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IRS Issues New Draft Forms and Instructions for ACA-Required Reporting in 2016

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On August 7, 2015, the IRS issued new draft forms and instructions to be used by certain health-coverage providers and employers who are required by the Patient Protection and Affordable Care Act (the "ACA") to report health coverage offered and provided in the prior calendar year on an annual basis beginning 2016 for coverage offered in 2015. These ACA-reporting requirements are contained in Internal Revenue Code ("Code") Section 6055 which applies to providers of "minimum essential coverage" (such as health insurance issuers and sponsors of self-insured group health plans, like multiemployer trusts), and Section 6056 which applies to employers with 50 or more full-time employees, taking into account part-time employees ("applicable large employers" or "ALEs"). Some of the significant changes to the prior versions of the draft forms and instructions (described in more detail below) include:

- Guidance on how ALEs should report offers of COBRA continuation coverage under Code Section 6056;
- An explanation of the newly-increased penalties for ALEs and providers of minimum essential coverage who fail to satisfy their reporting requirements; and
- New guidance for reporting under Code Section 6056 for ALEs who contribute to multi-employer health plans.

See our May 2015 article for a description of the prior versions of the above reporting forms and instructions, which were issued for optional reporting in 2015 (required in 2016) of coverage offered or provided in 2014.

Forms 1094-B/1095-B — Reporting by Providers of Minimum Essential Coverage

Among the newly-issued documents are the draft Form 1095-B ("Health Coverage") and instructions to the Forms 1094-B/1095-B. (The 2015 draft Form 1094-B, a transmittal form for the individual Form 1095-B, was issued in June 2015.) Forms 1094-B and 1095-B are used by providers of minimum essential coverage who are required to report under Section 6055 of the Code on health coverage provided in the prior calendar year, and furnish related statements to covered individuals. The information reported on the Forms 1094-B and 1095-B allows the IRS to determine whether an individual owes a tax penalty for failing to obtain certain health coverage required by the ACA's Individual Shared Responsibility Rules (also referred to as the "Individual

Mandate"). The draft Form 1094-B/1095-B instructions include several substantive changes, such as:

- ***No Reporting Required for Certain Supplemental Coverage.*** Final IRS regulations provide that Code Section 6055 reporting is not required for minimum essential coverage that supplements other minimum essential coverage if: (1) both coverages have the same plan sponsor, (2) the supplemental coverage supplements government-sponsored coverage (*e.g.* Medicare) or (3) for individuals who do not enroll in the supplemental coverage. The draft instructions clarify that coverages do not have the same plan sponsor for purposes of this exception *(i.e.,* separate reporting is required) if those coverages are not reported by the same entity. For example, an employer who maintains an insured group health plan and a self-insured health reimbursement arrangement ("HRA") covering the same employees would trigger two separate Forms 1094-B/1095-B. The insurer would separately report the coverage it provides, while the employer would be required to report the coverage provided through the HRA.

- ***Reporting Coverage of Non-Full-Time Employees.*** The draft instructions provide that ALEs who sponsor self-insured health plans (and therefore are required to report under both Code Sections 6055 and 6056) may report coverage of individuals who are not full-time employees during any month of the year using either the Form 1095-B or Part III of the Form 1095-C. The prior version of the instructions required those ALEs to report non-full-time employees on Part III of Form 1095-C. However, we note that the draft instructions for Forms 1094-C/1095-C, perhaps unintentionally, have not been updated to include the same flexibility.

Forms 1094-C/1095-C — Reporting by ALEs

The newly-issued documents also include the draft Form 1095-C ("Employer-Provided Health Insurance Offer and Coverage") and instructions to the Forms 1094-C/1095-C. (The 2015 draft Form 1094-C, a transmittal form for the individual Forms 1095-C, was issued in June 2015.) Forms 1094-C and 1095-C are used by ALEs who are required under Section 6056 of the Code to report on the coverage offered to full-time employees in the prior calendar year. ALEs who sponsor self-insured health plans (considered providers of minimum essential coverage) will also use the Form 1095-C (Part III) to report the information required by Code Section 6055, rather than using the Form 1095-B. The information reported by an ALE allows the IRS to determine: (1) whether the ALE offered certain health coverage to its full time employees and the extent to which the ALE may be subject to any tax penalties under the ACA's Employer Shared Responsibility Rules contained in Code Section 4980H (also referred to as the "Employer Mandate" of the "Pay-or-Play Rules"); and (2) whether any of the ALE's employees are eligible for a premium tax credit to use in purchasing individual coverage on the health insurance exchanges. Substantive changes to the prior instructions include:

