plan) that independent plan fiduciaries can use to select and monitor investment alternatives, and informs the independent plan fiduciary that the person is not undertaking to provide impartial investment advice or to give advice in a fiduciary capacity.
- **Selection and Monitoring Assistance.** A person who merely identifies investment alternatives meeting criteria specified by the plan fiduciary of a participant-directed plan and/or provides objective financial data and comparisons with independent benchmarks to the plan fiduciary.
- **Financial Reports and Valuations.** A person providing an appraisal, fairness opinion, or statement of value to an ESOP, an investment fund (such as a collective investment fund or pooled separate account), a plan, plan fiduciary, plan participant or beneficiary, or IRA or IRA owner, solely for compliance with ERISA reporting requirements or other federal or state laws.
- **Investment Education.** A person providing general plan information, asset allocation models, certain interactive investment materials and other general investment information.

## Potential Impact of the New Investment Advice Definition

If adopted as proposed, the new definition of investment advice and related carve-outs will have a significant and sweeping impact on fiduciary status for retirement plan service providers. Notably:

- One-time advice may now give rise to fiduciary status. The proposed rule eliminates the requirement in the 1975 regulations that investment advice be provided "on a regular basis".
- Advice must only be a "consideration" in making investment or management decisions, not a "primary basis" for investment decisions, as stated under the 1975 regulations.
- Advice does not have to be "individualized", as provided in the 1975 regulation. Under the proposed rule, advice must only be "specifically directed" toward a recipient to give rise to fiduciary status.
- Acknowledging fiduciary status will automatically give rise to fiduciary status.
- Providing investment advice to individuals (rather than merely plans) will now clearly give rise to fiduciary status. Although this was a generally accepted interpretation of the 1975 regulation, it is now explicitly a part of the new definition.
- Providing investment advice to IRAs will give rise to fiduciary status, as will the provision of advice related to rollovers or distributions to IRAs.

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## New Proposed Prohibited Transaction Exemptions

Given the existing patchwork of narrowly tailored PTEs available to investment advice fiduciaries to meet specific business practices, and the significant expansion of individuals who will be considered plan fiduciaries under the new definition of investment advice, the 2015 proposed rulemaking package updates a number of PTEs and introduces two new PTEs. Similar to the proposed definition of investment advice, the new proposed PTEs and proposed amended PTEs are broadly written and intended to accommodate today's evolving retirement landscape.

Perhaps the most significant proposed PTE, the "Best Interest Contract PTE" would allow fiduciaries providing investment advice to set their own compensation practices (including receiving commissions and revenue sharing), provided the fiduciary commits to putting the client's best interest first and discloses any conflicts of interest that may prevent them from doing so. Specific requirements include:

- Contractually acknowledging fiduciary status;
- Warranting that the adviser has adopted policies and procedures reasonably designed to mitigate the harmful impact of conflicts of interest;
- Providing a series of fee-related disclosures;
- Notifying the DOL of reliance on the PTE; and
- Adhering to standards of impartial conduct, including giving advice in the customer's best interest, avoiding misleading statements, and receiving no more than reasonable compensation.

The DOL also proposed a PTE to provide relief for principal transactions in certain debt securities with either an ERISA plan or an IRA. The exemption would permit certain financial institutions and fiduciary advisers to engage in the purchase and sale of certain debt securities where the buyer or seller is a plan, participant account, or IRA and receive a payment for themselves or an affiliate as a result of the fiduciary adviser's and financial institutions advice. Similar to the Best Interest Contract Exemption, the adviser and the financial institution would have to enter into a written agreement under which the adviser contractually acknowledges its fiduciary status and agrees to follow a best interest standard imposing impartial conduct principles.

Finally, the DOL proposed a number of amendments to existing PTEs that are intended to bring those PTEs into conformance with the proposed new rule. In most cases, the amendments impose impartial conduct standards on fiduciaries who intend to rely on the PTEs. The proposed modifications include:

- (PTEs 75-1 and 86-128) Certain transactions involving plans, broker-dealer and banks
- (PTE 77-4) Open-end mutual fund investments
- (PTE 80-83) Securities transactions involving indebtedness
- (PTE 83-1) Mortgage pool acquisitions
- (PTE 84-24) Certain transactions involving insurance agents, insurance companies and other parties

## Next Steps

The 2015 proposed rulemaking package promises to be the subject of intense discussion in the retirement industry in the coming months — especially considering the withdrawn 2010 proposed rules elicited more than 300 comments and hearings before Congress. The DOL has requested and will accept comments on its proposal for a period of seventy-five (75) days following publication in the final register (on or before July 6, 2015), followed by a public hearing within thirty (30) days of the close of the comment period. After reviewing comments, the DOL will prepare a final rule, which will become effective sixty (60) days after publication in the Federal Register, though the majority of the requirements will become applicable eight months after publication in the Federal Register. If you have any questions, please contact the author of this article.

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# Plan Sponsors Gear Up for Required ACA Reporting of Coverage

ERIC J. SCHILLINGER

As mid-2015 is fast approaching, employers and plan sponsors that have not yet contemplated their reporting obligations under the Affordable Care Act may wish to consider starting now. In early 2016, insurers, plan sponsors of self-funded plans and employers with 50 or more full-time equivalent employees will need to collect and report voluminous and detailed participant and employee data, including names, Social Security Numbers, full-time employee status, and months during which coverage was offered and provided in 2015. On February 8, 2015, the Internal Revenue Service ("IRS") released updated draft forms for the reporting required by the Affordable Care Act under Sections 6055 and 6056 of the Internal Revenue Code (the "Code"), to assist the IRS in determining the following:

- An employer's liability for an assessment under the employer shared responsibility or "Pay or Play" provision under Section 4980H of the Code;
- An individual taxpayer's assessment liability for failing to maintain individual coverage under Section 5000A of the Code; and
- An individual taxpayer's eligibility for the premium tax credit for purchasing individual Exchange/Marketplace coverage under Section 36B of the Code.

While reporting in 2015 for coverage offered in 2014 is voluntary, reporting under Code Sections 6055 and 6056 is mandatory beginning in 2016 for coverage offered in calendar year 2015, and for years thereafter for coverage offered during the preceding calendar year. [The IRS previously issued draft forms in July 2014 and draft instructions in August 2014 (see our July 2014 newsletter article for a brief description of the reporting forms, and our May 2013 and March 2014 newsletters for detailed discussions of these reporting requirements).]

Section 6055 requires providers of "minimum essential coverage" (including insurers and plan sponsors of self-insured group health plans, such as employers or sponsors of multi-employer plans) to report the coverage provided in the prior calendar year using Forms 1094-B (transmittal) and 1095-B (information return) and furnish related statements to covered individuals. The reported information will assist the IRS in its administration of the individual shared responsibility requirement under Section 5000A of the Code. Section 6056 requires employers with the equivalent of more than 50 full-time employees ("applicable large employers" or "ALEs") to report coverage offered to full-time employees in the prior calendar year using Forms 1094-C (transmittal) and 1095-C (information return) and furnish related statements to covered employees, to assist the IRS with administering the employer shared responsibility provision under Section 4980H of the Code and determining individual eligibility for the premium tax credit under Section 36B of the Code.

## Forms 1094-B and 1095-B (Reporting by Providers of Minimum Essential Coverage)

The final instructions for the Forms 1094-B and 1095-B are substantively identical to the draft instructions for those forms, as described below. (Note: ALEs that sponsor self-insured health plans will instead report the information required by Code Section 6055 on the Forms 1094-C and 1095-C.)

### *Form 1094-B (Transmittal of Health Coverage Information Returns)*

Insurers and non-ALE sponsors of self-insured group health plans will use the Form 1094-B to transmit the individual Form 1095-B information returns. Note: While multi-employer plan sponsors of self-insured group health plans must complete the Form 1094-B and related Form 1095-B, each contributing employer that is an ALE has a separate obligation to complete the Form 1094-C and Form 1095-C for all of its full-time employees, including those who are covered by the multi-employer plan. The multi-employer plan should provide the contributing

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employer with the necessary coverage information for that group of employees.

### *Form 1095-B (Health Coverage)*

The Form 1095-B is the individual return used by health coverage providers to report minimum essential coverage provided to covered individuals, as follows:

- **Part I: Responsible Individual.** Part I is used to report information about the "Responsible Individual," *i.e.,* the primary insured employee, former employee or other person enrolling individuals in coverage. (The Responsible Individual is not the named health coverage policy holder for its employees.)
- **Part II: Employer Sponsored Coverage.** Part II is used to report information about the employer sponsoring the group health coverage and will be completed by the insurance company if the coverage is insured. If the employer-sponsored coverage is self-insured, Part II will be left blank.
- **Part III: Issuer or Other Coverage Provider.** Part III is used to report information about the coverage provider (*e.g.,* insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor).
- **Part IV: Covered Individuals.** Part IV is used to report the name, Social Security Number ("SSN"), and coverage information for each individual covered by the plan, including non-employees (such as retirees, dependents, and COBRA participants). (A reporting entity may use a date of birth in lieu of a SSN if it is unable to obtain a SSN after using "reasonable efforts.") If there are more than six covered individuals, the reporting entity will use additional Forms 1095-B to report the required information in Part IV.