- ***Clarification of the 98% Offer Method (Form 1094-C).*** The 98% Offer Method allows an "ALE Member" (a single entity that is an ALE, or an entity that is part of a controlled group that is determined to be an ALE) to use simplified reporting on the Form 1094-C (the employer is not required to complete the "Full-Time Employee Count" in Part III, column (b)) if the employer satisfies certain requirements. In a welcome clarification, the draft instructions

finally address how employees in a Limited Non-Assessment Period should be treated to determine if this reporting method is even available. The instructions state that employees in a Limited Non-Assessment Period need not be taken into account for the employer to take advantage of the 98% Offer Method, provided the employer certifies that it offered, affordable health coverage providing minimum value to at least 98% of its employees for whom it is filing a Form 1095-C employee statement, and offered minimum essential coverage to those employees' dependents. A Limited Non-Assessment Period is a period during which an ALE Member is not to be subject to a Code Section 4980H penalty for a full-time employee, regardless of whether that employee is offered health coverage during that period.

- ***Clarifications for Employers Contributing to Multiemployer Plans (Form 1095-C).*** Certain employers who contribute to multiemployer plans may use the "multiemployer interim rule relief" for purposes of determining Code Section 4980H penalties and reporting 2015 offers of coverage on the Form 1095-C. The multiemployer interim rule relief provides that an ALE is treated as offering health coverage to an employee if the employer is required by a collective bargaining agreement to make contributions for that employee to a multiemployer plan that offers, to individuals who satisfy the plan's eligibility conditions, health coverage that satisfies the affordability and minimum value standards (and offers at least minimum essential coverage to those individuals' dependents). To claim this relief with respect to an employee, the draft instructions clarify that an employer may enter Code 1H (no offer of coverage) on line 14 for any month for which the employer enters Code 2E on line 16 (indicating that the employer is eligible for multiemployer interim rule relief for that month). The draft instructions further provide that Code 1H may be entered without regard to whether the employee was eligible to enroll in coverage under the multiemployer plan. While the clarifications are welcome to employers for returns due in 2016, the draft instructions state that for coverage offered through multiemployer plans in 2016 (and reported in 2017) and future years, the manner of required reporting may be different.

- ***Offers of COBRA Coverage (Form 1095-C).*** According to the draft instructions, an employer should report an offer of COBRA coverage to a former employee upon termination of employment as an offer of coverage using the appropriate indicator code on line 14 *only if* the former employee enrolls in the coverage. If the former employee does not enroll in the coverage, the employer should instead enter code 1H on line 14 (no offer of coverage). Last, the draft instructions require employers to report an offer of COBRA coverage to an active employee (*e.g.*, because of a reduction in hours) in the same manner and using the same code as an offer of that type of coverage to any other active employee.

- ***Determining Monthly Cost to Employee (Form 1095-C).*** For purposes of reporting the employee's monthly share of the lowest cost self-only coverage that provides minimum value (used to determine whether the employer offered the employee affordable coverage), the draft instructions provide that an employer may divide the total employee share of the premium for the plan year by the of months in the plan year.

- ***Form 1095-C Formatting Changes.*** The draft instructions note that the Form 1095-C was revised to include a first month of the plan year indicator (plan start month) in Part

II (optional for 2015) and a Part III "Covered Individuals Continuation Sheet" (required if the entity is reporting more than six covered individuals in Part III of the Form 1095-C).

Clarifications and Additional Information Regarding the Filing Process (Both Instructions)

Both the instructions to the Forms 1094-B/1095-B and Forms 1094-C/1095-C include the following changes to the processes for filing the forms with the IRS and furnishing individual statements:

- ***Substitute Statements.*** Code Sections 6055 and 6056 also require the reporting entity to furnish a copy of the reporting form to the "responsible individual" (health-coverage provider) or full-time employee (ALE), or provide a "substitute statement." Both draft instructions include a reference to IRS Publication 5223 (currently under development) which contains detailed guidelines on the preparation and use of substitute statements.