Form 1095-B filers must furnish a copy of the form to the person identified as the Responsible Individual on the form or provide a "substitute statement." Truncation of SSNs and the Employer Identification Number ("EIN") is permitted on statements provided to the Responsible Individual.

## Forms 1094-C and 1095-C (Reporting by Applicable Large Employers)

The final instructions for the Forms 1094-C and 1095-C include a number of substantive changes and clarifications to the draft forms, as described below.

### *Combined Reporting for ALEs That Sponsor Self-Insured Group Health Plans*

ALEs that sponsor self-insured group health plans must report under both Code Sections 6055 and 6056, which would normally require separate reporting on Forms 1094-B/1095-B *and* 1094-C/1095-C. (If the ALE sponsors fully-insured group health coverage, then the insurer will prepare the Forms 1094-B and 1095-B to report the Code Section 6055 information.) The draft instructions, however, permitted those ALEs to instead use Forms 1094-C and 1095-C (Part III) to report the information required by Code Section 6055 with respect to employees enrolled in the self-insured health plan. The final instructions clarify that ALEs may also use this combined reporting method to report self-insured health coverage of non-employees (*e.g.,* retirees, non-employee directors, and COBRA participants).

### *Form 1094-C (Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns)*

Similar to the Form 1094-B, the Form 1094-C is a transmittal form that ALEs will use to transmit the individual Forms 1095-C, as follows:

- **Part I: Applicable Large Employer Member (ALE Member).** Part I is used to report the identifying information of the ALE Member. An ALE Member is an ALE or, if applicable, an ALE that is a member of a controlled group of other ALEs (referred to as an "Aggregated ALE Group").
- **Part II: ALE Member Information.** Part II is used to report the total number of Forms 1095-C filed, whether the ALE Member was a member of an Aggregated ALE Group during any month of the calendar year, and whether the ALE used a particular coverage offer method (*e.g.,* the "Qualifying Offer Method"), or is requesting transition relief. Part II is also used to identify whether the Form 1094-C is an "Authoritative

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Transmittal." The draft instructions allowed an ALE to file more than one Form 1094-C (*e.g.,* one for each operating division), provided that one of the Forms 1094-C is designated as the "Authoritative Transmittal." The final instructions clarify that if an ALE uses multiple Forms 1094-C, only the Authoritative Transmittal is used to report the aggregate employer-level data for the employer's full-time employees (that information is left blank for the Forms 1094-C that are not designated as the authoritative transmittal).

- **Part III: ALE Member Information — Monthly.** An ALE Member will use Part III to report whether it offered minimum essential coverage, the number of its full-time employees and its total employees for each month during the prior calendar year.
  - For ALE Members that contribute to a multiemployer plan, the multiemployer interim relief rule provides that the ALE Member is treated as offering health coverage to an employee if the ALE Member is required by a collective bargaining agreement or related participation agreement to make contributions for that employee to a multiemployer plan, and that plan offers affordable health coverage that provides minimum value to eligible individuals and to those individuals' dependents (or is eligible for Code Section 4980H transition relief regarding offers of coverage to dependents). Accordingly, on Part III an ALE Member will treat its full-time employees for whom it contributes to a multiemployer plan as having been offered minimum essential coverage (regardless of whether coverage was actually offered) for the months in which the ALE Member is eligible to rely on the multiemployer interim relief rule.
  - An ALE Member must also identify whether it was part of an Aggregated ALE Group during any part of the prior calendar year, and whether the ALE Member is eligible for Code Section 4980H transition relief. Such transition relief is available for (1) ALEs with fewer than 100 full-time employees and (2) ALEs with greater than 100 full-time employees that owe a penalty under Code Section 4980H(a), which may receive an 80 employee reduction in the penalty, rather than the 30 employee reduction.
- **Part IV: Other ALE Members of Aggregated ALE Group.** Part IV is used if the ALE Member was part of an Aggregated ALE Group for any months during the prior calendar year. If Part IV applies, the ALE Member will enter the names and EINs of up to 30 other ALE Members in the Aggregated ALE Group in descending order, starting with the ALE Member with the highest average number of full time employees per month.

### *Form 1095-C (Employer-Provided Health Insurance Offer and Coverage Insurance)*

The Form 1095-C is the individual return used to report employer-sponsored coverage provided by ALEs, as follows:

- **Part I: Employee, Applicable Large Employer Member.** Part I is used to report the identifying information of the employee and the ALE Member.
- **Part II: Employee Offer of Coverage.** Line 14 is used to report the offer of coverage to the employee (and the employee's spouse and dependents, if applicable) through indicator codes from Code Series 1. For example, the code 1A is used to report that a "Qualifying Offer" was made, *i.e.,* an offer of minimum essential coverage providing minimum value with the employee contribution for self-only coverage equal to or less than 9.5% of the mainland single federal poverty line, and at least minimum essential coverage offered to spouse and dependents. A code must be entered for each calendar month, even if the employee was not a full-time employee for one or more months. The ALE Member will also report on Line 15 the amount of the employee share of the lowest-cost monthly premium for self-only minimum essential coverage that provides minimum value (if the Member offered such coverage). Last, ALE Members will use Line 16 to report the Code Section 4980H safe harbor or other relief, if applicable, for each month through the use of indicator codes from Code Series 2. For example, if the employee was not employed with the ALE Member for a particular month (and therefore the ALE Member did not incur an employer shared responsibility payment for that month), the ALE Member will enter the code 2A in line 16 for that month.

Note: ALE Members relying on the multiemployer interim

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relief rules for a full-time employee will generally enter code 2E on Line 16 of the employee's Form 1095-C. If the employee enrolled in the offered coverage, the ALE Member will enter code 2C.

- **Part III: Covered Individuals.** Part III is used by ALE Members sponsoring self-insured group health plans to report the information required by Code Section 6055, rather than on the Form 1095-B. The information reported in Part III is substantively identical to the information reported in Part IV of the Form 1095-B. Note: As explained above, ALE Members may also use Part III to report the information required by Code Section 6055 with respect to non-employees. However, employer-sponsored self-insured health coverage does not include multi-employer plan coverage, which is reported on the Form 1095-B.

As with the Form 1095-B, Form 1095-C filers must furnish a copy of the form to the covered employee or, in certain cases, may provide a substitute statement in lieu of a Form 1095-C copy. Truncation of SSNs and EINs is permitted on employee statements, but not on the forms filed with the IRS.

Other significant changes and clarifications made by the final instructions include:

- **One Form 1095-C for Each Employee of Each Employer, Including Each Member of a Controlled Group.** The draft instructions provided that, if an employee works for more than one ALE Member of a controlled group, then the 1095-C must be completed by each ALE Member. The final instructions clarify that, if an employee works for more than one ALE Member *in the same month,* only the ALE Member for which the employee has the greatest number of hours for the month will report on the Form 1095-C for the coverage provided to that employee for that month.

- **Determining the Total Number of Full-Time Employees.** The draft instructions required an ALE to determine the number of its full-time employees using the first or last day of the month and to use the same day for all months during the year. The final instructions expand these choices to include the first or last day of the first payroll period that starts during each month.

- **Offers of Coverage to Dependents.** The final regulations provide that an offer of coverage is treated as made to an employee's dependents only if the offer of coverage is made to an unlimited number of dependents, regardless of the actual number of dependents, if any, an employee has during a calendar month.

- **Additional Requirements and Restrictions for Simplified Employee Statements.** The draft instructions permitted ALEs that use the "Qualifying Offer Method" and the "Qualifying Offer Method Transition Relief for 2015" to provide employees with simplified employee statements, rather than a copy of the Form 1095-C. The final instructions require these statements must also include language directing the employee to IRS Publication 974, Premium Tax Credit (PTC). Simplified statements cannot be provided to employees enrolled in self-insured health coverage. Those employees must instead receive a copy of the Form 1095-C.

## Use of Third Parties to Prepare and File the IRS Forms and Employee Statements

The IRS has stated in its FAQ for Code Section 6055 reporting and FAQ for Code Section 6056 reporting that health coverage providers (*e.g.,* employers that sponsor self-insured group health coverage) and ALE Members may contract with third parties to file and furnish the required IRS returns and employee statements, but plan sponsors should take caution with this approach. The IRS FAQs state that entering into a reporting arrangement with a third party does not transfer a health care provider's reporting liability under Code Section 6055, an ALE Member's reporting liability under Code Section 6056 (except where a governmental unit employer properly designates a related entity to perform its Code Section 6056 reporting), or an ALE Member's potential pay-or-play liability under Code Section 4980H. For Code Section 6056 reporting, the FAQ also explains that, if an ALE Member uses more than one third party to prepare the required IRS returns and employee statements, there must still be only one Code Section 6056 authoritative transmittal (Form 1094-C) reporting aggregate employer-level data for all full-time employees of the ALE Member, and only one employee statement for each full-time employee with respect to employment with that ALE Member.