- ***Individual Statements Regarding Coverage Provided Under Expatriate Health Plans.*** Generally, the individual statements may not be furnished electronically without consent. However, consistent with Notice 2015-43, the draft instructions provide that individual statements regarding coverage under an expatriate health plan may generally be furnished electronically without affirmative consent, unless the recipient affirmatively refuses consent or requests a paper statement.

- ***Extensions for Filing the Required Forms and Furnishing Individual Statements.*** The first due date for filing the reporting forms with the IRS is February 29, 2016 (March 31, 2016 if filing electronically). The draft instructions, however, explain that reporting entities can obtain an automatic 30-day extension of the filing deadline by submitting a Form 8809 ("Application for Extension of Time To File Information Returns") to the IRS on or before the due date. Similarly, for furnishing individual statements (first due by February 1, 2016), both draft instructions provide that the responsible entity may seek an extension of up to 30-days by sending a written request (not the Form 8809) to the IRS' Information Returns Branch that is postmarked prior to the original due date.

- ***Electronic Reporting; Waivers.*** Generally, reporting entities who are required to file more than 250 of a particular form annually (e.g., the Form 1095-C) must do so electronically. The draft instructions indicate that IRS Publication 5165 specifies the communication procedures, transmission formats, business rules, and validation procedures for returns filed electronically for calendar year 2015 through the Affordable Care Act Information Returns ("AIR") system. The draft instructions also provide that a reporting entity may seek a waiver of the electronic-filing requirement by submitting a Form 8508 ("Request for Waiver From Filing Information Returns Electronically") at least 45-days before the due date of the form.

- ***Penalties.*** The draft instructions describe the penalties for entities that fail to properly complete, timely file or furnish the reporting forms or individual statements. Effective

January 31, 2015, a reporting entity (for example, an ALE with respect to the Forms 1094-C and 1095-C), may be subject to a $250 per failure (previously $100) penalty, subject a calendar-year maximum of $3,000,000 (previously $1,500,000). The draft instructions also provide that consistent with prior sets of FAQs on Code Sections 6055 and 6056, the IRS will not impose penalties for reporting incorrect or incomplete information if the filer can show that it made good faith efforts to comply with the information reporting requirements. No relief is available, however, for reporting entities that fail to timely file or furnish the required returns or individual statements.

- ***Correcting Returns and Individual Statements.*** The draft instructions provide guidance on correcting forms filed with the IRS and individual statements, including charts containing examples of errors and the applicable corrections.

DOL Claims Procedures Require Certain Key Elements in Benefit Determination Notifications

In ERISA section 503, Congress granted the U.S. Department of Labor ("DOL") the authority to create regulations that set forth procedures for determining benefit claims and to afford claimants an internal right of appeal. The claims regulations promulgated by the DOL under ERISA section 503 require, among other things, that a plan administrator who denies a request for benefits to set forth in the initial claim denial a "description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimants' right to bring a civil action . . ." 29 C.F.R. § 2560.503-1(g)(1)(iv).

Plans Can Specify a Deadline by which a Lawsuit for Recovery of Benefits Must Commence

ERISA does not provide a statute of limitations for lawsuits brought under section 502(a)(1)(B) of ERISA to recover benefits. The only statute of limitations contained in ERISA (ERISA section 413) is for a breach of fiduciary duty claim. In light of ERISA's silence on a limitations period for benefits claims, courts borrow the most closely analogous state statute of limitations — typically a breach of written contract statute of limitations — and apply that to the action for benefits. Plans can choose to specify a different limitations period, and often specify a shorter limitations period than the analogous state statute of limitations. The U.S. Supreme Court in *Heimeshoff v. Hartford Life & Accident Insurance Co.*, 134 S.Ct. 604 (2013), upheld a limitations period contained in a plan document where the limitations period is not unreasonably short and no controlling statute prevented the limitations provision from taking effect.

The District Court Held Mirza's Benefits Lawsuit Was Time-Barred

In *Mirza*, the federal district court for the District of New Jersey upheld the plan document's 12 month limitations period, finding that the plan administrator did not violate ERISA section 503 or the DOL's claims regulations for not including the plan-imposed deadline to seek judicial review in the benefit denial letters. (The Third Circuit ultimately disagreed.)