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Neither the final instructions to the Forms 1094-B and 1095-B nor the final instructions to the Forms 1094-C and 1095-C expand on the IRS FAQ regarding the use of third parties for Code Section 6055 or 6056 reporting. For example, the final instructions do not indicate whether the use of a third-party preparer will affect the content of the IRS returns, or whether a third-party preparer may sign the Form 1094-B transmittal on behalf of the health coverage provider or the Form 1094-C information return on behalf of a reporting ALE Member.

## Penalties for Noncompliance

An entity that fails to comply with the reporting requirements under Code Section 6055 or 6056 (*i.e.,* by filing late, incomplete, or incorrect IRS returns or employee statements) is generally subject to penalties under Code Sections 6721 (incorrect IRS returns) and 6722 (incorrect individual statements) of $100 per failure ($250 for intentional failures), up to $1,500,000 for one calendar year. The IRS has indicated that for the first mandatory year of reporting in 2016, it will not impose such penalties if the reporting entity "can show that they have made good faith efforts to comply with the information reporting requirements," for failures where the entity reported incorrect or incomplete information on the return or statement (*i.e.,* the special 2016 transition relief does not apply to late returns or employee statements). The IRS also noted that entities that fail to timely file and furnish the IRS returns and employee statements may still be eligible for penalty relief if "the IRS determines that the standards for reasonable cause under [Code Section] 6724 are satisfied."

## Next Steps for Plan Sponsors

Because reporting under Code Sections 6055 and 6056 will be required beginning in 2016 (for coverage offered this year), employers and other entities subject to those requirements should familiarize themselves with the reporting instructions and ensure that a system is in place for collecting the data required in the IRS forms and employee statements. If you have any questions, please contact the author of this article or the Trucker ✦ Huss attorney with whom you normally work.

# New Final ACA Rules Regarding Limited Wraparound Coverage as an Excepted Benefit

FREEMAN L. LEVINRAD

On March 18, 2015, the Department of Labor, the Department of the Treasury, and the Department of Health and Human Services (the "Departments") jointly issued final rules (the "Final Rules") amending proposed regulations previously issued under the Affordable Care Act (the "ACA") regarding the inclusion of "limited wraparound coverage" as a new "excepted benefit" under a pilot program, which will require reporting to either the Office of Personnel Management or the Department of Health and Human Services. The Final Rules permit employers and plan sponsors to begin offering limited wraparound group health plan coverage to part-time employees and retirees for the period beginning no earlier than January 1, 2016 and no later than December 31, 2018, and ending on the later of the following:

- Three years after the date wraparound coverage is first offered; or
- If the benefit is collectively bargained, the date on which the last collective bargaining agreement relating to the coverage terminates (determined without

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regard to any extension agreed to after the date the wraparound coverage is first offered).

As such coverage is intended to "wrap around" individual Exchange/Marketplace coverage or Multi-State Plan coverage, the Final Rules permit an individual to qualify for the premium tax credit under Section 36B of the Internal Revenue Code (the "Code") and also have combined coverage that is comparable to employer-provided group health plan coverage.

## Limited Wraparound Coverage Requirements

To be an "excepted benefit", the coverage must: (a) "wrap around" eligible individual insurance coverage that is not a "grandfathered health plan" or a transitional individual health insurance plan (as described in the March 5, 2014 Insurance Standards Bulletin Series — Extension of Transitional Policy through October 1, 2016), and does not consist solely of excepted benefits (*e.g.,* a dental or vision-only coverage policy, or a cancer-only policy), or Multi-State Plan coverage, and (b) satisfy all of the following requirements:

***1. Cover additional benefits.*** The plan must provide meaningful benefits that cover a defined package of services and demonstrate risk-sharing. This means that the plan cannot simply provide benefits under a coordination of benefits provision or an account-based arrangement that reimburses out-of-pocket costs, for example. Under the Final Rules, a wraparound plan may provide the following types of coverage:

- Expanded in-network medical clinics or providers;
- Benefits that are not essential health benefits;
- The cost of prescription drugs not covered by the primary plan;
- Home health coverage; and
- Access to on-site clinics at no cost.