Dr. Neville Mirza was a medical provider who treated N.G. and to whom N.G. assigned the right to pursue a benefit claim from the health plan in which N.G. participated. Mirza brought an action to recover payment of the denied $34,500 benefit claim from Insurance Administrator of America, Inc. ("IAA") (the plan's claims administrator) and Challenge Printing Company of the Carolinas, Inc. ("Challenge") (the plan sponsor).

The Challenge plan provided that "no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered)." Mirza submitted a claim for medical services to IAA for payment under the Plan for services provided to N.G. IAA denied the claim, and Mirza subsequently appealed that denial through two levels of appeal. On August 12, 2010, IAA sent Mirza a final written determination denying his claim and advising him that he had a right to bring a civil action under ERISA section 502(a). None of IAA's written determinations of the benefit claim or appeal stated that, under the Plan, the claimant had only 12 months to bring a civil action under ERISA section 502(a), despite the appeal denial letter's statement that the claimant had a right to bring a civil action under Section 502(a). Mirza engaged The Law Office of Sean R. Callagy (the "Callagy Firm") sometime between the final appeal denial letter in August 2010 and February 10, 2011.

Around the same time that Mirza had submitted a claim and appeal, IAA also handled a separate appeal from another provider, Spine Orthopedics Sports ("SOS"), for the same Plan participant, N.G., and the same Plan. The Callagy Firm (which represented Mirza) represented SOS during the appeal process. During the course of SOS's pursuit of a claim and an appeal, on November 23, 2010 (some 3 months after Mirza received a final determination on his appeal from IAA), IAA advised a member of the Callagy Firm that the Plan had a one year contractual statute of limitations to initiate a civil action. IAA finally denied SOS's appeal on April 11, 2011 and provided a copy of the Plan with the denial letter.

The Callagy Firm on behalf of Mirza commenced a lawsuit stemming from the denial of benefits under the Plan on March 8, 2012. IAA and Challenge moved for summary judgment on the grounds that Mirza's action was time-barred by the Plan's 12 month statute of limitations.

The district court held that the 12 month time limit specified in the plan was not manifestly unreasonably and was therefore enforceable. The district court rejected Mirza's argument that IAA's failure to advise Mirza of the plan's deadline for claimants to seek judicial review in the final denial letter equitably tolled the plan's time limitation.

The Third Circuit Holds that the DOL Claims Regulations Require Written Disclosure of Plan-Imposed Time Limits on the Right to Bring a Civil Action

On appeal, the Third Circuit reversed and remanded the decision by the district court. The Third Circuit held that plan administrators must inform claimants of plan-imposed deadlines for judicial review in their benefit denial letters. Where the plan administrator fails to do so, the Third Circuit held that a court should set aside the plan's time limit and apply the limitations period from the most analogous state-law cause of action. Applying New Jersey's six year statute of

limitations for breach of contract claims, the Third Circuit held that Mirza filed his complaint within the statutory limitations period.

Unlike the district court, the Third Circuit focused its analysis not on equitable tolling but instead on whether defendants violated the DOL claims regulations in failing to including the plan's 12 month time limit for seeking judicial review in the benefit denial letter. The relevant regulatory provision at 29 C.F.R. § 2560.503-1(g)(1)(iv) requires that an administrator set forth a "description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination." IAA and Challenge argued that the regulatory provision refers to two separate requirements — (1) notice of the plan's review procedures and the time limits for those procedures and (2) notice of the right to sue. The Third Circuit disagreed with the defendants' view, finding that the defendants' arguments ignored the word "including." To the extent the regulatory provision was ambiguous, the Third Circuit held that it was obligated to construe it broadly and in favor of Mirza "because ERISA is a remedial statute."