***2. Be limited in amount.*** The annual cost of coverage per employee and covered dependents may not exceed the greater of the maximum annual contribution for health flexible spending accounts ("FSAs") ($2,550 for 2015), or 15% of the primary plan's cost of coverage.

***3. Not be discriminatory.*** The coverage:

- Cannot impose any preexisting condition exclusion;
- Cannot discriminate against any individual with respect to eligibility, benefits, or premiums on the basis of any health factor of the individual (or any dependent of the individual); and
- Cannot discriminate in favor of highly compensated employees (note: all other group health plans offered by the plan sponsor must also satisfy the non-discrimination requirement of Section 2716 of the Public Health Service Act or Section 105(h) of the Code, as applicable).

***4. Eligibility requirements.*** Eligibility must be limited to individuals who are not enrolled in health FSA coverage and are either of the following:

- A part-time employee (and his or her dependents) or a retiree (and his or her dependents) who is eligible for coverage under another group health offered by the employer. This means that an employer may not discontinue offering group coverage to encourage employees to obtain subsidized Exchange/Marketplace coverage. Under the Final Rules, "part-time" employees are employees who are reasonably expected to work less than 30 hours per week at the time of enrollment. To make a determination regarding an employee's part-time status, the Final Rules state that an employer may rely either on the Code Section 4980H definition or any other reasonable interpretation. Furthermore, to the extent that the employer has full-time employees, it must offer them coverage that is substantially similar to coverage that would allow the employer to avoid an employer-shared responsibility assessment under Code Section 4980H(a) (if such provisions were applicable), provides minimum value, and is reasonably expected to be affordable under the safe harbor found in Code Section 4890H; or
- An individual covered under a Multi-State Plan. Wraparound coverage eligibility may be limited to individuals who are covered through a Multi-State Plan authorized under Section 1334 of the ACA. This option requires:
  - Review and approval of the coverage by the United States Office of Personnel Management;

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- Beginning in either the 2013 or 2014 plan year, the employer must have offered its full-time employees coverage that is similar to coverage the employer would have been required to offer to avoid a Section 4980H(a) assessment;
- The employer must have offered a substantial portion of its full-time employees coverage in 2013 or 2014 that provided minimum value and was considered affordable; and
- For the duration of the pilot program, the employer's annual aggregate contributions for both primary and limited wraparound coverage must be substantially the same as the employer's aggregate contributions for coverage offered to full-time employees in 2013 or 2014.

***5. Report coverage.*** Employers would report the wraparound coverage in the form and manner to be prescribed in subsequent guidance to either the Office of Personnel Management (if wraparound coverage is offered in connection with Multi-State Plan coverage) or the Department of Health and Human Services.

## Conclusion

The Final Rules provide welcome guidance to plan sponsors that wish to provide certain groups of employees, particularly part-time employees, with comparable benefits to those offered under the employer's group health plan, but without disqualifying individuals from claiming a premium tax credit on the Exchange. If you have any questions regarding this information, please contact the author of this article.

## FIRM NEWS

On April 16, **Callan Carter** gave a webinar on IRC Section 6055 and 6056 through the EPIC Webinar Series entitled, *ACA Health Coverage Reporting For Employers — Final Forms.*

On May 27, **Callan** will present a webinar for BLR/HR Webinars, entitled, *Incentive-Based Workplace Wellness Programs: Best Practices for HR.*

On April 30, **Kevin Nolt** spoke at the annual CalCPA Foundation's Employee Benefit Plans Annual Audit Conference on audit compliance issues.

On May 5, **Kevin** spoke at the 2015 San Jose Fiduciary Summit on an Ask the Experts local professional panel.

On May 7, **Mary Powell** and **Elizabeth Loh** presented a webinar through the Firm entitled, *Wellness Programs — Overview of Laws Regulating Wellness Programs, Including the Recently Issued Proposed EEOC Regulations!*

The Trucker ✦ Huss *Benefits Report* is published monthly to provide our clients and friends with information on recent legal developments and other current issues in employee benefits. Back issues of *Benefits Report* are posted on the Trucker ✦ Huss web site (www.truckerhuss.com).

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In response to new IRS rules of practice, we inform you that any federal tax information contained in this writing cannot be used for the purpose of avoiding tax-related penalties or promoting, marketing or recommending to another party any tax-related matters in this *Benefits Report*.

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MAY 2015

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