In holding that the defendants had violated the regulatory provision, the Third Circuit noted that its interpretation of the regulation was consistent with that of the First and Sixth Circuit Courts of Appeals in *Ortega Candelaria v. Orthobiologics LLC*, 661 F.3d 675 (1st Cir. 2011) and *Moyer v. Metro. Life Ins. Co.*, 762 F.3d 503 (6th Cir. 2014). Both the First and Sixth Circuit held that the regulation included the right to bring a civil action as part of the procedures for which time limits must be provided. The Third Circuit distinguished the rulings that upheld plan-imposed limitations periods even though the denial letters did not include notification of the limitations period in Second and Ninth Circuit Courts of Appeal in *Heimeshoff v. Hartford Life & Accident Ins. Co.*, 496 F. App'x 129 (2d Cir. 2012), and *Scharff v. Raytheon Co. Short Term Disability Plan*, 581 F.3d 899 (9th Cir. 2009), on the basis that those other Circuit court decisions were decided under federal common law and the court did not interpret the DOL claims regulations. The Third Circuit noted that in *Scharff*, the plaintiff did not rely on the language of the DOL claims regulations to argue that defendant's failure to disclose the plan's contractual limitations period in a denial letter violated a regulatory requirement and instead argued that the defendant violated the doctrine of "reasonable expectations" under federal common law. The Ninth Circuit held that the defendant's disclosures in other documents were sufficient to not run afoul of the reasonable expectations doctrine. In *Heimeshoff*, which was later appealed to the Supreme Court, the Second Circuit chose not to base its decision on the DOL claims regulations and instead held that the plaintiff in that case had notice of the limitation and was therefore not entitled to equitable tolling.

The Third Circuit pointed out certain practical considerations for its interpretation of the regulation. First, it felt that if defendants were not required to disclose a plan-imposed time limit for seeking judicial review of a denied benefit claim, plan administrators could bury the limitation period in a lengthy plan document and not have any obligation to disclose it in a significantly shorter claim denial letter that the participant was more likely to read. The Third Circuit also believed that by not including a statute of limitations in ERISA for benefit claims, Congress delegated the authority to plan administrators and fiduciaries to develop their own deadlines for judicial review and the DOL thought it important to ensure that benefit denial letters informed claimants of deadlines for judicial review in the benefit denial letters. It felt that the requirement to inform claimants of the plan-imposed time limit to bring a lawsuit imposed but a "trivial burden" on plan administrators. The Third

Circuit held, following the Sixth Circuit's decision in *Moyer*, that failure to so inform claimants renders the adverse benefit determination not in substantial compliance with ERISA section 503.

The Third Circuit found no need to apply equitable tolling and found no need to reach the issue of whether Mirza, through his law firm's work on another provider's claim, was on notice of the plan's contractual limitations period. It felt that if court allowed plan administrators argue that claimants were on notice of the contractual limitations period or otherwise failed to exercise reasonable diligence, plan administrators would have no reason to comply with the DOL claims regulations which the Third Circuit believed required disclosure of the plan-imposed deadline in the adverse benefit determination. The Third Circuit held that the proper remedy was to set aside the plan's 12 month limitations period for filing a lawsuit and to instead apply New Jersey's six-year breach of contract statute of limitations. It reversed the district court's decision and remanded the case back to the district court for further proceedings.

Circuit Split

The Third Circuit's opinion deepens a split among the federal courts of appeals on the disclosure question. The Third Circuit agreed with the federal Courts of Appeals for the First and Sixth Circuits that plan administrators must inform participants of any plan-imposed deadline for bringing a civil action under ERISA section 502 in the benefit denial letters. The Ninth Circuit in *Scharff* and Eleventh Circuit in *Wilson v. Standard Insurance Co.*, 2015 WL 3477864 (11th Cir. June 3, 2015), have previously ruled the other way. In the face of disagreement among the federal courts of appeals, the issue may be one that the Supreme Court will eventually choose to decide.

Best Practice

Many plans have their own contractual limitations period for suing on a denied benefit claim, especially after the Supreme Court's ruling in *Heimeshoff* upheld the enforceability of plan-imposed deadlines to request judicial review. The contractual limitations periods often are shorter than the analogous state statute of limitations that courts would apply to an ERISA benefits claim, and in that way, the contractual limitations periods provide earlier closure to disputes over benefits and thereby added security to plan administrators and plan sponsors. For those plans that have limitations periods for judicial review written into the plan document, we think the Third Circuit ruling offers an opportunity to further protect plan fiduciaries by improving the content of benefit denial letters — even those plan fiduciaries that are in jurisdictions outside of the Third Circuit. Although the courts of appeals disagree as to whether the DOL claims regulations require disclosure of a plan's contractual limitations period, we think that the best practice — the safest practice — is for plan administrators to disclose any plan-imposed deadlines in the benefit claims and appeal denial letters.

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